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“FEELING MORE SELF-CONFIDENT, CHEERFUL AND SAFE”. EXPERIENCES FROM A HEALTH-PROMOTING INTERVENTION IN COMMUNITY DWELLING OLDER ADULTS – A QUALITATIVE STUDY.

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Abstract

Objectives: Studies show that regular exercise in combination with nutritional support can be effective in managing sarcopenia, which is age-related involuntary loss of skeletal muscle mass and strength. Qualitative investigations of participants’ experiences from interventions in this domain are scarce. In this study, we explored older persons’ experiences from an intervention designed to prevent sarcopenia, with the aim of capturing the participants’ thoughts and opinions.

Design: A qualitative study embedded in the multicenter randomized clinical trial The Vitality and Vigor in the Elderly study, VIVE2. Focus group interviews were conducted. Manifest and latent content analyses were performed.

Participants: Community dwelling older adults (n=20) 71–86 years of age with minor limitations in mobility.

Results: The experiences from the intervention were categorized and interpreted in one overall theme “Feeling more self-confident, cheerful and safe”. The theme encompasses the categories psychological effects of participating in the intervention, physical effects of participating in the intervention, the importance of social support and the importance of a tailored set-up. The

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Conflicts of interest: All authors state that they have no conflicts of interest.

Ethical considerations: All participants were provided with written and oral information about the study and all signed an informed consent form prior to their participation in the focus group interviews. This part of the VIVE2 study was approved by the Regional Ethical Review Board of Medical sciences in Uppsala (Reg. no. 2012/154).

participants described their motives for participating in the intervention as being based on concerns regarding the negative health effects of continuing a sedentary lifestyle, difficulties of getting started on their own and lack of confidence in accomplishing change on their own. Participants also expressed that one main objective for participating was to lose weight.

Conclusion: In this study we have captured the experiences of older adults with minor mobility limitations who participated in a lifestyle intervention. The experiences are interpreted in one overall theme “Feeling more self-confident, cheerful and safe”. The central understanding of the participants’ experiences was that the intervention affected them in several ways, both psychologically and physically, and that supporting factors included the social support, which became a prerequisite for success. A noticeable finding was the discrepancy between the motive of the participants, to lose weight, and the aim of the study, to improve muscle function. The expectation to lose weight seems to reflect what is commonly known as to be healthy. To our knowledge, at least in Sweden, there are no campaigns or public information highlighting the risks of sarcopenia and the complex issue of if, and when weight loss is desirable for older individuals. This finding highlights the importance of providing such information to this target group. The findings in this study provide valuable knowledge for research teams, practitioners and decision makers when designing and setting objectives for health-promoting interventions for older individuals.

Keywords

Older adults; health-promoting intervention; qualitative; nutrition; exercise

Background

Since population ageing is increasing globally, it is of great importance to find interventions that can help older adults age healthily, preserve physical function and muscle mass, and enable independent living (1). Worldwide, however, about 30% of people aged between 70 and 79 years old and 50% of people over 80 years old do not meet basic WHO guidelines for physical activity in older age (2).

In older adults, involuntary loss of skeletal muscle mass and strength, i.e. sarcopenia (3), is associated with an increased risk of falls and fractures, reduced quality of life, functional decline, impaired ability to manage daily activities and increased mortality (3–6). Several studies have shown that sarcopenia is highly prevalent among elderly persons, with estimates of prevalence up to 29% in western countries (7, 8). It is therefore of growing interest to find interventions that can prevent sarcopenia in older adults. Earlier studies have shown that regular exercise can be effective in preventing and managing sarcopenia and that nutritional status and nutritional factors could be of importance (9, 10). There is, however, still lack of evidence concerning the synergistic effects of exercise and nutrition. The designs of intervention studies in this domain differ in terms of population, type of exercise and type of nutritional component studied, and consequently the results are inconsistent (9). Furthermore, qualitative investigations of participants’ experiences from interventions in this domain are scarce, especially evaluations of studies combining exercise programs with nutritional interventions.

A recent review and meta-synthesis of how older adults experienced physical activity interventions pointed out the importance of focusing on physical activity as being fun and enjoyable, sociable, and including relevant short-term benefits (11). In another review concerning facilitators and barriers for physical activity in older age, the authors concluded that, besides enjoyment, one predictor of physical activity for older adults is the degree of self-efficacy (12). Self-efficacy, according to Albert Bandura, can be defined as a person's belief in their capability to perform, for example, physical activity (13). Other important strategies for enhancing physical activity among older people have been defined in qualitative studies, such as raising awareness of the benefits of physical activities and improving environmental access to physical activity opportunities (14).

The present qualitative study was embedded in the multicenter randomized clinical trial: The Vitality and Vigor in the Elderly study (VIVE2). The study was designed to find an efficient intervention that combined regular exercise with a nutritional supplement to prevent sarcopenia (15). By adding a qualitative approach to the evaluation of this intervention, increased knowledge not captured by quantitative methods could be obtained. In this sub-study, we aimed to explore older persons' experiences of an intervention designed to prevent sarcopenia, with the aim of capturing the participants' thoughts and opinions.

Methods

The intervention prior to the present study

In total, 149 subjects were enrolled in the VIVE2 study, 86 in Boston, USA and 63 in Stockholm, Sweden. The intervention consisted of supervised group exercise sessions, three times a week for six months. The sessions included both aerobic and strength training exercises, and were led by physiotherapists. The participants were also encouraged to perform physical activity in their daily life between sessions. Besides the exercise program, the participants were randomized to receive either a daily nutritional supplement or a placebo. The supplement was an oral sip feed providing 150 kcal, high amounts of whey protein (20 g), and high levels of vitamin D (800 IU). A complete description of the VIVE2 study protocol is published elsewhere (15).

Sampling and recruitment

VIVE2 was a multicenter study and at the Swedish study site it was decided to include a qualitative evaluation in addition to the quantitative secondary outcomes. This qualitative sub-study was only conducted at the Swedish site due to pragmatic reasons. The participants were recruited through purposeful sampling, a technique widely used in qualitative research for the selection of information-rich cases (16). During March 2014, participants from the VIVE2 intervention were asked by mail to participate in focus group interviews. The participants in the VIVE2 intervention were older adults (>70 years of age), not physically active (< 20 minutes of physical activity per week) and with minor limitations in mobility.

Focus group interviews were conducted two to four weeks after the participants had completed the six-month intervention. By this time, 23 individuals had completed the intervention and 22 of them were invited to take part in the present study. In addition to

having completed the entire intervention, other inclusion criteria were a willingness to participate and the ability to speak Swedish fluently. Two potential participants rejected participation, one due to health reasons and one for undefined reasons. One was not invited to participate due to not speaking Swedish fluently. When the focus group interviews were conducted, it was not known whether a participant had received the nutritional supplement or the placebo. Table 1 contains further information about the participants.

Data collection

Focus group interviews were conducted; this is a method that collects data through group interaction and a technique that is well-motivated when the participants share a common experience (17). In this case, the researchers are able to get a broad variety of opinions and thoughts from the participants (17, 18). The qualitative data that is collected can make quantitative data more understandable and interpretable (19).

Interviews were performed between May and September 2014. In total, four focus group interviews were conducted, each lasting between 60 and 90 minutes. Each group contained four to eight men and women, giving a total of 20 participants.

The focus groups were led by a moderator (ÅvB, first author, registered dietitian). An observer (MS, last author, trained nutritionist, PhD) was also present and took notes and operated the tape-recording devices. The moderator had been involved in the intervention at the baseline visit and at the two follow-up visits. The observer was well-versed in the study design but was not part of the VIVE2 research team and had not met the participants before the focus group interviews. The focus groups were conducted at the rehabilitation clinic where the intervention took place, a location that was familiar to the participants.

A semi-structured interview guide including open-ended questions was used, which had been developed by the researcher and reviewed and revised by the co-authors (Table 2). The participants were encouraged to speak freely about their experiences of participating in the intervention. As the participants shared their experiences, probing questions were used to obtain more in-depth information about their thoughts and opinions. At the end of each focus group the moderator and the observer shortly summarized key-points from the discussion to ensure agreement in the group about what had been discussed and the participants could then verify and/or clarify these points. After each focus group the moderator and the observer also debriefed the session together with the aim of clarifying their initial thoughts about the material.

The interviews were tape recorded and, thereafter, transcribed verbatim by the first author. After four focus group interviews, the moderator and the observer agreed that no new material was derived from the discussion and that the thoughts and opinions of the participants' experiences had been covered.

Analysis of data

Content analysis (CA) was chosen to analyse the data. CA is a dynamic form of analysis of verbal data orienting towards summarizing the content of the data. Content analysis can be applicable at various depths, and it focuses on differences and similarities in the data (20).

The content analysis in this study was inductive and based on the methodological approach described by Graneheim and Lundman (21).

The analysis was performed in several steps. First, the transcribed material was read through several times to get a sense of the data. Subsequently, meaning units were identified and condensed. The analysis software Opencode was used in this part of the process (22). Meaning units were then coded, the codes were allocated to subcategories and the subcategories were then divided into categories that constituted the manifest content. The categories were reflected upon and discussed and one theme, mirroring the underlying meaning across the categories, was defined. The analysis process involved going back and forth between the steps to make sure that the content was correctly understood. Manifest and latent content analyses were performed. The concepts of credibility, dependability and transferability were taken into account throughout the analysis process to support trustworthiness (21). The first and the last author collaborated through the whole analysis process and part of the research team was involved in finalizing the analysis to ensure credibility. The aims of these discussions were to strengthen trustworthiness and promote analytical rigor. Under each of the categories, direct quotations were used to illustrate the participants' experiences associated with each subcategory as expressed in their own words. The method of analysis was judged appropriate to the aim of the study. The analysis was performed in Swedish and the results translated into English.

Results

The participants in the focus groups (n=20) had a mean age of 77.5 years, nine were married and eleven lived alone. Eight of them had a post-secondary education, twelve of them had been professional employees before retirement and four had been self-employed. Their mean BMI was 26.5 and only one participant was a daily smoker (Table 1).

At the beginning of each focus group, the participants were asked about their reasons for wanting to participate in the intervention. The primary motive they stated for participating was a concern about the negative health effects of a sedentary lifestyle. Other reasons described by the participants were difficulties in getting started with exercise on their own and lack of confidence in accomplishing it on their own. Several participants also expressed that their main objective for participating was to lose weight by becoming more physically active. Other motives mentioned in the groups were receiving a doctor's examination and being "monitored".

"Feeling more self-confident, cheerful and safe"

The experiences from the intervention were categorized and interpreted in one overall theme "Feeling more self-confident, cheerful and safe". The theme encompasses four categories: psychological effects of participating in the intervention, physical effects of participating in the intervention, the importance of social support and the importance of a tailored set-up. The first two categories describe experienced effects and the latter supporting factors. The theme, categories and subcategories are shown in Table 3.

Psychological effects of participating in the intervention

This category encapsulates four sub-categories. One important psychological consequence described by the participants was a stronger motivation and awareness of the need for physical activity, which included a stronger motivation even “outside” of the intervention. The participants reported an increased awareness of the importance of physical activity for remaining healthy and independent.

“Now I’ve started to take the stairs at home too, I’ve used the elevator for fifty years”
(Female 86 years, group 2)

Their awareness also included feelings of having a guilty conscience when not being physically active in everyday life.

“The times you really rest, feeling a sense of harmony, are after an exercise session. Then you don’t have a guilty conscience, which you would have if you had rested and not done anything ...” (Male 85 years, group 1)

They also reported a greater confidence in their own ability to change their behavior.

“You now know that the possibility exists, the possibility to change, and even if you cannot change so much right now, “I have the possibility, I know these movements”” (Female 78 years, group 1)

Another subcategory within the category of psychological effects was positive effects on frame of mind. This included feelings of optimism, which were described as producing a ripple effect on their everyday life and resulting, for example, in an increased interest in the outside world.

“I have become more interested in the outside world. Before I kind of switched off and I didn’t know so much, but now it’s fun to find out about things and now I have a computer that I am going to learn to use and get going with and have in front of me, and it feels great now. Previously I thought “no that’s nothing for me”, like that, “it’s to do with age” a bit like well I thought nah,” I’m so old ...” (Female 86 years, group 2)

For some, participation enabled them to appreciate the possibilities for continuing to be physically active and they outlined strategies to help them succeed (subcategory strategies for continued physical activity).

“I will do it (the exercises) at the outdoor gym that we have at the campsite where I live. There they have these kinds of sticks ... frames and stuff, which are very good ...” (Male 85 years, group 2)

While part of the group expressed distinct strategies to continue being physically active after the intervention, others focused on barriers and expressed an absence of strategies, and worry about managing to be physically active on their own.

“It is quite frightening that I quit (doing the exercise) so soon afterwards; it scares me a bit, what should I do to continue?” (Female 75 years, group 2)

Physical effects of participating in the intervention

The majority of participants experienced positive physical changes as a result of the intervention, although some of them also expressed negative side effects from the exercises, which is why this category includes the subcategories positive and negative physical effects. Among the positive physical changes were improved walking pace, increased activity level and vigor, and greater strength and balance.

“When I participated here, I started to be able to go down the stairs to the subway and commuter trains without holding on to something... yes, going up I had no problems but down I didn’t dare to go at all, not without having my hand on something (shows how he was holding the railing), but now I can” (Male 73 years, group 1)

Some of the participants also lost weight and they expressed positive views regarding this.

“I have lost some weight as well, not so much, but anyway. I am more on the ball now” (Male 80 years, group 4)

The negative consequences included knee pain, tiredness, and impaired mobility.

“Well, it has been both good and bad for the knees and back sometimes, partly when I stand with weights and lift them but then it’s almost as if my left leg gives way sometimes, but I’ve managed anyway” (Male 76 years, group 3)

The importance of social support

During the focus group interviews, the participants described how they perceived the intervention as having an effect on them in several ways, and the majority described the social support from the group as being a significant supporting factor. The participants emphasized the group as being a prerequisite for completing the intervention, for going to the sessions and doing the exercises (subcategory support as a prerequisite).

“...and it’s this tiredness that I suffer from, it is just like pulling down a window blind. I don’t have the energy to do anything so I go to bed, but then I thought “I must go there, I have to go there” and I started walking in the corridors and like, and I think it is important to meet nice people to talk to and laugh with....So many people who really did not have the energy to go they just came to meet the group and were so happy when they left” (Female 71 years, group 3)

Many described being in a group with individuals of a similar age and with similar problems as important. This support was also described as a bonus, something they had not counted on when agreeing to participate (subcategory support as a prerequisite).

“So, it’s okay, my purpose was specifically to improve or get a little more knowledge of what is going on with my body and with my muscles, that’s what I was focused on. But then of course you met other people, who maybe have the same or similar problems, and then it’s there, the social aspect...” (Male 71 years, group 4)

Being part of a group with a cheerful atmosphere was appreciated by many (subcategory Cheerful atmosphere in the group).

“Ah yes but then everything was like, what should I say everyone were nice, it was great fun” (Female 80 years, group 4)

The importance of a tailored set-up

The fourth category includes thoughts and opinions about the set-up, central for how the intervention was experienced. This includes the subcategory professional support. Many participants reflected on the importance of the physiotherapists leading the exercise sessions being qualified, supportive of the participants, noticing everyone and helping to explain the different exercises and the reasons for performing them.

“...Then it was the leadership that was very important, and then the consistency; we were expected to be consistent with our exercise three times a week. Something that maybe most of us have some difficulties with because we are very relaxed, we don't want anyone to give us orders and say “you should do this and that”. Then we began to discover that it was a bit uncomfortable when the leaders demanded that we did it properly and they almost nagged us when we did it the wrong way so we got a bit annoyed actually, but they were right! We were actually supposed to do things the correct way, so...it was very positive having qualified leaders” (Male 71 years, group 4)

Some of the participants thought that the leaders should have been even more explicit concerning the reasons behind some of the movements the group performed.

“I think the motives are very important and I therefore made comments about this all the time, and I have told them (the leaders), WHY do we do these exercises?” (Male 85 years, group 2)

Meeting qualified leaders was associated with feeling safe, “being in the hands” of healthcare professionals.

“Yes, they (the leaders) explained HOW to perform the exercises to get results...she (the leader) was quite good at seeing if you happened to make mistakes and that made me feel safe..” (Male 76 years, group 3)

The participants had opinions about the schedule, the type of exercises and locality. They did not appreciate exercising several days in a row but wanted the sessions to be distributed over the week. They highlighted the importance of exercises tailored for older peoples' conditions and that the exercise room should be spacious and well-ventilated. The location and accessibility of the rehabilitation clinic was also very important.

“I think we should have been offered exercise four times a week instead of three, given that it is a long time between Thursday and Monday...” (Male 85 years, group 1)

“Shouldn't we exercise the upper part of the body as well, I know many in our group asked this, it was very concentrated on the legs and so on...” (Female 72 years, group 2)

“For me it was very important that the bus to get here stops outside my house ...since I still had difficulty walking then when I started...” (Female 71 years, group 2)

Comments on the nutritional supplement

Although this intervention combined exercise sessions with a daily nutritional supplement, almost none of the participants in the focus groups broached the topic of how they experienced the supplement, and none of them continued the discussion when the moderator mentioned the supplement in follow-up questions. The material from the interviews contained only a few individual comments on the distribution of drinks.

Discussion

This study presents insights into how mobility-limited community-dwelling older adults at risk of sarcopenia experience a lifestyle intervention. The main findings include the theme Feeling more self-confident, cheerful and safe which encapsulates how the participants experienced taking part in this intervention and how it affected them in several ways and resulted in a ripple effect on their daily lives. The result also reflects the social support as a prerequisite to success and the tailored set-up, including the professional support, as factors essential to consider when designing tailored interventions for this group of older adults.

A noticeable finding in this study was that a main motive for participating in the intervention, besides increasing physical activity, was to lose weight. The main objective of the VIVE2 intervention was to investigate whether a nutritional supplement could enhance the effect of physical exercise in a group of older adults at risk of sarcopenia. Although enhancing performance and keeping muscle mass was the aim of the VIVE2 intervention, many of the participants signed up with the, in some ways, contradictory motive of hoping to lose weight.

It is interesting to discuss the meaning of this result. Studies have shown that older individuals often strive towards a lower weight even though their weight falls within the “healthy” range category, and evidence indicates that overweight (BMI 25–30 kg/m²) is not actually a risk factor for older adults (23–25). As concluded in the literature concerning obesity in older individuals, there are both benefits and risks associated with weight loss for older individuals and the emphasis should be on maintaining muscle mass rather than weight loss (26). Although most of the research on body image focuses on younger people, the evidence shows that dissatisfaction with body image also exists among older individuals. However, older individuals focus more on body function than appearance and socio-economic, racial and gender factors play a role (27, 28). It is difficult to ignore the fact that, in our modern society, slenderness is often associated with health, happiness, youthfulness and social acceptability. This result could be interpreted as an indication that weight loss was the outcome that some of the participants of this intervention expected and aimed for or as an expression of social desirability. In an attempt to theorize the relationship of class, health and lifestyle, Simon J. Williams points at how Bourdieu’s theories can be useful in discussions about health-related behaviors (29). In Bourdieu’s theories, health-related behaviors are described as accomplished unthinkingly, based on our “habitus”, our “structuring structure” which is formed in the context of our social location. Williams uses

this theory to emphasize the importance of not seeing health-related behaviors solely as personal choices, and to question whether responses to questions about what motivates people to perform certain health-related behaviors are in fact after-constructions and justifications of behavior, rather than descriptions of them. Nevertheless, this discrepancy between the aim of the VIVE2 study and the expressed motives of the participants is an important finding for research teams and practitioners to take into consideration when working with this target group of older individuals.

The results of this study were interpreted in one overall theme Feeling more self-confident, cheerful and safe encompassing both experienced effects and supporting factors. The result can be discussed in the light of Bandura's Social cognitive theory (13). This theory has often been used when discussing older peoples' engagement in physical activity (30–33). The theory describes outcome expectations and social structural factors as mediators for goals and behavior and contains the key concept of self-efficacy (13). According to Bandura, self-efficacy is dependent on four sources: performance accomplishment, vicarious experiences, verbal persuasion and physiological states (13). Self-efficacy can be increased by performance accomplishments and mastery experience, and successes increase the belief in one's own capability. The participants of this study described how they established confidence in being capable of changing their lifestyle, and that they experienced major physical changes and acknowledged several supporting factors.

The results of this study could be interpreted such that the intervention did have an effect on self-efficacy among the participants and provided the participants with increased outcome expectations, and strategies to identify facilitators for being able to complete the intervention and possibly continue being physically active after the intervention. In the literature, the relationship between physical activity and self-efficacy has been described as complex and reciprocal, and self-efficacy as both a determinant for and a consequence of physical activity (34, 35). Self-efficacy was not a defined outcome variable when designing the VIVE2 study. However, based on the present findings, it seems likely that self-efficacy was impacted and that, as also shown in previous studies, it is an important variable to take into account when designing and evaluating interventions for older adults (32).

The supporting factors described in the result included the social support from the group and the tailored set-up. The importance of social support has been highlighted as crucial both in quantitative and qualitative literature regarding older people's adherence and response to physical activity interventions (11, 14, 36–38). When reflecting on their experiences from the intervention, almost everyone in the focus groups pointed out the social support as a significant factor, while almost no one mentioned seeking the social support as a motivator for deciding to participate. There could be several reasons for this result, for example that the participants did not reflect on their need for social support when applying or their difficulty in admitting or expressing a need for social support. Prior studies have shown that social isolation and loneliness are associated with advancing age as well as impaired mobility (39–41). The participants in this study described the tailored set-up, including the support from professional instructors, as important, results that are also supported in other studies on older adults engaging in physical exercise (36, 37, 42). These greater gains and

supporting factors are very important to elucidate as they played a major role for the older individuals who are the target audience for such interventions.

It is noticeable that almost none of the participants chose to discuss the intake of the nutritional supplement during the focus groups. They did not express any opinions about how they experienced consumption of these oral sip feeds. One reason could be the fact that this was a double-blind trial and, when the focus group was conducted, it had not been revealed who had received the supplement or the placebo. Part of the explanation could also be that the participants associated their experiences, both the psychological and physical results, with the exercise and the social support, which they stated as being very central, and therefore did not attach any particular importance to the supplement. It is possible that the participants might have been more concerned about the supplement if they had known if they had received the supplement or the placebo.

The strengths of this study include the choice of method, focus group discussions, which enabled the investigators to obtain data with broader perspectives. Further, the interviews were conducted close to the time when the participants completed the intervention and in an environment that was very familiar to the participants. The analyses were both manifest and latent, the process was transparent and the quotations in the results section confirm the findings. Limitations include the risk of selection bias, since there is a risk that only positive participants signed up for the focus group interviews. However, only two of those invited to participate declined. Focus group discussions give researchers an opportunity to explore people's understandings and to examine these within a social context, a context important to consider when interpreting the data (43). The focus groups were conducted with a sub-sample of participants included in the VIVE2 study at the Swedish site and the groups were heterogeneous in terms of gender. As mentioned, the first author had been administrating the VIVE2 intervention, which can be seen as both a strength and a limitation in the analysis process. Prior understanding may possibly overshadow new meanings and hinder ability to observe everything in the data, although being familiar with the concepts and context of the study is a strength. The transparency of the analysis process and the close collaboration with the co-authors supports the trustworthiness of this study. Due to the qualitative design of this study, the result cannot be generalized, however the results are in line with other similar evaluations of how older adults experience lifestyle interventions (11).

Conclusion

In this study we have captured the experiences of older adults with minor mobility limitations who participated in a lifestyle intervention. The experiences are interpreted in one overall theme "Feeling more self-confident, cheerful and safe". The central understanding of the participants' experiences was that the intervention affected them in several ways, both psychologically and physically, and that supporting factors included the social support which became a prerequisite for success. A noticeable finding was the discrepancy between the motive of the participants, to lose weight, and the aim of the study, to improve muscle function. The expectation to lose weight seems to reflect what is commonly known as to be healthy. To our knowledge, at least in Sweden, there are no campaigns or public information highlighting the risks of sarcopenia and the complex issue

of if, and when weight loss is desirable for older individuals. This finding highlights the importance of providing such information to this target group.

The findings in this study provide valuable knowledge for research teams, practitioners and decision makers when designing and setting objectives for health-promoting interventions for older individuals.

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Table 1

Characteristics of study sample

Age, years mean $\pm$ sd	77.5 $\pm$ 5.5
Women, n (%)	8 (40)
Men, n (%)	12 (60)
Marital status, n	
Married	9
Divorced	6
Widow/widower	3
Unmarried	2
Living alone, n	11
Work before retirement, n	
Labourer	2
Self-employed	4
Professional employee	12
Domestic work	1
Missing data	1
Education, n	
Primary and lower secondary education	8
Upper secondary education	4
Post-secondary education	8
Smoker, n	1
Body Mass Index, BMI (kg/m ²) mean $\pm$ sd	26.5 $\pm$ 3.74

Table 2

Primary question guide for the focus group interviews

1. Short introduction. Information concerning: Informed consent, voluntary participation, tape recording, Presentation of moderator and observer.
2. What was your reason for wanting to participate in this intervention?
3. What has been positive and negative during your participation?
Potential follow up questions:
4. Have you made any other changes concerning your lifestyle during this time period?
5. Now that the intervention is completed, what are your thoughts regarding exercise and lifestyle?
6. The moderator makes a short summary of the discussion, did we miss anything? Do you want to add anything?

Table 3

Table of results. Theme, categories and subcategories from the content analysis

Theme	Category	Subcategory
Feeling more self-confident, cheerful and safe	Psychological effects of participating in the intervention (Experienced effects)	Stronger motivation and awareness of the need for physical activity Confidence in own ability Positive effects on frame of mind Strategies for continued physical activity
	Physical effects of participating in the intervention (Experienced effects)	Positive physical effects Negative physical effects
	The importance of social support (Supporting factors)	Support as a prerequisite Cheerful atmosphere in the group
	The importance of a tailored set-up (Supporting factors)	Professional support Schedule Exercises Locality