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Frail Elders' Experiences With and Perceptions of Health

Zahra Ebrahimi,[1] Katarina Wilhelmson,[1] Crystal Dea Moore,[2] and Annika Jakobsson[1]

Abstract

In this study we explored frail elders' experiences with and perceptions of the phenomenon of health so as to develop a deeper understanding of living with diseases and disorders in old age. Frail elders participated in qualitative interviews that explored the meaning of the phenomenon of health for them. Eleven men and 11 women, who had diverse ratings of self-perceived health ranging from poor to excellent, were selected by means of a purposeful strategic sampling of frail elders taken from a broader sample that participated in a larger quantitative study on health. In total, 22 individual interviews were analyzed using Giorgi's descriptive phenomenology. We found that frail elders described health as being in harmony and balance in everyday life, and this occurred when participants were able to adjust to the demands of their daily lives in the context of their resources and capabilities.

Keywords

aging; Giorgi; health and well-being; lived experience; older people; phenomenology; vulnerable populations

The proportion of the population who are elders (aged 65 and older) is increasing and will double globally from 2006 to 2050 (World Health Organization [WHO], 2011). In Sweden, about 17% of the population is aged 65 and older, and approximately 20% of Swedes will be in this age bracket by 2030 (Lennartsson & Heimerson, 2009). As people age, their reserve capacity decreases, and the risk of morbidity and frailty increases (Fried et al., 2001). Frailty is an emerging perspective in the understanding of aging and health in elders (Fried, Ferrucci, Darer, Williamson, & Anderson, 2004), and there are a number of different definitions of frailty among older adults.

The Functional Domain Model links frailty in elders to the degree of functional disability in relation to their capacity to accomplish activities of daily living in the physical, cognitive, vision/hearing, and weight loss domains (Strawbridge, Shema, Balfour, Higby, & Kaplan, 1998). The Burden Model defines frailty by means of a Frailty Index which assesses the degree of burden of disease, symptoms, complaints, disability, and cognitive impairment (Rockwood, Andrew, & Mitnitski, 2007). The Biologics Syndrome Model defines frailty as a biological syndrome involving reductions in capacity and impairment of the defense mechanisms against stress; for example, disease which results in a decline of the physiological system (Fried et al., 2004).These frailty models, which are based on different theoretical constructs, identify different groups of elders at risk for disability (Cigolle, Ofstedal, Tian, & Blaum, 2009). Frailty is commonly constructed as a multidimensional geriatric syndrome of disability and vulnerability (Fried et al., 2004).

Like frailty, the phenomenon of health has been described in various ways across diverse disciplines. The World Health Organization's definition is the most widely used despite considerable criticism of it (Larson, 1999). This was the first holistic definition, with health construed as "a state of complete physical, mental and social well-being and not merely an absence of disease or infirmity" (WHO, 1946, p. 100). Nonetheless, critics point out that it is difficult to measure and quantify health, that the definition of well-being is unclear, and that it is not possible to attain complete health (Larson). To adequately define health, a multidimensional perspective must be employed. This can include the clinical model, which focuses on physiology; the role performance model, which emphasizes the social aspect; the adaptive model, which highlights the individual's capacity and flexibility in a

[1]University of Gothenburg, Gothenburg, Sweden
[2]Skidmore College, Saratoga Springs, New York, USA

Corresponding Author:
Zahra Ebrahimi, Sahlgrenska Academy, Institute of Medicine, Unit of Social Medicine, Department of Public Health and Community Medicine, University of Gothenburg, Box 453, 405 30 Gothenburg, Sweden
Email: zahra.ebrahimi@socmed.gu.se

challenging environment; and the eudemonistic model, which views individuals as civilized, cultured persons who have the capacity for continuous growth (Smith, 1981). Some researchers recommend a revised definition of health based on the WHO, wellness, and environment models (Larson). A multidimensional definition of health views humanity through a lens of wholeness, unity, and individuality, which necessitates a multiprofessional approach (Smith).

It is critically important to explore frail elders' experiences of health, because their perceptions and descriptions of health are essential for the patient-centered planning of health care services. Bryant, Corbett, and Kutner (2001) found that to elders, health meant going and doing something meaningful, which required four components: something worthwhile to do, balance between abilities and challenges, appropriate external resources, and positive personal attitudinal characteristics. Peace of mind is an important basis for older people's experiences of health, according to Nyström and Andersson-Segesten (1990). Elders' experiences of health and ill health encompass their perceptions of the positive and negative poles of autonomy, togetherness, tranquility, and security in daily life (From, Johansson, & Athlin, 2007). Unfortunately, many frail elders experience health and social care services that are not responsive to their main concerns, despite their high usage of such services (Themessl-Huber, Hubbard, & Munro, 2007).

Health is physical and mental soundness and well-being (Eriksson, 1984). In addition, Eriksson linked health with suffering and illness, and the experience of health is consistent with manageable suffering (Eriksson, 1994). Chronic diseases can manifest themselves in patterns of physical impairment and disability that can negatively influence how elders perceive their own health (Johnson, & Wolinsky, 1993) and quality of life (Kempen, Steverink, Ormel, & Deeg, 1996). From the perspectives of elders, living with chronic diseases means a daily struggle to create health despite illness and infirmity (McWilliam, Stewart, Brown, Desai, & Coderre, 1996). Elders who live with chronic diseases must mobilize all their resources to master everyday living, otherwise feelings of blame and shame arise because of their sense of responsibility and their inability to cope effectively with the demands of daily living (Benner, & Wrubel, 1989). It is important to support efforts that help older adults regain normality and adjust to their everyday real-life context, because these are the first steps in recovering from illness to health (Godfrey & Townsend, 2008).

Frail elders' experiences of health might be disturbed by the slightest changes in their lives because of their already reduced spare capacity. Research on frailty from the perspective of those experiencing it is limited. We assume the phenomenon of health can be best articulated by frail elders themselves because they are dealing with the challenges associated with frailty on a daily basis. In this study we took a phenomenological approach describing lived body, time, and space (Bengtsson et al., 1999) to achieve a holistic and multidimensional perspective on health in frail elders, based on their own experiences with and perceptions of health. To be able to explore how frail elders' experienced health, we interviewed a number of people aged 67 to 92 years, both men and women, who had at least one chronic disease and had sought emergency care in the west of Sweden.

Method

In this study we employed a phenomenological approach based on the subjective lifeworld perspective (Dahlberg, Drew, & Nyström, 2001; Merleau-Ponty, 1996). According to Husserl (1930), the best manner to study a phenomenon is to go back "to things themselves" (p. 19). Thus, we went back to frail elders to gain a valid understanding of their own experiences and perceptions of their health. We used a semistructured lifeworld interview, inspired by phenomenology, to collect data. The interview was aimed to capture a rich description of the phenomenon from the participants' own perspectives (Kvale, 1997; Kvale & Brinkmann, 2009). Both the participant and interviewer might be likened to two travelers who wandered together in the participant's lifeworld by means of an open and flexible conversation (Dahlberg et al., 2001; Kvale).

A reductive approach was taken, in which preunderstanding was bracketed and interviewers were reflexively self-aware from data collection through to analysis. The participants were given the opportunity to describe their subjective experience of the phenomenon, in other words their unique "lived body" (Dahlberg et al., 2001; Merleau-Ponty, 1996). Phenomenological method seeks to reveal the nature of humanly experienced phenomena (Parse, Coyne, & Smith, 1985). Our purpose in using this method was to discover and reveal the meaning of experienced health through the analysis of frail elders' descriptions, with an open mind to any new and unexpected insights.

Sampling and Participants

The sample was selected from a larger project termed "Continuum of Care for Frail Elderly Persons, From the Emergency Ward to Living at Home," a multiprofessional intervention for frail elders living in a community in the west of Sweden (Wilhelmson et al., 2011). The main study included elders who had sought emergency treatment in a hospital, and who were either 80 years and older, or 65 years and older with one or more chronic diseases and who depended on help in at least one activity

according to the Activities of Daily Living (ADL) scale (Åsberg-Hulter, 1990; Jakobsson, 2008). People who were receiving palliative care, suffering from dementia or cognitive impairment, or in need of immediate emergency care were excluded (Dunér, Blomberg, & Hasson, 2011; Hasson, 2010; Wilhelmson et al.).

In this study strategic purposive sampling, with the goal of identifying participants with varied experiences relating to the phenomenon of health, was employed to provide rich, relevant, and diverse data (Tong, Sainsbury, & Craig, 2007). In total, 22 frail elders were selected: 11 men and 11 women. All participants except one were recruited from the 161 participants in the main project. Informants' self-perceptions of their general health were measured by one statement: "In general, you would say your health is," followed by responses on 5-point Likert-type scale: poor, fair, good, very good, or excellent. Two men and 2 women from each category were selected for interview. The first 2 elders in each gender and health category who agreed to be interviewed were included in the study. There was only one person (a man) who chose the category of "excellent," so a woman was recruited from outside the main project who met the inclusion criteria.

Ethical Considerations

Several strategies were utilized to promote ethical and responsible data collection. Kvale and Brinkman's (2009) suggestions for the ethical conduct of interview studies informed the study design and implementation. The participants received information about the purpose of the interview and the procedures involved by telephone in advance of the interview and then orally and in writing on the day of the interview. Participants were informed that participation was voluntary, that they could stop the interview and withdraw from the study at any time, that their interview content was confidential, and that any information reported would not enable individual participants to be identified. The interviewer (the first author) sought to create a positive and open environment for conversation by disclosing the ethical issues related to the project and conveying appreciation of the elders' willingness to participate and share their experiences and stories. As a result, they felt their contributions were important, and that they were doing something beneficial for themselves and society. The interviewer employed active listening, empathy, flexibility, openness, and respect for the lifeworld story of every individual, and created a balanced and open environment. The interviewer was sensitive to signs of participant fatigue and was open to breaks being taken when needed. The study was approved by the Ethics Committee of Gothenburg University.

Data Collection

Data were collected through 22 semistructured lifeworld phenomenological interviews (Kvale, 1997). The first author, who is a registered nurse, specializes in elder care and conducted all interviews in the participants' homes. She has worked with elderly people for 10 years in the Swedish health care system and has conducted more than 150 structured interviews as part of the larger project from which this sample was drawn (Wilhelmson et al., 2011).

The interviews started with a general conversation and information about the study. The specific conversation about the study topic was audio recorded and began with the main question: Can you tell me what health is for you? Further questions were then asked, depending on the interview content, to gain a deeper understanding of the participant's perceptions of the phenomenon of health, as follows: Can you describe a day, an everyday situation, where you experience health? What gives you the feeling of good health? What is the most important thing to enable you to experience good health today? Can you describe a day, an everyday situation, where you don't experience good health or you experience poor health? What gives you the feeling of poor health? What are you missing today that would enable you to experience good health? In addition to these follow-up questions, the interviewer used probes to gain a deeper understanding of the participant's everyday life situation by using such phrases as, "Please tell me more about your experience, thoughts, and emotions," and "Please give me some examples from your everyday life."

The interview guide was based on our two research questions: (a) What is the phenomenon of health according to the experiences and perceptions of frail elders?; and (b) What strengthens and weakens the experiences of health by frail elders? The first question is the focus of the present article, and the second is the focus of a forthcoming analysis. The substantive portion of the recorded interviews lasted between 18 and 63 minutes (the majority lasted 40 minutes or longer) and were transcribed verbatim. Background information about the study and the informed consent process was not recorded; therefore, the total time spent in discussion with each elder (on average, 1.5 hours) was longer than the recorded portion of the interview. A total of more than 11 hours of recorded audio data about these frail elders' experiences and perceptions of health were collected. The visits ended with general and spontaneous reflections and questions.

Data Analysis

The transformation from raw data to the essence of the phenomenon was performed according Giorgi's

phenomenological analysis (Giorgi,1985, 1997, 2009), as modified by Malterud (1996). The method was implemented using the following steps:

1. Three of the authors read each interview several times to become familiar with the whole and to gain a common understanding of the entirety in its context. The first author worked most closely with data and the second and fourth authors provided extensive support and peer debriefing during each step of the data analysis process. The third author assisted during the last phases of data analysis by providing a fresh perspective.
2. We scrutinized the text line by line to break it into meaning units, i.e., different aspects of the meaning of the phenomenon of health from a caring science perspective. A meaning unit was delineated when there was a change of meaning in the description of the phenomenon provided by the participant. A meaning unit could vary from a word to a sentence or a paragraph.
3. All meaning units of similar content were organized under the same category. In this step, meaning units were decontextualized, and simultaneously the material was made more manageable and easily structured for additional vertical analysis.
4. All meaning units were reread and the text was condensed to express the meaning in more general terms within a caring science perspective. In this step, there was an abstraction from the original meaning units, but the condensed meaning units were still close to the original text.
5. To summarize the material in a trustworthy manner, the first author used her various understandings of the material as keywords for clustering and summarizing the interview content. These keywords were then used as search terms to examine the relationships between and among the themes.
6. The emergent themes were then recontextualized by cross referencing the themes with all the interviews in their original form to ensure that the parts (themes) were representative of the entirety (the original materials), as well as to discover any possible statements that were contrary to the emerged general themes.
7. To capture the essential structure and themes that were necessary for building the essence of the phenomenon of health, free imaginative variation was conducted by freely moving between and among the themes to see the phenomenon from a new and fresh perspective. This process was characterized by openness and flexibility, and the themes were contextualized and decontextualized until the essential structure appeared and shaped the essence.
8. The essence was then described and defined within a holistic caring science perspective.

Throughout the iterative data analysis process, the method and emergent findings were discussed and critiqued during four seminars and two workshops with the study authors and other experienced qualitative researchers in the social and caring sciences, to promote openness and decrease the influence of preunderstanding.

Results

According to this group of frail elders, the phenomenon of health was described in terms of harmony and balance of the salient components of health in their everyday lives. These components included being able to master daily life, the experience of the body working by itself, being happy and satisfied with one's existence, being validated as a worthy and competent person, and being involved. Healthy existence in frail elders was based on their experiences of being in harmony and balance in the present, or the ability to live the routine life to which they were accustomed. The essence of health was the interdependent essential structures on which balance and harmony in everyday life were built. If one of the essential structures was altered, this balance and harmony could be disturbed, and ill health experienced. To regain balance after a disturbance of one of the essential structures, the elders adjusted their perceptions of their lived experience to take account of the disturbed structure. This process of maintaining balance through changing perceptions and expectations was much like shifting the position of a fulcrum to keep a structure balanced. In other words, the threshold of what constituted health was dynamic over time. It depended on the movement of the perceived balance point, which was contingent on the elder's appraisal of variable life conditions. This balance point or fulcrum could be moved and adjusted to secure balance and harmony, and as such, was an essential additional structure for the experience of health.

These frail elders described the experience of health "here and now" in relation to its historical context, and in relation to their interests and habits. Broadly speaking, these essential structures had two dimensions: the person, and the society/environment surrounding the person. The experience of harmony and balance was influenced by characteristics inherent in the individual elder and factors in the social environment surrounding him or her. Being in harmony and balance depended on these essential intertwined building blocks, and how they were balanced on the fulcrum, as shown in Figure 1.

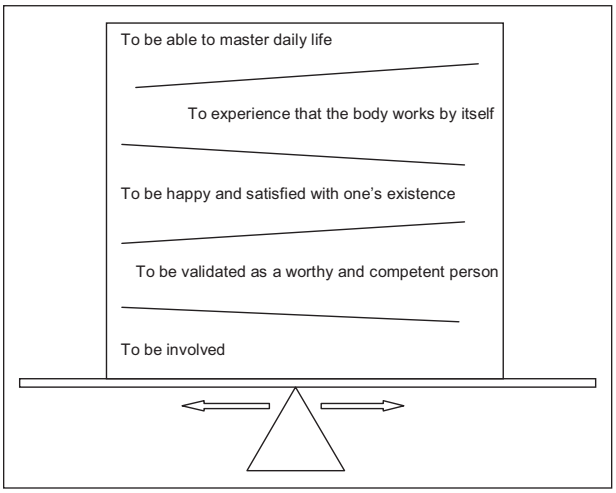

Figure 1. Essential structures of the phenomenon of health
Frail elders keep the essential structures of the phenomenon of health balanced and in harmony in their everyday lives through dynamic adjustment of the fulcrum via changes in their perceptions and expectations of these structures.

Being Able to Master Daily Life

Each day, the participants made great efforts to cope with their everyday lives, despite age and disease-related ailments and limitations. They did their best to find their individual balance point, based on varying capabilities and limitations, so they could experience harmony and balance. The goal of these daily efforts and adjustments was to master life, to do something useful, and to not be a burden on others. They pointed to their daily coping and mastering as a sign of good health. A 92-year-old man said,

> I am doing the best I can. I do. It applies to coping also in society . . . trying to do the best I can. I am neither a burden to neighbors nor to you. I am not much trouble to those who surround me, and I can handle myself.

The threshold for the experience of health and being in harmony and balance not only varied for the same person over time, but was also different for different people. This threshold depended on the individual's changeable goal for health, which was based on the individual's constant evaluation of capabilities and limitations. A 78-year-old woman said, "Health for me is that I can do something. . . . I want to get up and prepare my breakfast." A 67-year-old man said, "As I said before, to be able to go to the toilet by myself, that is the concept of health for me." To be independent and to master life was important for frail elders' experiences of maintaining harmony and balance. The participants made constant efforts to be independent and maintain control over their lives so they could manage their ordinary activities. An 82-year-old man said,

> Health for me is that I feel well and I manage to do something I am used to doing. I have quite a routine situation, with no major changes. . . . I try to be active, have mobility, and keep up as much as possible.

An 81-year-old man said,

> It is so nice when you can care of yourself, and do not have to be dependent on others. It is the most important thing in this world, I think. If you cannot do it, you might as well die.

The Experience of the Body Working by Itself

These elders linked their experience of being in harmony and balance with their physical being and daily bodily functioning. Harmony and balance were achieved if they were able to maintain the functionality of their bodies, albeit a limited functionality for some, and control their daily symptoms and complaints. The experience of the body working by itself, in both the physical as well as cognitive aspects, was a prerequisite for the experience of good health. A 76-year-old man said,

> It is simply the physical well-being that I, my body, works without me needing to think about it all the time. . . . There have been deviations from the norm coming with age. . . . I have less and less control over my legs and the manner in which I am walking. Walking cannot be accomplished without thinking. An ordinary person does not think about every step he must take. . . . I get weaker . . . my body is inflexible. It is not as controllable as it has been.

The participants greatly appreciated good balance, vision, mobility, and well-functioning cognitive abilities, which enabled them to experience themselves as fully functioning. They reflected on their bodily functionality in terms of sustaining their regular life and managing daily activities that gave them a sense of freedom and wholeness, thereby promoting balance and harmony. For many, frailty necessitated a shift in their perceptions of their current functionality to maintain this balance. For example, a 67-year-old man observed,

> To dare to get up and go over to the toilet bowl, to this handicapped chair, it is an important part of health for me: There is mobility. To be able to get up and go even if it is with a cane, it is mobility.

An 82-year-old man related, "Health for me is to move free, to walk, to keep the brain going so that I can read the newspaper and understand what I read."

Being Happy and Satisfied With Existence

Inner peace and satisfaction were necessary components of the experience of harmony and balance, and these depended on the individual's insight and understanding of changing life conditions. Acceptance of life as it was, happiness, and contentment with life itself were among the signs of being in harmony and balance. An 82-year-old man said, "I feel satisfied with life as it is. It is very good." An 84-year-old woman observed,

> I feel enjoyment to be able to get up. Everyone says that I am alone. Yes, it is clear I am alone, but I do not get ill by it. I have many good memories, very many. I can go and laugh to myself and think about it. I am so excited about life. I feel great bliss today. When I can think clearly about something I really understand, I can be very happy.

Acceptance of constantly changing conditions coupled with the perception that aging and death are natural parts of life facilitated the necessary adjustments that promoted harmony and balance. The frail elders' inner peace, satisfaction, and well-being stemmed from their abilities to think positively, see the happy side of life, and be proud and strong in their struggle to move forward despite increasing disability. An 83-year-old woman observed,

> I am very happy, grateful, for what I have and the life I had, for all my life. And that I can get up in the morning . . . that I have survived the disease. . . . I can enjoy now when everything blooms. It is so much, it is, just look out here. God, how rich I am to experience all this again—another spring again.

Finally, an 84-year-old woman was grateful that she could "still experience the things around me. I think it is extremely important."

Being Validated as a Worthy and Competent Person

The experience of harmony and balance was constructed in relation to society and the environments surrounding the elders. Other people's attitudes and thoughts about them were assessed as an important part of the elders' experiences of good health. Knowing that others saw the person behind the disease and disability and dealt seriously with the frail elder's problems and ailments were important to the construction of harmony and balance. An 84-year-old woman explained:

> Yes, health is not just being perfectly healthy, because I have been handicapped all my life since I was eighteen. But I have had a good life, and I think that I have had good health until now, in the older days. . . . No one has viewed me as handicapped before, but now many people view me that way. It is not easy getting old in Sweden. Of course, it gets harder because as you get older, many are complaining that we old are many and we are expensive. They can make huge statements. They believe that my head is not on right, almost talking baby talk to me sometimes.

A 67-year-old man said,

> It is sometimes like this with health professionals, although they are trained and they think they know better what it's like: You sit in a wheelchair. There is something wrong with your head and not with your leg. . . . They sometimes don't believe me, and it makes me terribly ill.

Being in harmony and balance also depended on the experience of dignity. The participants appreciated other people's attention to and confirmation of their daily challenges and suffering. A 72-year-old woman said, "Nobody ever becomes angry and answers me inappropriately. . . . I have been very well treated by health care professionals."

Being Involved

To have human contact, to be in a social context with other people, and to be outdoors and in nature gave these elders a sense of involvement and well-being. Participating in the community and being among other people gave them a sense of belonging. The participants saw themselves as a part of the whole as a result of this participation. A 72-year-old woman explained:

> I can go out and take part in the social life both inside and out with enjoyment. I can still go out shopping and I am happy for it. It would be healthy to be able to participate socially, by being out among others, and going to the cinema, theater, and an amusement park.

A 78-year-old woman said,

> That is when I hear and talk to people. I was not expecting any visitors today. I had no visits yesterday. I wanted to talk to the kids [children] on the

> phone but there was no one there, and I felt lonely and sad. Yesterday I needed comfort, too. I was not feeling well.

Harmony and balance were constructed in relationship to other people, especially when the elders felt themselves as a part of the whole. To be able to keep up with social life, and to maintain old and develop new connections were signs of being in harmony and balance. An 84-year-old woman said, "I enjoy being close to people, and sitting and talking and discussing and so on." An 85-year-old man said, "So I keep up to date with what is happening in the world." A 92-year-old man indicated, "I am happy that I am as I am. . . . It is not all ninety-two-year-olds who can see reasonably. And then I am absolutely clear in my head, so I can follow current developments." Finally, a 67-year-old man observed, "It is important to me that I have contacts through my computer here and follow the developments in society."

Discussion and Implications

The essence of this lifeworld phenomenological description of health was harmony and balance in everyday life, and this was built on five essential structures and the crucial balance point or fulcrum. These structures were intertwined and necessary, and like building blocks, they shaped the essence. These frail elders experienced good health when they were able to alter their perceptions, or in other words, shift their fulcrum in such a way as to achieve a harmony and balance of the essential components. The complete experience of health was based on the interactions between two dimensions: the person, and the environment surrounding the person. The threshold of what constituted health was dynamic over time, and depended on the adjustment of the perceived balance point, which was contingent on the elders' appraisals of their variable life conditions.

This finding is in agreement with Benner & Wrubel´s (1989) definition of health: "A phenomenological definition of health must incorporate being as well as becoming, must be based on integrated view of mind/body/spirit, and must be based on situated possibility rather than on the premise that radical freedom is possible" (p. 160). In addition, the intertwining of the five essential structures of health was constantly changed over time, which is in line with the yin–yang model that defines health as a balance between two dynamic, inseparable, and integrated components of mind and body (Saylor, 2004).

According to the lifeworld phenomenological perspective, the essence of a phenomenon can be described in three dimensions; that is, lived body, time, and space (Bengtsson et al., 1999). In this study, the lived body was characterized as the individual's experience and perception of being in harmony and balance, which depended on how the person experienced being and existence in relation to the world. The second dimension was time, which focused on the frail elder's experience of being in harmony and balance in the "here and now." The participants oriented their own current experiences and perceptions of health by placing these in their historical contexts or previous health states. Being in harmony and balance in the "here and now" varied over time, depending on the current changes in the five essential structures of health, and the elders' abilities to shift the fulcrum—their perceptions of and adjustment to the changes—to keep the structures in balance.

The third dimension was space, which was the context in which frail elders lived or, in other words, their everyday lives. These frail elders made a daily attempt to maintain harmony and balance, experiencing health despite vulnerability. This finding is in line with Eriksson´s (1994) linking of health and suffering: that health can be experienced if one can endure the suffering. The smallest remaining function and resources, which were critical to sustaining the ever-changing balance, were appreciated highly. This demonstrates the significance of the frail elders' everyday lives and their attempts to balance their lives in the space where health was experienced.

The findings from this study corroborate the complexity of the phenomenon of health and articulate its multidimensionality, which is in agreement with the WHO's definition of health as physical, mental, and social well-being (1946, 1993). The findings also emphasize the individual's everyday life in the social context as the place where health is experienced. The findings are consistent with Breslow's (1972) finding that confirmed health as multidimensional well-being which is not only an attribute of individuals, but also a reflection of the social environment. The study demonstrated that the multidimensional experience of being and becoming in harmony and balance was constantly changing and being reconstructed, depending on changes in both the person's functioning and the world surrounding the person.

The experience of health as being in harmony has been demonstrated in a previous phenomenological study of 400 people in four age groups (7 to 19, 20 to 45, 46 to 65, and 65+ years), where health was defined for all age groups as "harmony sparked by energy leading to plentitude" (Parse et al., 1985, p. 34). In the same study, people over 65 years of age defined health as "synchronous contemplation fired by transcendent vitality in generating completeness" (p. 33). The findings of the present study also emphasize the stability of the health experience and being and becoming in harmony and balance over time. These frail elders, much like people in any other age group, experienced health and a sense of multidimensional well-being

when they found themselves in balance in their everyday lives. Findings from the present study, combined with previous research, suggest that the experience of health is time- and age-independent. The ability to find balance among the interdependent components is contingent on the human capacity to adjust perceptions in the process of the appraisal of health—regardless of where one is in the life course.

Strengths and Limitations of the Method

The phenomenological analysis was aimed to provide a better understanding of the phenomenon and its structure better than before (Dahlberg et al., 2001), and this study has further illuminated the phenomenon of health among frail elders. The study's design, sampling strategy, interview and analytical method, validation, and reporting of findings have been guided by the aim of the study, which was to describe the phenomenon of health from the frail elders' perspectives. The critical approach and reflexivity were in accordance with consolidated criteria for reporting qualitative research (Tong et al., 2007), and also followed the guiding concepts of engagement, processing, interpretation, critique, usefulness, relevance, and ethics (Stige, Malterud, & Midtgarden, 2009).

The goal of the strategic sampling was to capture diverse experiences among a representative group of frail elders, both male and female, who varied in the self-perceptions of their general health status, and in their age (67 to 92 years). Limitations of the sampling strategy include the exclusion criteria. The criteria excluded a large group of frail elders, including those with dementias, those in need of immediate assessment and treatment by a physician, and those who were in the palliative stage. These groups were excluded for practical and ethical reasons. Frail elders who were not in need of or did not access emergency hospital services were also excluded. Finally, the sample was recruited from one area of Sweden, which potentially limits the transferability of the findings to other cultures that differ in terms of socioeconomic variables and sociopolitical context. Despite these limitations, attempts were made to produce as varied a sample as possible, and this increases the diversity of the reported experiences and the probability that the findings are transferable to other groups of frail elders in similar contexts.

A semistructured lifeworld interview, which is neither an everyday conversation nor a closed questionnaire, requires a well-conceptualized interview guide (Kvale & Brinkmann, 2009). The key questions of the interview guide were tested through two pilot interviews, then discussed and adjusted by three of the authors to ensure that the questions were relevant to participants' consciousness of the phenomenon of health. The fact that some interviews were short could be one limitation of the study. The research design allowed for more than one interview with each elder to address this issue, but we found that even the short interviews were relevant and comprehensive; therefore, we decided not to burden participants with another visit.

Data collection through interviews depends on the interviewer's background, experience, knowledge of the subject under investigation, and attitude during the interview (Kvale & Brinkmann, 2009). The interviewer was a geriatric nurse with many years of clinical and interviewing experience. Being an interviewer in a lifeworld phenomenological interview was a challenge, which required the interviewer to be completely present in a paradoxical world of being. Involvement, engagement, empathy, and active listening were required, while simultaneously seeking objectivity and displaying naivety through the bracketing of knowledge and beliefs about the investigated phenomenon. This combination of empathy, openness, and objectivity created a favorable environment for the participants' perspectives of the phenomenon of health to emerge. The interviewer's interest and engagement in the participants' lifeworlds, as well as active listening, aimed to balance the "power asymmetry" that occurs in all interviews (Kvale, & Brinkmann), and allowed the participants to have control and direct the process.

Credibility and Trustworthiness

We chose this approach to the research to maximize its credibility and trustworthiness (Patton, 1999; Rolfe, 2006). The data collection methods, the bracketing of all prior knowledge and theories about the phenomenon, and our constant reflexivity about our presumptions guided us throughout the study and helped to preclude premature interpretations. There was a structural and systematic organization through all steps of the analyses from raw data to discovery of the essence. All interviews, meaning units, and corresponding page numbers where the meaning units were derived were numbered, which allows anyone to follow the essential themes in the original text to the source. Three of the authors, with different professional credentials, experiences, and backgrounds, analyzed and discussed the findings step by step, and one of us was involved in the last step of analysis which was to provide a fresh perspective on the data analysis process. Investigator triangulation in the data analysis allowed for a comprehensive multiperspective view of the investigated phenomenon, which increased the credibility and trustworthiness of the findings (Patton; Thurmond, 2001). The themes and findings have been exposed for discussion and debriefing, and have also been reviewed in two workshops and four phenomenological seminars (Burnard, Gill, Stewart, Treasure, & Chadwick, 2008).

The purpose of descriptive phenomenology is to describe the essence of the phenomenon in general terms (Giorgi, 2009). The findings have been validated by recontextualizing the emerging themes in the original data, and by conducting a systematic search for the voices that contradicted the emerging themes. Free imaginative variation and shifting the focus and view of the phenomenon of health were also undertaken to validate the findings.

It is highly relevant for all aging adults to ask frail elders about the phenomenon of health. Just as the existence and significance of light is more clearly articulated in darkness, so the existence and importance of the phenomenon of health is made visible and articulated in frail elders, because they deal with health and ill health on a daily basis. The themes and the essence of the phenomenon of health in this study are consistent with the World Health Organization's (1946) definition of health, which suggests some degree of transferability.

Conclusion

The findings from this study and other research suggest that the desire and goal of human beings to be in harmony and balance in everyday life and thereby experience health is universal. The frail elders' experiences of health in this study were not contrary to other people's experiences of health (Parse et al., 1985). To attain this balance, frail elders must continuously adjust their expectations regarding their life situations over time. This means that the phenomenon of health is a conceptualized one, because harmony and balance are difficult to measure quantitatively. The findings from this study emphasize that health is a subjective and dynamic phenomenon. The state of being in harmony and balance is highly individualized; it is therefore important to focus on the individual life situations of frail elders to illuminate the factors that help them achieve harmony, balance, and thereby well-being in their everyday lives.

We recommend that health and social care staff should pay more attention to frail elders' everyday lives, and support them in their efforts to balance the building blocks of the phenomenon of health to promote harmony and balance. Medical and social care staff can support frail elders' experiences of health by focusing on the health balance point in the everyday lives of individual elders. Future research will explore what strengthens and weakens the ability to achieve harmony and balance.

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Bios

Zahra Ebrahimi, RN, is a doctoral student at the University of Gothenburg Institute of Medicine/Social Medicine in Gothenburg, Sweden.

Katarina Wilhelmson, MD, is a postdoctoral researcher at the University of Gothenburg Institute of Medicine/Social Medicine in Gothenburg, Sweden, and a project manager at the Swedish Institute for Health Sciences.

Crystal Dea Moore, MSW, MA, PhD, is an associate professor at Skidmore College, Saratoga Springs, New York, USA.

Annika Jakobsson, RN, is a postdoctoral researcher at the University of Gothenburg Institute of Medicine/Social Medicine in Gothenburg, Sweden.