A sanctuary from everyday life: Rheumatology patients’ experiences of in-patient multidisciplinary rehabilitation - A qualitative study

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Abstract

**Purpose:**

To explore how rheumatology patients experience the personal impact of an inpatient rehabilitation stay and to elucidate the impact of contextual factors on the outcome.

**Methods:**

Exploratory qualitative individual interviews were conducted with 15 rheumatology patients (73% female) who had completed a two-week inpatient rehabilitation stay. Data collection, analysis and interpretation of data were performed within a phenomenological-hermeneutic framework inspired by Paul Ricoeur’s interpretative philosophy.

**Results:**

The analysis derived one core theme, *A sanctuary from everyday life*, and five subthemes: 1) *Being seen, heard and acknowledged as an equal and whole person*; 2) *Professional care and compassion*; 3) *Social relations and interactions between patients*; 4) *Individual rehabilitation, but challenges regarding shared decision making*; and 5) *Rehabilitation as a personal process but problems with coherence and transferability of learning to everyday life*.

**Conclusion:**

Patients experience inpatient rehabilitation as a sanctuary, in the following three ways; through individually planned multidisciplinary interventions at the hospital; recognition and compassion from the multidisciplinary staff and through social relationships and interactions with fellow patients. There is a need for improved coordination across primary and secondary health care, to ease coherence and transfer of learning to the patients’ everyday lives.

Keywords: phenomenology, hermeneutic, interview, goal-setting, patient-patient relationships, shared decision-making
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**Introduction**

Rheumatic diseases can impact almost every aspect of patients’ everyday lives, be they physical, psychological or social [1-8]. All rheumatic diseases share some features: they relate to the muscles, tendons, joints and bones and vary in character and course [9]. The symptoms and consequences of rheumatic diseases can lead to changes, such as partner or parent roles, social relationships and give rise to a sense of stigmatization in the community and society in general, which can further lead to an altered identity and self-perception [1,6,10-13]. Furthermore, there is a tendency to develop anxiety, depression, isolation and a feeling of loneliness, [5,10,13,14] powerlessness, frustration and loss of orientation in life [1].

Symptoms and consequences of rheumatic diseases may also lead to frequent sick days, extensive periods of illness, job loss or early retirement [1,7,10,12,15,16]. These are consequences that can ultimately have economic and social repercussions for the individuals concerned [1,10,17].

Many people with rheumatic diseases experience reduced quality of life and problems in everyday life, despite the increasing attention on early diagnosis and treatment, and the continuous development of new pharmacological and surgical treatment options [1,10,11,18-20]. Thus, there is a need for holistic and coherent rehabilitation, to achieve a better everyday life and an increased quality of life for people with rheumatic diseases.

In Denmark, the municipality has the primary responsibility for offering general rehabilitation to citizens. Citizens with rheumatic diseases who still experience problems due to the disease despite pharmacological treatment and primary care services, can be referred to specialist inpatient multidisciplinary rehabilitation [21].
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Multidisciplinary rehabilitation is considered beneficial for patients with rheumatic diseases [22,23]. However, quantitative studies indicate that it is difficult to detect a general and lasting effect of 1-4 weeks of inpatient multidisciplinary rehabilitation [24-26].

Only two studies, one quantitative and the other qualitative, have explored patients’ experiences of inpatient multidisciplinary rheumatology rehabilitation [27,28].

The results of the studies showed that rheumatology patients experienced rehabilitation stays positively [27] and, specifically, felt increased self-respect and dignity during their stay [28]. The studies made it clear that psychological and relational factors play a key role in the rehabilitation of this patient group [28], but that variables such as the type of the disease, age, educational level, gender and mental state also play a significant role in patients’ overall experience of the stay [27]. Both studies argue for a need for further research on the importance of contextual factors for stay outcome.

Therefore, the aim of this study was to explore how patients with rheumatic diseases, experience the personal impact of an inpatient rehabilitation stay and to elucidate the impact of contextual factors on the outcome.

Material and methods

Design

Because the study aimed to gain an in-depth understanding of participants’ lived experiences of inpatient rehabilitation, a qualitative approach was adopted [29]. Data was collected through semi-structured interviews [30] and the analysis was inspired by the French philosopher Paul Ricoeur [31]. Ricoeur’s phenomenological-hermeneutic approach is a philosophical way of thinking, where a phenomenological understanding
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is combined with hermeneutic interpretation and explanation. Ricoeur argues that interpretation is a prerequisite for the achievement of a deeper understanding of a human being’s everyday life [32].

Setting and participants

Participants were recruited from the Danish Hospital for Rheumatic Diseases (DHR). DHR is the only Danish hospital offering specialist multidisciplinary bio-psychosocial inpatient rehabilitation to patients with rheumatic diseases [21]. A rehabilitation stay at DHR lasts, on average, 14 days [33]. The stay is planned and carried out in collaboration between patients, relatives and the multidisciplinary team, which comprises a rheumatologist, a specialist in orthopedic surgery, physiotherapists, occupational therapists, nurses, nursing assistants, a social worker and a dietician [34].

Participants were recruited during their rehabilitation stay if they were 18 years or older. The nursing staff acted as gatekeepers and helped to identify relevant participants. If potential participants agreed to be contacted, they were informed about the study orally and in writing by the first author. Patients were excluded if suffering from dementia or had other cognitive impairments. To achieve maximum variation, and given the exploratory nature of the study, we strove for variety in the participants’ rheumatic diagnoses, ages and genders [35].

Initially, all 17 eligible patients indicated an interest in participation in the study. Two resigned before being interviewed, for personal reasons. The characteristics of the 15 participants are shown in table 1.

*(please insert table 1)*

Data collection and processing
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Depending on participants’ preferences, interviews were held either at their homes – to allow them to be in a familiar environment – about a week after discharge from DHR, or in an undisturbed room on the ward, on a day close to discharge.

To collect as deep and relevant information as possible, a semi-structured interview guide was developed in accordance with the aim of the study. A patient research partner was involved to help in the development of the patient information and consent form and prioritize and determine the relevance of interview questions [36]. The patient research partner was a member of the user council in the research department at the hospital and the patient research partner had experiences from a previous rehabilitation stay.

The interview guide (table 2) consisted of five questions with related sub-topics and questions, whose purpose was to probe for additional input, depending on responses given during the interviews. Thus, it was possible to pursue and explore interesting topics that came up during the interviews, and achieve nuanced descriptions of the various aspects of the informants’ life worlds and their experiences of specific situations [37].

(please insert table 2)

All interviews were audio-recorded and transcribed verbatim by the first author [12]. The software program NVivo version 11.4.2 was used to achieve an overview of the data and facilitate a systematic analysis process.

Data analysis

The analysis entailed a dialectical movement between the whole and the parts of the content, in a hermeneutic spiral [38]. According to Ricoeur’s philosophical thinking, interpretation and understanding require a distance and objectification. This happened in
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a process between the reader and the text, through extensive reflexive work [32]. The process involved three steps: 1. Naive reading, where the reader acquired a general understanding of the text as a whole; 2. Structural analysis (please see table 3 for an example), which encompassed a movement from what the text says to what the text speaks about and the development of themes; and 3. Critical analysis and interpretation through a dialectic movement between explanation and understanding. The process was extended by the inclusion of relevant literature, theory, research and the authors’ understandings [38,39].

(please insert table 3)

The analysis was performed in accordance with Dreyer and Pedersen’s approach [40], as is considered appropriate for a study whose aim was to create meaning and significance across a comprehensive data set [38]. Dreyer and Pedersen’s interpretative method is inspired by Ricoeur’s “hermeneutical function of distanciation” [38]. Based on this, narratives were developed in a poetic language, to represent the meaning and significance of the text [38].

Ethical considerations

Prior to the study, permission to store and process the data was obtained from the Danish Data Protection Agency (J.nr. 2017-41-5281). Data was stored and managed in accordance with the European data protection regulations [41]. According to Danish law the study did not require formal permission from the Regional Committee on Health Research Ethics as it did not involve any biomedical material.

The participants were informed about the opportunity to withdraw from the study until the analysis was finished and that they would remain anonymous. Participants gave their oral and written consent to participate. To achieve valid consent,
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the readability of the patient information and consent material was considered essential. Therefore, the material was developed in cooperation with a patient research partner. Furthermore, the understandability of the material was tested through cognitive interviews with three rheumatic inpatients [42]. The first author sat next to the patients when they were asked to read the information and consent material. The patients were asked whether they found the text understandable and their understanding of specific hard words and concepts was explored. In addition, hesitation during reading was explored.

Subsequently, the readability level was tested by the Gunning-FOG-score [43,44] and thereafter adapted.

Findings

The interviews were conducted in November and December 2017. Twelve out of fifteen participants were interviewed at DHR the day before or on the day they were discharged from the hospital. Three participants were interviewed in their own homes approximately one week after discharge. The duration of the interviews was between 22 and 75 minutes. There was great variation in the participants’ diagnoses, and several had more than one diagnosis: eight had osteoarthritis, five chronic musculoskeletal pain, five inflammatory arthritis, and the remaining three had, respectively, hypermobility, systemic Lupus Erythematosus and a discus prolapse.

During the analysis, one core theme and five subthemes emerged, which are presented in the following, illustrated by selected quotes.

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The participants experienced the rehabilitation stay as a sanctuary from everyday life and attached great importance to the fact that they did not have to focus on daily obligations and chores. Instead, they could concentrate on themselves, their illness and its management.

*I’ve taken this stay as a break from everyday life. So actually, I’m on vacation from everyday life. So that I can focus more on myself*#11.

*It has been a great relief compared to being at home where I had to cope with part-time work and be tired after that. So, it has been a free space to come down here and get away from work and duties*#12.

During the rehabilitation stay the participants experienced to have sufficient time and mental resources to provide self-care.

*Being seen, heard and acknowledged as an equal and whole person*

To feel seen, heard and acknowledged as an equal and whole person was vital for the participants’ experience of the quality and benefits of the rehabilitation stay.

*Well, you’ve just been heard from the beginning..., understanding. That you were taken seriously, what you say..., it means a lot*#9.

Particular attention was paid to the experience of genuine interest from the multidisciplinary staff as well as fellow patients, which was manifested through openness, positivity, patience and inclusiveness, and not least, being seen as a whole human being and not just as a person with a diagnosis.
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The way I was greeted..., it simply gives such a boost in a good way..., that in itself helps it to be a good experience – you have more energy and desire to go ahead with it#8.

All participants described this experience as a consistent cultural value pattern at the hospital, regardless of whether it was in relation to health professionals, kitchen staff, cleaning staff, etc. or to fellow patients.

The culture is something else, it really is – And it was like, ehm, the staff, they don’t – I mean, they accommodate everything. It doesn’t matter what you come out with, even if it has nothing to do with the rheumatism. They do something for you. You are treated like a complete human being. You are not just a rheumatic person – if you understand what I mean #6.

Three contextual factors were given special importance to the experience of being seen heard and acknowledged as an equal and whole person; professional care and compassion, social relations and interactions between patients and an individually planned rehabilitation stay.

Professional care and compassion

The participants considered professional care and compassion to be the most fundamental contextual factors in facilitating their self-care. All participants highlighted these factors in their descriptions of the rehabilitation stay. According to the participants, care and compassion were present in the immediate and spontaneous meetings with the professional staff, which led to an experience of security.
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*I thought it was all so encouraging..., Got a hug..., I was absolutely astonished* #14. Another informant also stated;

*All whether you have something to do with them, they’re just equal to a smile and say good morning or good day or something when they go past. It actually means a lot* #3.

In addition, care and compassion were also expressed through the planned rehabilitation interventions, where the participants experienced adaptation to their individual needs, support for self-care, tests of assistive devices and personal conversations regarding everyday life and quality of life.

*I had a contact nurse..., she motivated me..., she gave me a push, and that was just what I needed* #14

**Social relations and interactions between patients**

The subtheme social relations and interactions between patients reflected the participants’ experience of feeling recognized by other patients and a shared understanding.

The social relations and interactions between the patients were described as a valuable and indispensable element of the rehabilitation stay.

*... half of this is the social part* #8.

Thereby, the participants experienced mutual understanding, care and genuine interest, which amplified their experience of being part of a social community. The experience of a community created additional motivation to participate actively in their stay.

*It hits you so hard to be afflicted by illness and then it is fantastic to meet other people who still have a life* #2.
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Through mutual exchange of experiences and successes, the participants experienced that they could give and receive care, hope, joy, good feeling and motivation.

*When they come then they are a bit down..., but then it doesn’t take long, two or three days, and then they blossom #15.*

*Individual rehabilitation, but challenges regarding shared decision making*

This subtheme reflected that the participants felt their rehabilitation stay was individually planned, but with room for improvement in relation to awareness of shared decision-making in goal-setting.

During a multidisciplinary assessment before the rehabilitation stay, the participants experienced that the multidisciplinary staff tried to involve their everyday lives, expectations and desires in their assessment.

*They go in and take a look at me – this means of course both physically and the disease but also on me as a human being how I need to function at home and in my everyday life #15*

The participants felt that they were actively participants in planning, goal-setting and the implementation of their rehabilitation stay, but this involvement was not without its challenges for the participants, who had not expected this involvement and had no specific expectation of the rehabilitation stay.

*Well, I didn’t really have any expectations, I mean to start with, it was sort of, a bit like: I will just take it as it comes, because I didn’t know what I should do, like, how I should approach it, I mean, to everything #1.*
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Rehabilitation as a personal process but problems with coherence and transferability of learning to everyday life

This subtheme reflected the fact that the participants experienced the rehabilitation stay as part of a personal rehabilitation process, but they also expressed concerns about whether they were able to transfer new learning and habits to their everyday lives.

*I mean, you come home with a very large, full backpack. Like, you have to empty it at home, you know, and then put the things in boxes. And say how things are going right now and when you will get the time and do it and do the right thing now, you know* #6.

As another participant expressed;

*You may get a 14 day boost here, some training is pushed into action, but you are not that well built up either* #2

The participants had many thoughts and considerations about how the optimization of their physical, psychological and social functions, initiated during the stay, should be structured and implemented in their everyday lives after discharge, and expressed a lot of uncertainty about their ability to persevere.

Participants who had been offered readmission after a few months experienced it as a motivational factor in structuring and maintaining the intervention that was initiated during the stay.

*Well, I am so privileged ... because I have to go back in 3 months. Because I really think it makes sense to follow up. Then I also have to, like, prove myself to myself, but also that I can do it and that; well, then, it would be embarrassing to come and say, well, I have not trained in 3 months* #8.
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Discussion

In this study we examined how rheumatology patients experience the personal impact of a two-week inpatient rehabilitation stay and further to elucidate the impact of contextual factors on the outcome.

The metaphor “a sanctuary from everyday life” was derived as a general theme of the informants’ experiences, thereby emphasizing the essential significance of the informants being admitted, rather than receiving outpatient or municipal rehabilitation. By staying in hospital, the informants felt that they were given the necessary peace to be able to exercise self-care and participate actively in the rehabilitation.

A particular finding was the existential significance the informants attributed to the experience of being seen, heard and recognized as a whole and equal human being, and the impact this had on their overall experience of quality and benefit from the rehabilitation stay. Dager et al. similarly revealed, in an interview study with 23 rheumatology patients, that being met with respect and interest in a supportive, encouraging, and understanding environment led to an experience of regaining dignity and respect, which had a positive impact on the changes and benefits that the patients felt they got out of their stay [28]. According to Honneth’s theory of recognition [45,46], humans have a fundamental need for recognition in order to experience a positive self-relationship and, as a result, develop as a human being and achieve successful self-realization [45]. According to Honneth [45], recognition can be achieved through three spheres: the private sphere – being given emotional attention; the solidarity sphere – being valued in the social community; and the judicial sphere – being regarded as a respected and autonomous person [47].
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Being treated with professional care and humaneness was the most fundamental contextual factor in facilitating informants’ self-care. According to Honneth’s concept of the private sphere, it is precisely recognition through the care of another human being that will result in the individual being able to build confidence in their own resources, values and beliefs [47], which is consistent with the findings of this study. Similarly, nursing professor Kari Martinsen highlights care as a basic prerequisite for all human life. Martinsen describes caring as a relational concept that describes one person’s response to another’s dependence. This dependence is exacerbated in the context of illness, suffering and disability [48]. In an English qualitative study on the need for support for rheumatology patients’ self-care, patients’ continuous need for emotional support is emphasized [49]. The findings from our study support this.

Recognition through care, according to Honneth, is also a prerequisite for the human being to be able to participate in close relations and in social situations [46]. This underpins the fundamental importance that the informants in the present study attributed to social participation and relations with health care professionals and fellow patients. This bears importance for the experienced outcome of the rehabilitations stay.

According to Honneth, recognition through appreciation in social situations leads to the individual feeling valuable in a solidarity-based community [46]. This supports the value, which the informants in the present study attributed to social relations and interactions between patients, in relation to their impact on one’s own emotional state, participation and benefit from the rehabilitation stay. In another Danish qualitative study, patients were also found to consider interpersonal interactions as therapeutic [50]. The significance of having fellow patients is highlighted in further studies, where it was found that support from fellow patients was important for the
Experiences of in-patient rehabilitation patients’ well-being and motivation for further social participation. Furthermore, it was a facilitator in the process towards a more active self-management and altered illness perception [28,49-51]. However, the ability to enter into social relations and one’s personal interest in doing so may vary [50]. The health professionals should therefore consider these matters in facilitating social interactions and communities between patients.

The participants experienced that they were seen as equal partners, with associated autonomy and co-determination [52]. This can be interpreted as a patient-centred approach based on shared decision making. Shared decision making consist of information sharing and talk about goals, options and decisions [53]. The essence of a patient-centred approach is pointed out in a study by Dager et al., wherein patients experienced ownership of their rehabilitation stay and, through the individually structured goal-setting, were motivated to actively participate in the rehabilitation interventions [28]. Other studies have also shown that a patient-centred approach has an impact on patients’ experiences of both quality and benefits of health-care interventions [54,55].

Recognition through respect for the rights of the individual in practice, according to Honneth, leads to an experience of equality and self-respect [46], which supports the significance that the informants attributed to the fact that the stay was personally adapted and that they could relate the interventions to themselves and their everyday lives.

The goal setting process in the patient-centred approach was perceived as challenging for some informants in the present study, as they had difficulty expressing their expectations of the stay. These findings are consistent with another Danish qualitative study on goals in rehabilitation, where lack of knowledge about the services
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was one of the barriers to patients’ participation [56]. In a review regarding shared
decision making in goal setting in rehabilitation, the patients lack of knowledge was one
of the most commonly reported barriers for shared decision making and they often saw
the clinician as the expert which disempowered them to participate [57]. To achieve
shared decision making may require information to the patient as well as training for the
clinicians [57]. A review by Voshaar et al., also suggest that the identified barriers for
patients participation in goal setting can be met by training of clinicians and by inviting
patients, informing them about options prior to the goal-setting process, and briefing
them on the professionals’ expectations of the patients’ active participation [54]. By
applying the concept of shared decision making, a partnership is established between
therapist and patient, through which the parties must reach a choice of treatment
through dialogue, for which the exchange of information and knowledge is an important
prerequisite [52,58]. In this way, it can therefore be assumed that patients’ co-
determination and autonomy in relation to the goals and organization of a rehabilitation
stay can be further strengthened.

Another important finding in the present study relates to the challenges faced by
informants in transferring learning from hospital to their everyday lives. They did not
perceive the rehabilitation stay as a one-off event, but rather as part of a rehabilitative
process. Thus, they also felt solely responsible for the process that followed the
discharge. These findings are consistent with previous studies on the link between the
various health care rehabilitation agencies [59-61]. Glintborg describes transfers
between sectors as transitions, and points out that one must think in terms of both
organizational and life transitions, thus ensuring a coherent and holistic rehabilitation
[62]. With the right coordination, it can thus be assumed that it is possible to meet the
challenges that patients in the present study experienced in having to transfer the
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rehabilitation from hospital to their everyday lives. According to Glintborg, this requires face-to-face coordination or follow-up by one and the same person throughout the entire rehabilitation process across sectors [62].

Strengths and limitations

A limitation of this study may be that the recruitment of informants was done in collaboration with gatekeepers. This may have had an impact on the choice of patients to be invited, which could have diminished the validity of the study. Another limitation could be the actual context in which the interviews were held. Only three of the interviews took place in the informants' own homes, and the remaining twelve at DHR, where the first author was employed. The fact that the informants could perceive her to be present on behalf of DHR can be assumed to have influenced their responses during the interviews.

In addition, there is an asymmetrical power relation in the interview situation [63] and further, when conducting interviews in the hospital setting where the patient may feel dependent on care, they may be more reluctant to express negative experiences.

The two authors are both nurses and hold knowledge about rheumatology but are not involved directly in the rehabilitation clinic. Before the study, we assumed that the rather short stay had implications for the experience of impact of the rehabilitation stay, but this was not addressed by the participants and we were surprised how hard it was to transfer their knowledge to everyday life. We thus find that we stayed open minded to the informants experiences.
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The involvement of a patient research partner gave us the opportunity to understand and adapt the written material based on the patients’ perspective and ensured the relevance of the interview questions. The high number of informants and the wide variation in diagnosis, gender and age increases the transferability of the results [64]. Thus, it can be assumed that the results may also be relevant for other patient groups with chronic illness in connection with inpatient rehabilitation.

Conclusion

Patients experience inpatient rehabilitation as a sanctuary from everyday life, in the following three ways; through individually planned multidisciplinary interventions at the hospital; recognition and compassion from the multidisciplinary staff and through social relationships and interactions with fellow patients. Thus, rehabilitation professionals should facilitate patient-patient relationships. To be seen, heard and acknowledged as an equal and whole person were vital for the patients’ experience of quality and benefit from the rehabilitation stay.

There is a need to prepare the patients for shared decision-making to be able to formulate personal and meaningful goals and a need for improved coordination of rehabilitation across primary and secondary health care and ease transference of learning to the patients’ everyday lives.

Acknowledgments

We thank the nurses who acted as gatekeepers and all the patients who participated in the interviews and the patient research partner involved in the study. Thank you to Lorna Campbell for help with language editing.
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Declaration of interest statement

The authors have nothing to declare
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Table 1. Sex and age groups of the participants

<table>
<thead>
<tr>
<th>Informant</th>
<th>Sex</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>F</td>
<td>Late 20s</td>
</tr>
<tr>
<td>#2</td>
<td>F</td>
<td>Late 40s</td>
</tr>
<tr>
<td>#3</td>
<td>M</td>
<td>Late 70s</td>
</tr>
<tr>
<td>#4</td>
<td>F</td>
<td>Late 60s</td>
</tr>
<tr>
<td>#5</td>
<td>M</td>
<td>Mid 40s</td>
</tr>
<tr>
<td>#6</td>
<td>F</td>
<td>Late 60s</td>
</tr>
<tr>
<td>#7</td>
<td>F</td>
<td>Late 70s</td>
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<tr>
<td>#8</td>
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<td>#9</td>
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<td>Late 80s</td>
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<tr>
<td>#11</td>
<td>M</td>
<td>Late 40s</td>
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<tr>
<td>#12</td>
<td>F</td>
<td>First 50s</td>
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<tr>
<td>#13</td>
<td>F</td>
<td>Late 40s</td>
</tr>
<tr>
<td>#14</td>
<td>F</td>
<td>First 80s</td>
</tr>
<tr>
<td>#15</td>
<td>M</td>
<td>First 40s</td>
</tr>
</tbody>
</table>

F=female, M=male

Table 2. Interview guide

<table>
<thead>
<tr>
<th>Interview guide</th>
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<tbody>
<tr>
<td>How has the patient experienced the rehabilitation stay?</td>
</tr>
<tr>
<td>Can you tell us the reason why you were referred?</td>
</tr>
<tr>
<td>Try to tell in your own words how you experienced your stay.</td>
</tr>
<tr>
<td>Was there someone or something that made a special difference to you during your stay?</td>
</tr>
<tr>
<td>In what way?</td>
</tr>
<tr>
<td>Want to elaborate on that?</td>
</tr>
<tr>
<td>Now you have been hospitalized for X number of days.</td>
</tr>
<tr>
<td>What do you think about that?</td>
</tr>
<tr>
<td>Could it have been different?</td>
</tr>
<tr>
<td>Do you think you could have got the same out of it if you had been an outpatient?</td>
</tr>
</tbody>
</table>

Sub-topics and questions on sub-topics

<table>
<thead>
<tr>
<th>Expectations for admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>What thoughts did you have about the stay when you were referred to it?</td>
</tr>
<tr>
<td>How did you experience the preliminary examination at DHR?</td>
</tr>
<tr>
<td>What were your expectations of the stay after you had gone to the preliminary examination?</td>
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<tr>
<th>Experience of rehabilitation?</th>
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</table>
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How has the disease affected your everyday life?
Has your illness affected your quality of life?
Have you been through other rehabilitation services before being referred to DHR?
Can you tell us a little about them?

Experience of co-involvement, involvement and collaboration with professional staff

Did you feel that you and your everyday life were based on your admission?
Can you describe it in more detail?
Were there other things you thought that would have been more important for you to work with?
What had you agreed to work with during hospitalization?

Experience of professionals’ cooperation

How did you see the various professionals working together on the set goal?
Has there been cooperation with the municipality, workplace or other?
Are there any plans for you to continue training or other things in the municipality after your stay?

The importance of co-patients for their stay

How have you experienced being hospitalized with patients with similar illnesses?
Did it have any impact on you and your income from the stay? In what way?

Length of stay

What do you think about the length of your stay?
Would it have made a difference to you if you had been hospitalized for several days?
Can you elaborate on that?

Everyday life & quality of life

What did you get out of your rehabilitation stay?
Is there anything you think and / or do differently now than you did before?
(ADL, leisure, cohabitation, sex life, parenting and work)
How do you think you can / will use it in your everyday life going forward?
Do you think it will have an impact on your quality of life? In what way?
Can you elaborate on that?
Experiences of in-patient rehabilitation

Table 3: Illustration of the three levels of the structural part of the analysis after the initial naïve reading

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>(illustrated in a literary style with a quote from a single interview)</td>
<td>(was illustrated in a poetic description across all interviews)</td>
<td>(across all interviews)</td>
</tr>
<tr>
<td>They do something for you. You are treated like a complete human being. You are not just a rheumatic person – if you understand what I mean</td>
<td>I felt safe and accepted as a whole human being, not just a person with a rheumatic disease</td>
<td>Being seen heard and acknowledged as an equal person</td>
</tr>
</tbody>
</table>