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Chinese stroke survivors’ perceptions of participation in exercise or sitting Tai Chi

Jie Zhao¹², Yuli Zang¹, Janita P C Chau¹, Rong He³, David R Thompson⁴
¹ Nethersole School of Nursing, Chinese University of Hong Kong, Shatin, Hong Kong
² SoN, Yunnan Uni
³ Yunnan University of TCM, Kunming, Yunnan, PRC

ABSTRACT

Background: Exercise promotes functional recovery among stroke survivors and is recommended to be commenced as soon as is feasible. However, little is known about stroke survivors’ perception of participation in exercise or sitting Tai Chi, a more culturally appropriate and popular movement in China.

Aims: To explore Chinese stroke survivors’ perceptions of participation in exercise or sitting Tai Chi.

Methods: Face-to-face semi-structured interviews and content analysis of transcripts were conducted with a purposive sample of 30 stroke survivors. The qualitative study explored perceptions of post-stroke participation in exercise or sitting Tai Chi. The consolidated criteria for reporting qualitative research checklist was used to report
Results: Perceived facilitators of exercise participation were healthcare professionals’ encouragement and recommendations, family and peer support and survivors’ motivation, intention and self-perceived benefits. Perceived barriers were fear of falling, physical discomfort and challenges in standing. Despite some reservations, most participants were willing to try sitting Tai Chi.

Conclusions: Encouragement and support, motivation and perceived benefits were important for exercise participation after stroke. With the premise that all medical and nursing students in China are trained in Tai Chi, for stroke survivors with no access to formal exercise programmes, sitting Tai Chi may offer an appropriate alternative.

Word count: 201

Keywords: Exercise, Tai Chi, Qualitative research, Rehabilitation, Stroke, Stroke survivor, Nurse-led intervention
INTRODUCTION

Stroke is a major cause of death and disability worldwide. In China it is the main cause of death, accounting for at least one in five deaths, and a leading cause of long-term disability, affecting around 70% of stroke survivors.

Exercise can promote a better and quicker recovery in stroke survivors. Though the early adoption of exercise may be inhibited by functional limitations that stroke imposes, such as curtailing activities of daily living and increasing the risk of falling.

For exercise to confer optimal benefit it is recommended that it be commenced as early as is feasible. Planned, structured and repeated exercise aims to improve or maintain physical fitness. The American Stroke and Heart Association recommends that stroke survivors perform 20-60 minutes of aerobic exercise each day on 3 to 5 days per week, and that survivors of recurrent stroke also perform strength, neuromuscular and flexibility exercises for 2 to 3 days per week.

However, impaired physical and psychosocial functioning after a stroke often precludes or decreases exercise participation. A systematic review of 103 studies revealed that positive changes occur in the patterns of physical activity participation among stroke survivors in hospital or community settings over time, though the intensity of engagement remains low and inactive and sedentary behaviours remain predominant. For example, a cohort study found that stroke survivors in hospital and at home spent 96% and 92% of the daytime, respectively, sedentary.

Given stroke survivors’ physical impairment and activity limitations, it is important
to determine appropriate exercise regimens for them. In China sitting Tai Chi is one such form that can be practised regularly. Tai Chi is a traditional martial art and a popular mind–body aerobic exercise originating in ancient China. Sitting Tai Chi is a modified version of this adapted for those who find it difficult to stand to perform the movements and is just as effective but safer. Given the widely recognised benefits of Tai Chi in improving limb function and balance control, and reducing depressive symptoms, the sitting version is recommended as an approach to improving physical and psychosocial functioning among stroke survivors.10,11 However, there is a paucity of research regarding its applicability. Although there are systematic reviews of stroke survivors’ experiences of and preferences for diverse forms of physical activity and exercise, no studies explore stroke survivors’ perceptions of participation in sitting Tai Chi, a more culturally appropriate and popular form of movement, among stroke survivors in China.12,13

Thus, this study aimed to explore stroke survivors’ perceptions of participation in exercise or sitting Tai Chi in China.

METHODS

Design

A qualitative study design, using semi-structured face-to-face interviews and content analysis of transcripts was used.

Participants

A purposive sample of 30 stroke survivors was recruited from the inpatient and
outpatient departments of a tertiary traditional Chinese medicine hospital in Kunming, China. Eight eligible stroke survivors declined to participate in the study due to lack of time or interest.

The sampling strategy was based on the intention to explore a wide range of post-stroke exercise experiences among survivors of subacute and chronic stroke in different settings. Inclusion criteria were: (1) age ≥ 18 years; (2) clinical diagnosis of ischaemic or haemorrhagic stroke; (3) first stroke; and (4) hospitalised subacute (7 days to 6 months post-stroke) or chronic (over 6 months post-stroke) stroke survivor. Exclusion criteria were: (1) clinical diagnosis of cognitive impairment; and (2) clinical diagnosis of aphasia.

**Data collection**

Data were collected from July to August 2019 by the first author, a PhD candidate who received training in qualitative research methodology. Eligible stroke survivors were approached after a physician or head nurse referral and invited to participate following an explanation of the study. Informed written consent was obtained before data collection. Sociodemographic and clinical data were obtained directly from the participants or retrieved from their medical records. We used a semi-structured interview guide (Figure 1) developed and refined by us and piloted with two participants. Regarding the sitting Tai Chi, there are two questions about participation, which made clear if they wished to participate: 1) that the programme would be a 30-minute daily practice led by a Tai Chi master and accompanied by a caregiver; and 2)
what kind of support they would need. Interviews lasted 15 to 40 minutes, were conducted in a quiet, undisturbed area in the hospital and audio-recorded, with field notes taken. No repeat interview was conducted.

**Data analysis**

Interviews were conducted until data saturation was achieved: possible saturation occurred after interviews with 11 subacute and 12 chronic stroke survivors, after which interviews with the rest of the participants were carried out to ensure attainment of saturation. All interview recordings were transcribed verbatim within 24 hours. Accuracy of the transcripts and interpretation of important statements were optimised by referring to the recording again or communicating with the participants. The MAXQDA™ was used to code, organise and categorise the transcribed data using content analysis. This was done by first reading the transcripts iteratively to obtain an overall understanding of the data. Next, meaningful sentences or phrases were selected, condensed and divided into units of analysis, which were labelled and constituted codes. Based on their thematic similarity, related codes were grouped together to form subcategories, and further abstracted to formulate categories. This initial analysis was performed by the first author. Double-checking of the findings with the interview recordings and transcripts was conducted by a registered nurse. Regular discussions and debriefings with the research team and two supervisors with experience in qualitative research were held until a final consensus was achieved. Additionally, SPSS for Windows 25.0 was used to perform descriptive analysis of the quantitative data.
Trustworthiness

Various strategies were used to ensure the trustworthiness of the data with regard to credibility, dependability, transferability and confirmability. The construction of meaningful units, coding and labelling of categories and subcategories were conducted mainly through group discussions and debriefings. Field notes and self-reflective notes constituted the audit trail. Research methods and findings followed the consolidated criteria for reporting qualitative research (COREQ) checklist. The presence of rich information in our findings was therefore signified, supporting their transferability. Lastly, the categories, subcategories and representative statements generated were shared and discussed with selected participants, supporting the validity and confirmability of our findings.

Ethical considerations

The investigation conforms with the principles outlined in the Declaration of Helsinki. This study was approved by the Survey and Behavioural Research Ethics Committee of The Chinese University of Hong Kong (No. SBRE-18-662).

RESULTS

Table 1 shows the participants’ characteristics. Three main categories emerged from the data: similarities in exercise participation during the subacute and chronic phases, differences during them, and the potential practice of sitting Tai Chi (Table 2).

Similarities in exercise participation during the subacute and chronic phases

Stroke survivors’ physical functioning changes from the subacute to chronic phases,
influencing their exercise practice with respect to movements, complexity, frequency, intensity and duration. Nevertheless, we found similar features in terms of patterns and facilitators of and barriers to exercise participation during both phases.

**Patterns of exercise participation**

The majority of the participants (86.7%) struggled to perform exercise, regardless of whether they had exercised before their stroke. For those respondents who had post-stroke exercise participation (26 participants), all of them initiated self-directed exercise. None of them mentioned that exercise provided by health professionals was available. Being unrestricted by equipment, time, space or location was important (Table 3). Walking was the most preferred form (63.3%) among both subacute and chronic stroke survivors, followed by upper limb stretching (33.3%) or by supporting or guiding the hemiparetic arm with the healthy arm and climbing stairs (10%), which were adopted alone or in combination. Most participants performed exercise once or twice per day for 20–60 minutes, though this varied widely, even during the same period of hospitalisation or stroke phase. They spontaneously adjusted their frequency, duration and intensity depending on their physical condition on that day. One subacute stroke survivor stated:

‘It takes around 30 minutes to lift my arms 60 times. It depends. If I don’t feel tired, I will walk again. The corresponding time [of exercise] will be longer.’

(Stroke survivor 7, Subacute)

**Perceived facilitators of exercise participation**
Both of the subacute and chronic participants were highly motivated to engage in exercise to promote their rehabilitation. Facilitators of exercise participation included advice from healthcare professionals and support from family, friends and peers, as well as self-motivation, active acquisition of knowledge, and self-perceived benefits.

1. **Advice from healthcare professionals**

Advice from healthcare professionals in hospital was the primary and most effective initial motivator for both subacute and chronic stroke survivors to begin exercise early after stroke. Recognising stroke as a critical life-threatening event during their hospital stay led to greater attentiveness to this advice, though they did not recall receiving concrete suggestions about specific exercise routines. Rather, they chose to perform specific exercises according to their own understanding and preferences:

‘The doctor told me to perform more exercise instead of lying down all the time once I feel better.’ (Stroke survivor 7, Subacute)

‘On the day of discharge, the doctors and nurses told me repeatedly – you should do more exercise when you get discharged home.’ (Stroke survivor 25, Chronic)

2. **Support from family, friends and peers**

Another motivator repeatedly emphasised by participants was support from family, friends and peers. Family caregivers, mainly spouses, played an especially important role in providing support, often in the form of physical assistance and companionship:

‘My wife usually goes with me. She supports me with one hand.’ (Stroke
survivor 1, Subacute)

‘An old woman in our neighbourhood has the same problem [stroke]. We walk together every day. We are in a similar situation so we can encourage each other.’ (Stroke survivor 19, Chronic)

(3) Self-motivation

Participants expressed their motivation to achieve an optimal level of functioning, being eager to recover and not become a burden on their family. This self-motivation was considered as an intrinsic driver for exercise participation:

‘My wife has diabetes and I can’t let her take care of me [if I can’t look after myself]. I can’t be paralysed in bed [so I have to do exercise].’ (Stroke survivor 3, Subacute)

(4) Active acquisition of knowledge

Knowledge about stroke recovery empowered survivors to actively participate in exercise: though they had some understanding of stroke they consistently sought more information to aid their recovery.

‘Everything is on TV, on the smart phone [with Internet service]… information about the benefits of exercise after stroke [I searched for it and learnt a lot].’ (Stroke survivor 18, Chronic)

(5) Perceived benefits

The aforementioned factors helped participants initiate exercise and the perceived benefits enhanced adherence to exercise. However, time and patience were necessary
before any benefits could be perceived:

‘Every day, when I start, I feel that my left foot is numb but I continue walking. Eventually, 10 minutes go by, 20 minutes go by, and gradually the numbness begins to wear off.’ (Stroke survivor 10, Subacute)

‘Initially, I could only walk around the small pond in the yard. A child can run a lap around the pond in a minute but it took me 10 minutes to walk around it. I persisted and continued walking around the pond every day for about one month. Then, gradually I moved on to walking around our residence community. It has been three months now. I can walk around the residence community [about 1 km] twice a day. Besides, at the beginning, I found it a little bit difficult to lift my left foot. But the more I walked, the more strength it has gained. Now, the drag and drop of my foot has improved a lot.’ (Stroke survivor 19, Chronic)

**Perceived barriers to exercise participation**

Both the subacute and chronic participants talked about barriers to exercise participation that they experienced: fear of falling, physical discomfort and challenges in standing.

A fear of falling limited exercise intention and participation and reduced duration and frequency, highlighting survivors’ unwillingness to put greater effort into performing exercise unless they felt safe. Physical discomfort, typically fatigue and pain, hindered exercise participation despite indications that survivors tried to engage
in regular exercise, albeit with intermittent discontinuation. Some participants attributed their limited exercise participation to knee osteoarthritis and lower limb weakness which posed challenges in standing. Despite such obstacles, most participants tried to adjust and adapt to them:

‘I have no strength in this leg. That’s why I dare not move. I’m afraid I’ll fall down and will never be able to get up again.’ (Stroke survivor 4, Subacute)

‘I always get a headache after exercise. It has been like this for two years. I don’t know why. I can only do exercise for a while, then I have to rest for a while, exercise again, then rest again. Even so, the overall duration of exercise each day is relatively short.’ (Stroke survivor 30, Chronic)

**Differences in exercise participation during the subacute and chronic phases**

There were some haphazard patterns of exercise participation during the subacute phase and positive aspects during the transition from the subacute to chronic phase.

**Haphazard patterns of exercise participation in the subacute phase**

Participants mentioned a lack of dedicated facilities or places for hospitalised subacute stroke survivors to exercise, resulting in haphazard patterns of participation. Also, due to their physical weakness, these survivors could perform only 10 to 30 minutes of exercise per day. Some also believed that they had to be able to stand up before beginning exercise, thus delaying its initiation, as reiterated by survivors who did not participate in any exercise:

‘I haven’t done any exercise since I was hospitalised. I can’t stand up so I have
no way to participate in it.’ (Stroke survivor 4, Subacute)

Positive aspects in exercise participation during the transition from the subacute to chronic phase

Participants expressed that during their transition from the subacute to chronic phase of recovery their exercise participation increased steadily in intensity and variety, with family support playing a crucial role.

(1) Enhanced exercise participation

The relatively improved physical condition of chronic stroke survivors permitted their participation in more exercise:

‘My daily exercise duration adds up to five to six hours. Except for the times that I am sleeping or eating, I always try to do some exercise.’ (Stroke survivor 26, Chronic)

In addition to exercise duration, variety was also increased, with participants stating that they were no longer restricted to simple, basic routines, but gradually training their fine motor skills, building muscle strength, and doing mind-body exercises such as one stroke survivor performed Tai Chi:

‘I fill a plastic bottle with water [about 1 kg] and then lift it while walking around the house using my [hemiparetic] left upper limb.’ (Stroke survivor 26, Chronic)

‘My exercise now includes performing traditional Tai Chi in the yard with a couple of friends in the morning and walking in a park nearby in the evening.’
(2) Factors enhancing exercise participation

Participants mentioned perseverance and family support as important factors enhancing exercise participation. They acknowledged that exercise should be maintained uninterrupted, whilst pointing out that some survivors may perform limited amounts of exercise and feel satisfied, believing that even if they stopped they would be able to maintain progress. Whereas, in reality, doing so would be detrimental. Thus, sufficient patience and perseverance in adhering to exercise was deemed crucial:

‘Stroke survivors cannot simply stop doing exercise when getting better. I used to keep walking, and I recovered to the point where I stopped dragging my [right] foot. But I went back to my hometown for about two weeks and did not walk as usual. I came back to Kunming and started dragging my [right] foot again.’ (Stroke survivor 29, Chronic)

Participants indicated that family support helped them to maintain exercise participation by providing useful verbal reminders and instrumental help:

‘Sometimes I want to be lazy, but my wife pushes me to do exercise by saying – stop sitting and go out for a walk.’ (Stroke survivor 18, Chronic)

‘My daughter-in-law bought me a kilo of pine nuts. She asked me to exercise my fingers by picking up the pine nuts.’ (Stroke survivor 29, Chronic)

Potential practice of sitting Tai Chi

Most participants were willing to try sitting Tai Chi to aid recovery, though some were
hesitant and a few reluctant. 

Survivors willing to try

Participants willing to try sitting Tai Chi deemed a 30-minute duration as acceptable, though there was a discrepancy in the frequency between subacute and chronic stroke survivors.

(1) Possible duration and frequency of sitting Tai Chi

Most subacute stroke survivors expressed a willingness to try sitting Tai Chi for 30 minutes per day and willing to fit it into their regular hospital schedule:

‘I’m fine with the sitting Tai Chi. I can practise it as scheduled when in hospital. I have nothing to do in the afternoon.’ (Stroke survivor 4, Subacute)

However, chronic stroke survivors expressed a preference for a shorter frequency in view of other rehabilitation options:

‘Every day? Generally, there is no problem, but I would say three to five days per week will be better as I need to go to a rehabilitation centre two days a week.’ (Stroke survivor 18, Chronic)

(2) Situational restrictions

Participants expressed concerns arising from their short hospital stay and inability to remember all the movements:

‘I could participate, but I know it would take three to five months for Tai Chi to work. I won’t be in hospital for that long so I won’t be able to finish the training. Even if you teach me in the hospital, I am not sure if I will be able
to recall the movements after discharge.' (Stroke survivor 6, Subacute)

They also implied that the issue of being unable to continue performing sitting Tai Chi exercises after discharge from the hospital needed to be addressed by healthcare professionals.

(3) Limitation in arm mobility during practice

Participants expressed the erroneous belief that sitting Tai Chi required movements of both arms together:

‘I wish I could, but my arms can’t reach the same height. My right arm has lost its strength.’ (Stroke survivor 14, Subacute)

Survivors hesitant or reluctant to try

Some participants voiced a hesitancy towards trying sitting Tai Chi, asking if they could observe it first, and stating that they preferred to decide after observing others first, particularly those with similar conditions.

A few participants expressed a reluctance to try sitting Tai Chi because of the perceived unbearably slow motions involved, vague negative feelings, lack of interest, and poor awareness of its positive effects. Fatigue and pain were perceived as physical hindrances by some:

‘I can’t participate in it because of my shoulder pain. In fact, I suffer from serious post-stroke pain. The pain in my left shoulder is unbearable.’ (Stroke survivor 8, Subacute)

DISCUSSION
Our study offers a number of novel insights into Chinese stroke survivors’ perceptions of exercise and sitting Tai Chi.

**Post-stroke exercise participation**

Most participants reported a physically inactive lifestyle, especially in the early subacute stroke phase during hospitalisation, consistent with previous findings.⁸,¹²,¹⁹ Although the stroke survivors performed some exercise, the intensity was below guideline criteria. The lack of exercise participation and structured exercise-based rehabilitation programmes for stroke survivors is prevalent worldwide, particularly in low- and middle-income countries.²⁰ Our findings highlight that although participants received medical advice on the benefits of exercise during recovery, it was vague. This may be due to a shortage of staff, equipment, spaces, administration support, and an incompetency in screening, prescribing and familiarity with updated guidelines.²¹ Structured multidisciplinary stroke rehabilitation could ameliorate this and reduce stroke-related disability among stroke survivors, regardless of their age, sex and stroke severity, with nurses playing a key role as coordinators.²²-²⁴

Adequate knowledge, positive attitudes, self-perceived benefits, and strong social support are critical to stimulating and sustaining stroke survivors’ motivation to pursue such actions as exercise.²⁵ Post-stroke recovery is also a time- and confidence-consuming process, involving the challenge of adhering to prescribed or expected actions such as exercise to achieve optimal benefit. Poor exercise adherence is associated with decreased motivation and lack of perceived benefits.²⁶
survivors with caregiver support achieve greater improvements in physical function and increased time for exercise compared to those without such support. Reminders from family caregivers are, therefore, a good way of increasing survivors’ adherence to exercise. Timely communication by healthcare professionals may further help keep survivors and their families well-informed and enhance self-motivation.

Participants reported a fear of falling and challenges in standing. A fear of falling is negatively correlated with the hemiplegic hip abductor, knee extensor and ankle plantar flexor, and physical exercise has a positive impact on reducing fear of falling among stroke survivors. We also found physical discomfort (e.g. fatigue and pain) as another barrier to post-stroke exercise, echoing previous findings.

Potential of sitting Tai Chi

Stroke survivors have different physical functional impairments and, therefore, may require different forms of exercise, tailored to their individual needs.

Given stroke survivors’ fear of falling during exercise, the safest and most promising position for exercise would be the sitting position for those who find it a challenge to stand safely. Sitting exercises have positive physical and psychosocial outcomes in participants who are unable to exercise in the standing position. We found that most participants were positive towards sitting Tai Chi, which would appear a more culturally appropriate option for stroke survivors in China.

All medical and nursing students in mainland China undertake training in Tai Chi, but sitting Tai Chi, introduced nearly 30 years ago, despite its benefits is rarely offered.
Our findings suggest it be considered as a means of enhancing exercise among stroke survivors during their rehabilitation.

Limitations

Our study has some limitations. First, we classified stroke survivors as being in either the subacute or chronic post-stroke phase, a distinction which may be blurred and artificial, especially when participants were transitioning between the two, and which may threaten the credibility of our findings. Second, we excluded participants with noticeable cognitive and language difficulties from this study, which may reduce the transferability of the findings. Third, the participants were recruited from a traditional Chinese medicine hospital and were likely to have strong beliefs in this approach to post-stroke recovery (most acute stroke survivors choose general hospitals for treatment). Thus, our study findings, especially those related to sitting Tai Chi, should be interpreted with caution.

CONCLUSIONS

We investigated Chinese stroke survivors’ perceptions of participation in exercise or sitting Tai Chi and found that though they expressed a desire to exercise, barriers included a lack of professional support and structured exercise-based rehabilitation programmes. Facilitators included encouragement and support, motivation, and perceived benefits. For those stroke survivors with no access to formal exercise programmes, sitting Tai Chi was generally perceived positively and may offer a more culturally appropriate alternative. All the nursing students in mainland China received
training in Tai Chi. Sitting Tai Chi can be performed easily and conveniently regardless of location and requires no equipment. Whichever mode is chosen a nurse-led, collaborative and individually-tailored approach that engages stroke survivors and their family caregivers may prove the most beneficial for aiding early post-stroke recovery.

**Implication for practice**

- Both facilitators and barriers in exercise or sitting Tai Chi participation exist among Chinese subacute and chronic stroke survivors.
- Nurses should play a more active role in supporting the functional well-being of stroke survivors.
- With the premise that all medical and nursing students in China are trained in Tai Chi, a nurse-led family-based sitting Tai Chi intervention that aims to aid stroke survivors’ early recovery could be designed and evaluated.

**Acknowledgement**

None

**Conflict of interest statement**

The authors declare that there is no conflict of interest.

**Funding statement**

No external funding
References


counseling, psychotherapy, and behavior change: a look at theory and practice.


Figure legend

Figure 1: Interview guide


professionals from the American Heart Association/American Stroke Association.

*Stroke, 47, e98–e169. https://doi.org/10.1161/STR.0000000000000098*


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Table 1 Participants’ demographic and clinical characteristics

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*There were 21 (70%) ischaemic and 9 (30%) haemorrhagic stroke survivors.*
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<td>• Factors enhancing exercise participation</td>
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<td>• Survivors willing to try</td>
<td>• Possible duration and frequency of sitting Tai Chi</td>
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<td>• Situational restrictions</td>
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Table 3 Patterns of post-stroke exercise participation (N=30)

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<td>None</td>
<td>4</td>
<td>13.3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Frequency (n/day)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>4</td>
<td>13.3</td>
<td>4</td>
</tr>
<tr>
<td>1</td>
<td>12</td>
<td>40.0</td>
<td>7</td>
</tr>
<tr>
<td>2</td>
<td>11</td>
<td>36.7</td>
<td>3</td>
</tr>
<tr>
<td>≥3</td>
<td>3</td>
<td>10.0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Duration/session (minutes)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-20</td>
<td>4</td>
<td>13.3</td>
<td>4</td>
</tr>
<tr>
<td>21-30</td>
<td>7</td>
<td>23.3</td>
<td>6</td>
</tr>
<tr>
<td>31-60</td>
<td>13</td>
<td>43.3</td>
<td>1</td>
</tr>
<tr>
<td>&gt;60</td>
<td>2</td>
<td>6.7</td>
<td>0</td>
</tr>
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</table>
1. Do you participate in any exercises (guided by healthcare professionals or self-initiated, planned and repeated, aimed at promoting recovery and restoring health, e.g. rehabilitation exercises, limb stretching exercises, walking, running, dancing, conditioning exercises and Tai Chi) after stroke?

2. Which type of exercises do you participate in?

3. How did you get involved in these exercises?

4. What is the frequency of your exercises (daily, weekly) and duration of each session?

5. Why not?

6. If your condition permits, would you like to perform exercises?

7. If your condition permits, for how long would you like to perform exercises every day, and how many times a week?

8. What do you think are the advantages and disadvantages of doing exercises after a stroke?

9. Do you have any difficulties in performing exercises after stroke?

10. What kind of support would you like to get while performing exercises after stroke?

11. If you are invited to participate in a sitting Tai Chi programme under the guidance of a Tai Chi master and accompanied by a caregiver, would you like to participate in it for 30 minutes every day?

12. If you participate in the sitting Tai Chi programme, what kind of support would you like to get?