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'We are all in this together': a creative non-fiction story of older adults participating in power-assisted exercise

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ABSTRACT

In this study we aimed to explore older adults' experience of community-based power assisted (PA) exercise and its potential impact on social exclusion, isolation and loneliness (SEI&L). The lead author obtained ethnographic data over a 6-month period using three primary methods: participant observation (900 hours), a reflexive diary, and 10 semi-structured interviews. Participant observation provided a rich lens into a PA exercise centre describing the scene, characters, and dialogue that enabled the ethnographer to interpret stories of SEI&L. Participants expressing stories of SEI&L (6 service-users, age 66–90 years) and participants working at the centre (3 staff members, age 41–50 years; 1 volunteer, age 69 years) were invited for interviews with the purpose of expanding on data from the field. We used dialogical narrative analysis to construct story themes and meaningful structures from the data that enabled a nuanced understanding of the plots and characters woven into the ethnographic creative non-fiction. Shifting our perspective from story analysts to storytellers, we have constructed two emotionally vibrant composite narratives to show the mechanisms and meanings of SEI&L for older adult exercisers following bereavement in later life and when living with a debilitating chronic health condition. The therapy centre provided a safe and inclusive space for older adults to reconnect through accessible modes of exercise and an atmosphere fostering a sense of belonging and togetherness. This work offers rich insight into older adult's experiences of community-based exercise and raises awareness of SEI&L to help instigate personal and social change across multiple audiences.

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Social exclusion; social isolation; loneliness; older adults; power-assisted exercise; creative analytical practice

Introduction

Social exclusion, social isolation and loneliness (SEI&L) are associated with a host of negative mental and physical health outcomes including depression, cognitive decline, cardiovascular disease, increased emergency admission to hospital, and increased risk of mortality (Hawton et al. 2011; Holt-Lunstad 2017). SEI&L affects approximately one-third to one-half of the elderly population (Landeiro et al. 2017), with prevalence rates increasing during the Covid-19 pandemic (Wu 2020). Of particular concern are disproportionate rates of SEI&L among those living with a disability and chronic health conditions (Cohen-Mansfield et al. 2016; Olsen 2018). A loss of physiological functioning, alterations in social relationships, and difficulties accessing social and physical spaces in the community are some of the factors that have been shown to exacerbate SEI&L in these groups (Kitzmüller et al. 2018; Macleod et al. 2019).

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There is a close but complex association between the individual constructs that comprise SEI&L. While social isolation describes a lack of engagement with others and minimal, or unfulfilling social contacts, loneliness refers to the unpleasant feelings associated with a lack of certain relationships and unrealised intimacy (Newall and Menec 2019). Comparatively, social exclusion is the absence or denial of resources, rights, goods and services, and the inability to participate in normal relationships and activities, available to most (Macleod et al. 2019).

Recent theoretical developments outlined the dynamic multi-dimensional processes of social exclusion in later life. For example, Macleod et al. (2019) identified complex interactive relationships between seven domains of social exclusion, comprising: 1) service provision and access (e.g. transport), 2) civic participation (e.g. cultural, educational and political engagement); 3) social relations and resources (e.g. family and friends); 4) economic, financial and material resources (e.g. income, housing and assets); 5) environment and neighbourhood (e.g. neighbourhood conditions and facilities); 6) health and well-being (e.g. physical and mental health status), and; 7) discrimination and ageing (e.g. prejudicial treatment and identity exclusion). When testing the new framework, Macleod et al. (2019) found that the degree of exclusion experienced by people increased with age, with the oldest-old experiencing more exclusion overall and on each domain. Life events, such as bereavement and changes in health, amplified social exclusion for older adults, with health presenting as both a determinant and outcome of social exclusion (Macleod et al. 2019). Given the detrimental impact of SEI&L on older adult's health and well-being, continued exploration of the complex processes and mechanisms of SEI&L are needed to assist in the development of appropriate interventions.

A multitude of interventions (e.g. Gardiner, Geldenhuys, and Gott 2018) and initiatives (e.g. The Campaign to End Loneliness 2020) have been developed to address SEI&L, with one potentially promising approach being physical activity. For example, physical activity and group leisure activities such as supported walking programmes, have been implemented to generate opportunities for social and community engagement (Hwang et al. 2019). Collectively, researchers have reported that these group exercise initiatives have helped to motivate older adults to socialise, develop and strengthen friendships, and reduce feelings of loneliness by providing a sense of 'belonging' (e.g. Hwang et al. 2019; Stenner, Mosewich, and Buckley 2016). Further, Robins et al. (2018) suggested that group physical activity had a direct impact on the amount of social contact older adults engage in, and there were also possibilities for indirect improvements in SEI&L mediated through improved physical capacity, creating greater opportunity to engage in social activities. Nevertheless, improvements in SEI&L through physical activity interventions have been shown to be moderated by individuals' physical impairments, thus highlighting the need to consider what type of exercise services are offered to individuals (Raymond 2019).

Ironically, traditional leisure settings often marginalise groups that are at higher risk of SEI&L, including individuals with a disability and the elderly (Brittain, Biscaia, and Gérard 2020; Jin and Harvey 2020). For instance, Raymond (2019) identified disability-related stigmatisation in a seniors' club, in which older people with impairments who wanted to access mainstream social spaces faced obstacles preventing participation, including stigma regarding physical capacities and discrimination against impairment. Consequently, there is a need to consider societal attitudes and social practice as it pertains to inclusive participation in exercise settings, and how community-based exercise may help address SEI&L (e.g. Brittain, Biscaia, and Gérard 2020; Jin and Harvey 2020). One emerging approach to community-based exercise involves power-assisted (PA) equipment. Its contribution to SEI&L has not been examined to date.

The PA exercise setting provides a safe alternative for individuals with poor exercise capacity and impaired movement which prevent them from using conventional gym equipment (e.g. Rimmer et al. 2014; Young et al. 2021). Community-based exercise of this nature could play a vital role in addressing the high prevalence of SEI&L in the elderly by providing a tailored and inclusive exercise service. Nevertheless, few studies have explored the impacts of PA exercise on psychosocial health. Indeed, the extant research in this area has primarily been dedicated to physiological outcomes or

specific populations (e.g. stroke survivors), with the psychosocial influence of PA exercise among those experiencing SEI&L remaining comparatively underdeveloped (e.g. Jacobson et al. 2012; Young et al. 2021). In this study, we aimed to address this research gap to help understand older adult's nuanced perspectives and lived experiences of PA exercise. This is consistent with a growing consensus towards the value of constructing 'authentic' lenses through which to better understand SEI&L processes (see Cohen-Mansfield and Eisner 2020) and using immersive research approaches and data sources to enrich the analytical and representational perspectives of loneliness and physical activity in later life (e.g. Griffin and Phoenix 2016; Harvey and Griffin 2021; Neves et al. 2021). For example, ethnography has been used across various sport, exercise and health settings as a valuable methodology to build qualitative understanding, such as providing an unfiltered lens into the emotions experienced within a cardiac rehabilitation programme (Meredith, Wagstaff, and Dicks 2018), exploring the psychosocial factors affecting the development of overuse injuries in gymnastics (Cavallerio, Wadey, and Wagstaff 2022), and to understand the socially inclusive and exclusive physical cultures for older exercisers (Harvey and Griffin 2021). Therefore, ethnography was used in the present study as a frame for immersion within a PA exercise setting, which we believed could help provide ' meaningful ways of imagining and living within the ageing body across the life course' (Griffin and Phoenix 2016, 92).

A growing body of work also attests to the power of narrative analysis and representation for exploring and representing contextual understandings and stories of physical activity in later life (e.g. Hudson, Day, and Oliver 2015; Tulle and Dorrer 2012) and to explore embodied experiences of loneliness (e.g. Morgan, Burholt, and Carr 2020; Tarvainen 2021). Working with stories can help scholars to explore relationships between theoretical concepts and the complex, sensory experiences of human life (Frank 2012; Watson 2021). Increasingly, the sociology of ageing has embraced creative ways to represent older adults lived experiences as a way to engage the reader with the visceral and emotional aspects of the participants' lives (e.g. Breheny 2012). Stories in the form of creative non-fiction (CNF) was used in the current study to illuminate older adults lived experiences of SEI&L and give insight and meaning to ageing bodies and physical activity cultures. The use of CNF within sport, exercise and health settings is expanding (e.g. Quarmby et al. 2021; Richardson and Motl 2021) as researchers and practitioners increasingly acknowledge that stories offer a powerful translational tool for communicating information and engaging multiple audiences (Frank 2012; Phoenix, Smith, and Sparkes 2010). With these methodological foci in mind, our aim was to explore older adults' experience of a community-based PA exercise facility and its potential impact on SEI&L, using in depth ethnographic CNF. Given the limited psychosocial research conducted within the field of community-based PA exercise settings and the potential use of such initiatives to address SEI&L, our specific research questions were: 1) What are older adults' embodied experiences of using a PA exercise facility? 2) What are older adults' embodied experiences of SEI&L? and 3) What is the impact of community-based PA exercise initiatives on SEI&L?

Methods

Ethnographic principles and techniques underpinned by ontological relativism (i.e. knowledge is relative to differences in perception, and is mind-dependent) and epistemological constructivism (i.e. knowledge is constructed) were used to provide rich qualitative understandings of the social dynamics within a community PA exercise setting (Reeves, Kuper, and Hodges 2008). Ethnography is rooted in anthropology, and involves the application of fieldwork, including various methods, such as participant observation, for understanding and making sense of cultural and social life (Coffey 2021). Conducting ethnographic fieldwork allowed reflexive insight and embodied engagement with participants' experiences of SEI&L through immersing physically, socially, cognitively and emotionally within the culture of a PA exercise centre. This fieldwork allowed the development of an intimate understanding of older adult's everyday lives at the facility and how the social setting impacted upon SEI&L through accessing meaningful practices and listening to and reflexively

interpreting participant stories (e.g. Markula 2016). Stories gleaned from the ethnographic data became 'objects of study' in a narrative inquiry of older adults' experiences of SEI&L, in which the lead author transitioned between the stance of story analyst and storyteller to represent findings in a CNF (Smith 2016). The development of the ethnographic CNF presented participant stories in an accessible format through creative literary layering techniques showing what it was like to be a part of the exercise facility and the emotions and truths when living with loneliness (Cavallerio 2022).

We considered relational ethics, acknowledging interpersonal bonds with participants and taking responsibilities for actions, protecting the wellbeing and dignity of all research participants (Ellis 2007). Ethical approval was granted from the second and third authors' Faculty Research Ethics Committee.

Study setting

The study was conducted in a community PA exercise facility provided by an independent charitable trust with the aim to enable people 'to move more and feel better'. The centre provided enhanced exercise support and adaptations for older adults (85.68% of service-users were >60 years), deconditioned individuals, or for individuals managing long-term health conditions (81% of service-users had 2 or more long-term health conditions). Participants entered the service through self-referral, or health professional referral routes and completed a holistic health assessment with an exercise therapist before engagement with an exercise programme. The facility comprised 9 PA exercise machines targeting the main muscle groups (see supplementary material 1), static exercise bikes, a space for specialised exercise classes, and a social area providing refreshments. To enable sustainability of the facility, services were provided for a nominal fee. There was a supportive structural team in place to deliver services, including a Partnerships Development Manager, Centre Manager, Exercise Therapist, Exercise Circuit Coordinator and a group of volunteers.

Data collection

During data collection the first author had a relative insider status, given her role as an exercise therapist at the centre (Witcher 2010). Taking the stance of a participant observer, she had already established a good rapport with participants and was a part of the exercise community being explored. To record her experiences and emotions which shaped the development of data, she maintained a reflexive diary (Lichterman 2017). Ethnographic fieldwork occurred for a 6-month period (September 2019 – February 2020) and included participant observations (approximately 900 hours), reflexive diary entries and interviews. Participant observations comprised detailed field notes describing the day-to-day operations within the therapy centre, including the behaviours, conversations, emotions and interpersonal dynamics of service-users, staff and volunteers. The specific contexts observed included the opening and set up of the centre, service-user assessments, specialist exercise classes, the PA exercise circuit, the social seating area, and six staff meetings.

Participant observation was augmented by innumerable informal (in 'the field') and 10 formal, in depth semi-structured interviews. Observation data helped the research team to identify stories of SEI&L from service-users' (6 white British older adults, age 66–90 years, 5 female) who were invited to further share their experiences in a subsequent interview. SEI&L are sensitive topics wherein a formal interview away from the busy exercise centre provided participants with the opportunity to expand on their stories in a confidential and supported setting. Interviews provided in depth meaning and new perspectives on field notes, including the mechanisms of loneliness, the role of the exercise centre and the myriad of emotions associated with SEI&L. Staff, including a partnerships development manager, centre manager, and circuit co-ordinator (white British females, age 41–50 years) and 1 volunteer (white British female, age 69 years) were interviewed to broaden perspectives surrounding the institutional practices of the exercise centre, thereby augmenting the first author's field notes. A three-part guide was used for semi-structured interviews to probe certain developing areas

of interest, the first section was designed to elucidate the participant's background (e.g. 'Could you describe a typical day in your life?'), the second section aimed to explore the participants perceptions about SEI&L (e.g. 'What are your thoughts about loneliness?'), and the third section aimed to explore participants perceptions of the community PA exercise initiative (e.g. 'What is the social atmosphere like at the centre?'). The average duration of interviews was 60 minutes.

Data analysis and representation

The ethnographic data, including observation field notes, reflexive diary and interviews (transcribed verbatim) were analysed using dialogical narrative analysis (DNA). According to Frank (2012), DNA represents people's lives through immersive stories using dialogue that situate people in groups, showcasing the past, but also considering future responses for story retelling. The lead author practiced an iterative process of data collection and analysis, immersing into participants lives and expressing dialogue between multiple voices within the community and over time. Using DNA, various dialogical questions were considered (Frank 2012), including resource questions (what narrative resources shaped the stories?), circulating (who was telling the stories to whom?), affiliating (who was affiliated into the common understanding of the stories being told?), and identity and function questions (how did the stories express and change identities of the story tellers, and what was at stake through telling the stories?) (see supplementary material 2). Observation and reflexive diary notes provided detailed embodied experiences of the everyday circumstances in which participants told their stories through narrative resources, including informal talk (e.g. pockets of conversation in the social area, and around the exercise circuit), written materials and documents (e.g. information posted on the community board), and reflexive storied accounts of the setting (e.g. detailed descriptions of the scene, characters and group interactions). Fieldwork helped to cultivate stories associated with the research aims, which were deepened through formal interview dialogue with key characters (older adults experiencing SEI&L and participants working with older adults in the setting). For the analytical process to result in the development of narratives, each story was considered as a whole, and actions that may have fragmented stories were avoided. Subsequently, the lead author constructed themes and structures in the stories by highlighting key sentences and paragraphs in the data, adding notes to the transcripts, identifying meanings and how the stories were formed (Smith and Monforte 2020). Stories were selected through a process of phronesis, that is 'the analyst's cultivated capacity to hear, from the total collection of stories, those that call out as needing to be written about' (Frank 2012, 43). Specifically, two main story themes were interpreted from the data: first, bereavement in later life – coping with loss and loneliness, and second, debilitating chronic health conditions – illness symptoms mediate social transformation.

The first author then moved from a position of story analyst to that of a storyteller using creative analytical practice (CAP). CAP is a term for research practices casting empirical data into creative forms of representation that are evocative and highly accessible (Richardson 2000). In particular, ethnographic CNF was used to develop emotionally vibrant narratives, showing theory using creative writing strategies to conjure vivid images and emotions in the reader (Smith, McGannon, and Williams 2015). In keeping with the central themes interpreted from the DNA, two composite narratives were produced to represent the data through providing a mix of experiences amalgamated into two separate, but related, CNFs connected through characters and events (Orr et al. 2020; Spalding and Phillips 2007). Leading and passing characters were developed from an amalgamation of key participants with similar perspectives identified in central story strands. Two composite leading characters (Elizabeth and Gary) were created to allow multiple older adults' voices to be synthesised into compelling shared accounts of the DNA themes, offering clarity to the key messages we wanted to convey in the story through our DNA without losing the reader across numerous characters, and enhancing narrative flow (Cavallerio

2022). Captivating segments of dialogue and field notes were selected and pieced together to form a meaningful representative plot for each CNF, told using an omniscient narrator. A third-person omniscient narration (i.e. the all-knowing narrator) allowed the stories to flow between different characters thoughts and dialogue while providing rich descriptions of what was happening in the scene and allowing smooth transitions in time, which helped to develop a rich multi-dimensional depiction of experiences (Gutkind 2012). Observation data was particularly helpful when 'layering' the stories adding detailed accounts of the surroundings, such as sounds (e.g. the whir of PA machines), sights (e.g. the paint on the walls), taste and smell (e.g. sipping tea in the social area) and the way the characters moved and interacted in the setting (Cavallerio 2022). To maintain authenticity, direct quotations were woven throughout the CNF that drew on participants' actual experiences in the hope of embodying the many voices heard throughout the ethnography. Each narrative was edited and revised following reflexive support from the research team and member reflections, creating narratives that were considered fair representations of participants' experiences (Orr et al. 2020).

Rigour

Consistent with the philosophical underpinnings of this research, rigour was judged using a relativist approach considering the authenticity, and richness of data guided by characterising traits (Sparkes and Smith 2009). The rigour of the creative process which resulted in the ethnographic CNF was specifically judged using guidelines from Smith et al. (2015), selecting the most pertinent recommendations consistent with the aims of the study (see also Smith and McGannon 2018). Specifically, the authors sought to produce a narrative that contributed theoretically, and practically to social life in a community therapy setting, providing fresh insight and a deeper understanding of SEI&L and the use of PA exercise initiatives. The narratives aimed to represent complex SEI&L processes and embody a sense of lived experience within the exercise setting, inviting interpretive responses from readers. Narratives were written in an emotionally and intellectually evocative form to engage audiences and create incitement to action. Throughout this process, the second and third author acted as 'critical friends', helping the first author to reflect and sense-make, interpret the community culture, and support the lead author as she reflected on her beliefs and assumptions. The result of this process was an iterative approach to (re)writing and revising as the narrative developed.

Results

Bereavement in later life – coping with loss and loneliness

Elizabeth carefully dug through the bottom of her wardrobe, her long coats swooshing overhead. Where were her flat, comfy shoes, the ones she wore for exercise? Rummaging near the back of the small cave of footwear, Elizabeth came across a faded shoe box. The edges of the lid were crumpled and torn, and a thin layer of dust covered the surface. Her interest piqued, and with some effort, Elizabeth gently grasped the box and pulled it towards her. She whistled out a breath and blew the dust circling into the air. Lost in the darkness for years, the contents of the old box were suddenly flooded with light. Rested in crumples of white paper were Elizabeth's red dancing shoes. Elizabeth smiled. The shoes were still bright red and they shone, belying their years of rest in the old box. Elizabeth traced her finger over the elegant T-strap and around the heel. She was flooded with warm memories, sending a crescendo of tingles over her skin. Elizabeth was transported back to another time. Another her. Her hands were no longer wrinkled, but smooth, and they were held warmly in the embrace of Frank. She laughed as Frank whirled her around the floor, spinning her on the red heels. Elizabeth remembered his eyes, vivid blue, always a glint of trouble and adventure. Those eyes never changed, they dazzled all his life, all the

way to the end. A small tear formed, Elizabeth blinked, and the droplet rolled over and between the delicate creases of her face. 'My oak tree', Elizabeth whispered to Frank, 'my strong oak tree, I love you'.

Beep!

Beep!

BEEEEEEEEEEEPPPPP!

The first polite calls descended into a symphony of louder much longer honks. Alice slumped and tapped the steering wheel impatiently. Where the hell was Elizabeth? We can't be late again for exercise. Alice gazed through the misted window watching, the front door swung open and framed Elizabeth. She was hunched. Grappling with her walking stick, bag, and keys she ventured cautiously out onto the front step. Before slamming the door closed Elizabeth slowly kissed her palm and blew into the empty house. 'What in the world?' Alice uttered to herself. Elizabeth made a slow route down to the car.

'New boyfriend?' Alice grinned, looking inquisitively at Elizabeth who slowly manoeuvred into the passenger seat. 'Very funny', she breathed, clicking tight the seatbelt. 'It's not the hunk next door is it? You know he's mine, and if anyone should be blowing him kisses it's me!' Alice joked. Elizabeth's frown dissolved and she laughed loudly. These days only her close friend could make her chortle this much. 'Seriously though, are you okay?' Alice patted her hand affectionately. Elizabeth's smile melted, her small features arrested to a stoic statue, 'I keep talking to Frank'. She paused and looked ahead out the car windscreen. Alice still rested her palm on the back of Elizabeth's hand. She squeezed reassuringly. 'Alice am I losing it? Have I truly turned into a crazy old witch?!' She turned and half smiled, half grimaced. 'Mmm, old? Yes . . . . Witch? . . . Maybe. But crazy? No' her friend smiled, 'look it's hard, it's really hard to lose someone like Frank; to lose a husband. When James died, well, that was the nail in the coffin for me. I went into unmade bed mode; I literally couldn't get up and even walk. I didn't go back to work. I probably should have done. But it was as though I'd been picked up and flung against a wall!', Alice smacked her hands together, 'I just put a curtain over it really, which was probably the wrong thing to do'. Elizabeth nodded, fresh tears welling, 'people say that the first year is the worst when you lose somebody, but it's not, it's year after year after year', she croaked. 'It's a bit like clinging to the side of a swimming pool, I don't swim, and I'm terrified of the water! But you know when you've got somebody, and you've got a really solid relationship, and you suddenly realise when they're not there how secure you felt before'. 'I know, come here', Alice leant across and enfolded Elizabeth, who cried quietly into her shoulder. 'If it makes you feel any better, I talk to James' photo every day', Alice chuckled, 'it's important to have time to reflect and to treasure memories. We can be crazy old witches together'.

Claire, an exercise therapist, straightened her name badge and smoothed down her fleece. Stepping from the office she was touched with a chorus of warm chatter, the whir of machines, and the gentle hum of the radio. Claire had a warm disposition; she was kind-hearted and passionate to make a difference. She gazed across the long room, walls splashed with purple and grey, 'Move More . . . Feel Better' stencilled in bold, the ethos of the centre ingrained and shining. The therapy centre wasn't like any ordinary gym, nor was it a clinical space with white coats and stethoscopes. The facility was built on a charity's dream to enable all people regardless of health or disabilities to exercise safely and effectively. Claire thought back to her first day and her conversation with the CEO, Jack. 'We are really building the foundations of a new venture, there are not many other places like this and as a charity we are growing this venture in line with what is happening in today's society. People are living to an older age and they are having to spend more time on their health. I really appreciate the NHS (National Health Service), but they are under pressure, and health care is moving

more towards self-management and community organisations in the future. We are a part of that. We are at the forefront of something really special, creating a supportive environment embedded within our community. You can look back and know that you were a part of the first foundations. So, go sprinkle your magic!' Jack liked to inspire.

Claire smiled at the memory. A shout from across the room re-focussed her attention, 'Good morning Claire!', Alice waved from one of the power-assisted machines. She wore a bright yellow knitted jumper, she looked like the sun. Claire wandered over smiling. Alice was puffed and pink, her arms thrust forward and her legs pressed down, the machine guiding her in a co-ordinated dance. Claire still marvelled at the kit they had in the facility. Many people mistakenly believed that power-assisted exercise was a lazy option, but Claire saw them as a bridge to activity. The machines have motors that facilitate movement, they provided people like Alice another opportunity to exercise, where other forms of movement might be perceived as too difficult, or unsafe. Alice was certainly putting in a lot of effort. 'How are you Alice?' Claire enquired. 'I'm good, it's all the others!', she giggled. Her friend Elizabeth exercised next to her, focussed, absorbed. Claire grinned, 'how's the hip today?'. Alice rolled her eyes, 'ah you know, a bit achy. Don't get old Claire! It's called geriatric rot!' Her neighbouring friend laughed. She pushed her round spectacles up the delicate bridge of her nose. Her eyes were red rimmed and puffy, 'and you Elizabeth, how are you?', Claire turned. 'I'm okay, thank you'. She wasn't, but Claire didn't want to press her. 'Are you both staying for a cup of tea today?' 'Of course, we can't miss out on free refreshments and a natter', Alice chimed in.

The centre had a bustling social area. Chairs were arranged around tables in a small corner of the room. It was rare that any of the seats were empty. The centre manager, Paula, was making drinks for Elizabeth and Alice, who had just finished their exercise circuit. She stirred sugar into the tea, hot steam floated, snaking upwards to the ticking clock, 11.20 am. It had been a busy morning. Paula was a fair and calm leader, orchestrating the smooth running of the therapy centre. She gelled the skill sets of the team and allowed ideas to flourish. The team was small, but close, and they all had an innate sense of altruism and belief in the philosophy of the charity. Paula raised the mug and made a careful path over to the nattering group in the corner. As she made a cautious route around the seats, she considered how the centre had developed into a social hub. When they first set up the centre they were expecting the physical improvements from the power-assisted exercise, and that was evident – increased strength, reduced pain, enhanced mobility – but what was becoming more apparent was the connections mediated by the facility. The service-users were navigating their own health journeys, but they were attending the centre with a common purpose and sharing their experiences with each other and with the team.

'One tea with sugar?', Paula smiled, carefully lowering the hot mug onto a table surrounded by chatter. 'Lovely, thank you', Elizabeth beamed, grasping the handle and carefully blowing. Alice was sat next to her, she was leaning over the table in deep conversation with a lady called Dot, 'well we sing every Wednesday, it's really a lovely group. You should come along?' Alice opened out her hands in a welcoming gesture. Dot grinned, 'that's very kind, thank you, but I'm not sure my singing is up to standard'. 'Oh but the choir is so wonderful, I found after my husband died that singing has been my lifeline. When I sing it lifts me up. I'm in a different place. The GP wanted me to take all these pills for depression, but I told him, I'm on enough blooming pills already!', she chuckled. 'So, I sang more'. Dot scratched her chin, 'it does sound lovely. I find Sundays are the worst days for me. After 59 years of marriage and then he is suddenly gone, I will never get used to it'. Elizabeth nodded, listening in. 'But my son speaks to me on Spike … . Spike? No not Spike. Oh what's that thing called on the computer?!' she laughed. 'Skype!' Alice giggled. 'Yes, that's it! So, he speaks to me on Skype every night'. 'That's nice', Elizabeth remarked, sipping her tea. 'It is, but it's every day and I do find it hard to find things to talk about', she laughed, 'and even though he is caring and I love him, he is very protective. He won't let me go into town anymore on my own because he's frightened I will fall again'. Alice and Elizabeth frowned and nodded. Dot leaned in and beckoned them forward,

she whispered, 'but don't tell my son though; I have been borrowing my friends' rollator and walking into town every Monday to meet friends for a coffee', she grinned cheekily. 'You rebel!' Alice shouted, laughing. Elizabeth considered what Dot had said regarding her family, she stroked her chin and uttered, 'well it's great that your son is concerned about you. I've learned to accept that I'm not the first and most important thing in someone else's life. After my husband died, my daughters did a lot more socially, but then it got to the point where the first one dropped off and then the other dropped off because of her husband. He wanted his weekends to himself, which is understandable'. Dot nodded, 'yes, I know what you mean, I want my son to know that I'm around the corner, but I don't want them to feel like I'm a burden on them, an extra worry, because they have a lot of things going on in their lives. So, I must accept that I have got to have a life of my own and not expect them to provide me with my life. I'm lucky they keep in touch often'. The friends paused and sipped their tea. Alice sighed, 'sometimes living alone, I think "do you know what, I could be lying at the bottom of the stairs, and nobody would know that I am there, probably for about 3 days!"' she exclaimed, 'if not longer!'. The friends laughed. 'Well, I would know! I can't get rid of you!' Elizabeth giggled. Alice beamed and squeezed Elizabeth's shoulder.

At that point one of the volunteers at the centre, Charles, wheeled Bob over in his wheelchair. 'Coming through!' Charles giggled, weaving in and out of people to get to the social area. Bob clutched the sides, 'God, I survived the exercise, please don't kill me now with your driving!', he joked. Bob seemed interactive and happy. Today was a good day. His eyes seemed brighter, more open and engaged with what was going on in the room. Last week wasn't so good. He was hiding within himself, glazed over and fatigued; he seemed almost lifeless. 'Watch out here comes trouble!', Dot exclaimed. 'Hello ladies!' Bob waved as Charles slowed him to a halt at the table. His other arm rested motionless and frozen upon a pillow in his lap, his fingers scrunched into an inert tight fist. 'How are you Bob?' Dot picked a biscuit out the tin and nibbled. 'Tired after that', he nodded over to the power assisted machines, figures skipping up and down in the background, breathing. 'But I think I've got so much more confidence in moving and using my body than before. I have some measure of control over this', he tapped his motionless stiff hand. 'That's great Bob!' Alice applauded. 'Yeah, you do look a bit more spritely', Elizabeth noted. 'Plus, I can now stay 4 steps ahead of the wife and kids!' he giggled naughtily. There was a chorus of laughter and some eye rolling. 'Do you know what though, I was sitting in hospital yesterday and I was watching everyone outside in all that torrential rain, you know, that down pour? Well, I was watching everyone running in the rain. They were running in the rain! And I thought to myself when did that become a thing? And then I realised well of course it's a thing, but I just haven't seen it for a while because I don't get out! My world has shrunk', he confessed. 'Yes, it's very easy to become narrow minded', Elizabeth agreed. 'It is!' Bob nodded, 'but for me it's been a slow escape from loneliness, my world after this bloody stroke has gone from the size of a pea to gradually doing more and more, and this place has been a godsend'.

Elizabeth swished the dregs of her tea, circling in the bottom of the mug, she gazed at Alice, Dot and Bob still chatting. How lucky she felt to have Alice who has encouraged her to reconnect. The vibe here was lively. The centre was full of stories, full of life. Smiles, frowns, pain, love; a concerto of feelings. There were people from all walks of life; Bob, a young family man who had survived a stroke; Dot an 88-year-old widow and retired nurse. They were all united here within this safe space, an atmosphere inspiring transformation of thought, a bridge to self-belief and acceptance. Elizabeth carefully stood, grasping her stick she lumbered over to the coat pegs. Charles was already there holding her coat open. The volunteers were such an integral part of the centre, friendly and caring. 'Here you are Madam', he smiled, gently placing the coat over her hunched shoulders. 'Thank you', she turned and grasped his arm delicately, 'it's lovely here, there's so much support and it's the people', she shared. 'Well, welcome to the family', he beamed.

Transported back from the noise of the centre, Elizabeth now sat in quiet solitude. Surrounded by a web of connections only to be suddenly alone once again. She perched on a chair holding her red dancing shoes. Suspended in reflection, the only sound being the clock's consistent

tick,
tick,
tick.

One by one Elizabeth slowly slipped the shoes onto her petite feet. She gazed down at them and gently swivelled them side to side. The light shimmered off their sleek surface. Elizabeth closed her eyes and drifted into a bittersweet dream. Whirling around the dance floor, lost in her deceased husband's vivid blue eyes.

Debilitating chronic health conditions – illness symptoms mediate social transformation

Gary stood behind the door clutching the handles of his rollator. He could hear laughter coming from within the room beyond, it floated through the cracks, he imagined each laugh like a speck of light glowing and drifting. Gary tried to move forward. *Fucking move, feet*. He knew where he wanted to place his foot, but they were frozen, he was stuck. *Lift up*. Gary puffed and willed his leg to move, his body to shift. His legs trembled. A spasm built and rolled through him. It shook down to his feet, they juddered in place. Gary imagined a laughing puppeteer tying strings to his feet. He was tugging him in the opposite direction, jolting and flicking the strings. Gary looked at his feet exasperated, *move!* The puppeteer pulled the cords tighter and lifted him onto his toes. He revved in place, his feet jerking up and down. *Move!* Gary willed himself forward. Suddenly the strings loosened, and he began into small steps. Gary stumbled awkwardly through the door.

The centre was busy. The circuit co-ordinator, John, was buzzing around the machines, engaging enthusiastically with each person in the room. John was a bubbly character creating a warm, fun atmosphere at the centre. He ensured the exercise circuit flowed safely and was receptive to everyone's needs. John spotted Alice slouching, 'do you need a cushion for your back on that exercise Alice?' he called. Alice was exercising again with her friend Elizabeth. Red faced and sweaty, Alice palpated her back, 'yeah I think I do, thanks love', she pointed to the pile of pillows in the corner. John passed her a purple cushion. 'Thanks', she smiled. The therapy centre had accessories to ensure the exercises could be adapted and used effectively. Elizabeth exercised next to Alice. She winced as the machine guided her arms slowly above her head. 'That looks painful. Would you like a hand strap?' John was on the case straight away; he didn't miss a thing. 'Yeah, my arthritis is playing up today, I don't think I can reach all the way', she grimaced. John nodded and promptly fitted a hand strap to the machine handle. This allowed Elizabeth to gently mobilise the shoulder joint with a smaller range of motion. 'Such an attentive man!' Elizabeth grinned. 'How are things?' John asked. 'Yeah good. I had my review today with Claire', Elizabeth breathed as the machine whirred back into life. The service provided a holistic assessment of each person's health and fitness status. 'Oh, you survived then?!' John chuckled. Elizabeth giggled, 'it was actually very informative. It's different here from a normal gym because I know that we have a professional who can provide almost like a medical check, and I know that if anything was untoward that I can be referred onto a GP if necessary. So, I feel safe, but also with the review I can actually see if I have improved and that is really motivating. I need that motivation. I didn't realise I had improved so much' she explained, 'my legs are stronger, I did more sit to stands and I am walking quicker. At first, I thought that the exercise would just make my joints worse, but I think they are slowly improving, they're definitely not as stiff'. John nodded, 'that's great!' 'Yeah, and there's nothing like that human contact and praise, the feedback has helped, and these machines are brilliant. I think it's helped my self-esteem quite a lot. I went from here', Elizabeth held her hand low, 'to here', she lifted and stretched her hand higher.

'I can't'

'Well, maybe.?'

'I'll try'

'I'll try again'

'I can!'

Suddenly the door burst open and Gary pushed through with his rollator. Now that he had finally got his legs to move, he capitalised on the momentum and headed straight for the first machine. Paula, the centre manager, was answering emails at the front desk, 'Hello Gary!', she smiled welcoming. Gary nodded and breathed a barely audible, 'hi' as he careered towards the machines. Paula stared after him. His face was set into an expressionless mask, his eyes screwed up. Paula watched as Gary abruptly stopped in front of an empty machine. He paused for what seemed like an eternity and then his feet jumped round, hopping as he spasmed and stepped, turning the rollator to position himself, and then shuddered backwards sliding up onto the seat. Just getting on the exercise appeared an effort to him, what so many of us take for granted, our smooth, harmonious movements. He paused and breathed, pleased that he had made it onto the machine. Catching his eye, Paula smiled and walked over, 'good to see you Gary, how are you?' His lips were stuck in a thin line across his face, and his jaws looked solid and locked. Parkinson's has some cruel manifestations. 'I am … sorry … about my face … Paula', he spluttered, his words dripping out between gasps and snorts, as he pointed to his solid cheeks, his mouth barely cracked open. 'Please don't apologise', Paula touched his shoulder affectionately. He tried again to talk, it was strained and effortful, coming in waves of faint murmurs 'my medication … '.., Paula leaned forward to hear better, 'my … . medication … ' *Oh bloody hell! My medication is not working as well, and the Parkinson's is taking over. I can't move my face or walk and everything is a God damn effort*. He wanted to scream. 'Your medication has been changed?' Paula pondered. Gary sighed. A fog crept up and surrounded him, and he could hear the puppeteer laugh as he hooked and sewed the string into his lips and pulled each side menacingly, closing his mouth tighter.

Alice and Elizabeth had finished their exercise and hovered mischievously by the small white-board. The team often wrote interesting or inspiring quotes. Today was scribbled, *Exercising outside amongst the trees improves mood and well-being*. They considered this and whispered like naughty schoolgirls before Elizabeth stealthily popped the cap off the pen and scrawled something underneath. Scanning the room, Alice spotted Paula and John, she hurried Elizabeth and they retreated to the seats to have tea, giggling as they hobbled and shuffled over. 'What are they up to now?' Paula chuckled. John walked over to the scene of the crime and laughed, 'I think we've found the culprits who keep defacing the board!' Every week someone was associating the quote with alcohol or chocolate. Today they had written underneath, *pick some berries and make wine!* 'We should have known it was you two!' John called over to them. The room burst into laughter and applause as Elizabeth and Alice bowed in their seats.

Gary looked over to the scene from the exercise circuit. He barely cracked a smile, but his eyes lit up. *It is such a wonderful atmosphere here*, he considered, *but God how I wish I could call over to them, to join in with their conversation*. Gary felt isolated within his own body and from what his life used to be. *I still have a lot of bright ideas, I'm still a person. I haven't changed inside, just outside. It's still me*. The puppeteer stood in front of him and grinned as he slowly rolled out a length of cling film and began wrapping the film around Gary's body, trapping him inside. Gary let out a fractured sob. A neighbouring exerciser reached out and touched his arm, 'are you okay?'

At least I am respected here. Gary thought. *They understand, I don't have to explain. Out there I have to explain. They think I'm a moron, and they won't talk to me*. Gary reflected on a time when a cashier in his local shop would not speak to him. He felt cut off and slighted. He stared up at her and held his milk, trying to get her attention, 'good … . morn … . morning'. Her eyes swooped past him and fixed

on the milk, she snatched it and held out her hand, '80 p', she spat. Gary felt infuriated, sad and lonely. His escape was the poems he wrote. His mind and his soul shining out onto paper, blasting through the cling film, the strings, and the puppeteer.

I've got Parkinson's
I still have a brain
Don't treat me
As I'm insane

I'm a dragon
I can conquer the world
I've never just been
An ordinary man
I've had to fight
To keep my place

In this shallow human race
You think disability means weak
But it's a strength
I am human – and unique
You couldn't change places
For a day, let alone a week

That makes me strong
And those who can't see me
Are weak

The next time Gary was in the shop he slid the poem onto the counter. He looked up at the cashier expectantly. She lifted and read. Her face dropped with guilt. She smiled sheepishly, 'you write beautifully, I'm so sorry'. *She spoke to me after that, perhaps people just don't understand*.

Coming back to the present, Gary responded to the man exercising next to him, 'Yes . . . I'm fine' he breathed. The man smiled, the machine whirring underneath him, as he pressed the handles and puffed. Gary closed his eyes and focussed on his own movements. He relaxed into the chair and loosely held the handles, his feet rested in the large foot plates. Gary enjoyed the graceful sway and prompt of the machine. The assisted movements were smooth and powerful, his feet no longer jerking. A happy tune from the radio played in the background, 'ah I love this one!' John exclaimed as he began to swing his hips and dance. Soon everyone in the room joined in, bobbing their heads and smiling. Gary flung his arms in time to the music and nodded. 'Yes Gary!' Elizabeth called from across the room, giggling. They were all in this together. Paula looked around the room and pondered to herself,

> *Once that client comes through the door it's all about them. Everyone has good days, and everyone has bad days, and everyone has a sad story and everyone has a great story. If you want a shoulder to cry on, then you can cry on our shoulder. And if you want someone to laugh with, you can laugh with us. Those mixture of emotions and stories don't take anything away from the atmosphere, if anything, I think it just shows that we offer a place where you can be and feel whatever you want.*

Later that day Paula, Claire and John sat down with a cuppa for one of their regular staff meetings. Paula tapped a pen on the edge of her notebook, 'okay, so any updates, or anything we need to discuss?' Claire straightened in her chair, 'Dot seems to be making more connections, doesn't she?'. John nodded enthusiastically, 'Yes, I think that social area is so important. The uniqueness of the facility is that you get a small collection of people with various health conditions, they're not condition specific, discussing their challenges in life, and sharing their coping strategies. There's

a joint understanding and empathy towards one another, and reciprocal learning. I think on the back of a bereavement, and knowing that Dot felt lonely, it's great here, when the time is right, for re-engaging and re-entering the wider world'. Claire smiled, 'Yes, exactly! The centre is not just 4 walls, it's that integration into the community, the benefits gained ripple out to improvements at home', she explained, undulating her hands in the air like waves across a pond. John agreed and continued, 'Mm yeah, and even if there are no physical improvements, like we have a lot of people that have deteriorating conditions, but even if they have no physical improvements, it helps mentally here. They get out the house and have a place to exercise safely, a place to focus and to talk to others. They know then, they are not alone, and they have that drive to keep going'. Paula sipped her coffee and considered, 'I agree', she interjected. 'However, one of the challenges is how do we as an organisation reach people that are isolated or lonely that don't engage? Because there will be people out there that literally have no one, and potentially aren't even linking with any community services. As a charity how can we successfully reach more people?' The question hung in the air. Paula, still tapping her pen, left the team pondering and finally continued, 'so anymore customer updates?' John sat forward in his chair, 'Gary seemed to be struggling a bit today, don't you think?', he noted with concern.

Gary sat at his desk glancing at the blinking cursor on his computer screen. His wife had just dropped him back home; he hated to rely on her for so many things. The loss of his driving licence was a real blow, he couldn't believe it when those bastards took that last bit of freedom away from him. He felt isolated. The cursor blinked

blink,

blink,

blink.

Squandered hope in the ever-looming shadow of the evil puppeteer, Gary very slowly began to write.

I sit in this chair
I wonder: is there anybody there?
I let out a silent scream
That everyone can see
But nobody talks to me
Do you know how lonely I feel
In a room where nobody speaks?
I know I can't communicate very well
But, on that I, really don't want to dwell
But please I beg you to speak
if only you get a small squeak

Discussion

Using ethnographic CNF, we explored and showcased the lived experiences of older adults living with SEI&L who were engaging with a community PA exercise service. In particular, we were interested in the setting's social milieu and interpersonal dynamics. Two composite narratives highlighted the distressful emotions associated with SEI&L and portrayed a sense of the socially situated older body within the context of a PA exercise setting. It is for the reader to judge the resonance of the narratives, but we believe they add to a burgeoning area of research using narrative forms of inquiry to explore the subjectivity of ageing and physical activity/exercise in later life (Hudson, Day, and Oliver 2015; Phoenix and Sparkes 2009; Harvey and Griffin 2021). Further, we

believe they help to elucidate the complex meanings older adults assign to SEI&L and highlight avenues for intervention (Macleod et al. 2019). In line with Macleod et al.'s (2019) seven domains of exclusion, the first narrative showcased changes in social relations and resources in later life, including bereavement and alterations in family dynamics, as key determinants of SEI&L. The second narrative highlighted the contextual experiences of SEI&L while living with a debilitating chronic health condition and the subsequent impact of reduced physical capacity and function on reformed social communications, activities of daily living and social stigma.

Causes and mechanisms of SEI&L

The data that influenced the development of the first composite narrative is consistent with research highlighting bereavement as a principal risk factor for loneliness (e.g. Reiland et al. 2021). According to a report from Independent Age (2018), a third of bereaved older people aged over 65 years reported being very lonely, compared to just 5% who had not lost their partner. The narrative followed the story of Elizabeth and her friends, navigating bereavement and changing family relationships in later life. The narrative echoes a recent meta-synthesis of qualitative findings (Kitzmüller et al. 2018), wherein the story illustrated older adults being afraid of causing trouble for their children, expressing feelings of abandonment, isolation and disconnection when being cut off from family members. Moreover, the narrative underlined the impact of family's risk averse attitudes to older adults' engagement with society through complex caring behaviours designed to protect family members – potentially thwarting older adults' independence and self-determination (e.g. Spitze and Gallant 2004). Indeed, Dot's composite character in the narrative revealed her son undermining her autonomy to meet friends in town through fear that she will fall again. This led to Dot's covert risk behaviours, demonstrating that on some occasions removing physical risk could result in removing components of life that are valued – creating 'silent harms', such as compromised quality of life (Clarke et al. 2011).

In the second narrative the vulnerability and suffering of navigating the physical and social symptoms of Parkinson's Disease (PD) was revealed through the composite character, Gary. Body disintegration, including inhibited mobility and profound communicative changes caused major disruptions to social functioning. Salient social challenges were caused by hypomimia (i.e. facial masking), a decrease in voluntary control and increased rigidity of the facial muscles (Prenger et al. 2020). The inability to display internally felt emotions with facial masking has been shown to compromise close relationships, intimacy and psychological well-being (e.g. Wootton, Starkey, and Barber 2019). Further, and in line with Macleod et al.'s (2019) discrimination domain, the narrative represented instances of dehumanisation, stigma and exclusion of Gary in social settings due to individuals' misunderstanding PD processes and limitations. Similarly, research in illness and disability has pinpointed feelings of exclusion as a significant restriction to building and maintaining social relationships through stigma and a perceived loss of social identity (Bradshaw et al. 2021; Raque-Bogdan et al. 2019; Twisttmann Bay et al. 2019). Gary partially compensated for the social symptoms of PD through exploring other channels of communication (e.g. poems) to overcome SEI&L and to improve emotional processing (e.g. Charon 2006). Yet, writing poems and participating in the PA exercise did not provide restitution from illness. Indeed, the narrative reference to the 'puppeteer' highlights a perceived loss of control and reveals the vulnerability and powerlessness in the wake of PD, reflections illuminating a 'chaotic' narrative of illness (Frank 2013).

Community-based PA exercise

Consistent with existing literature examining the impact of group-based exercise on SEI&L (e.g. Hwang et al. 2019), the therapy centre provided a safe and inclusive space for service users to reconnect through accessible modes of exercise and an atmosphere fostering a sense of belonging and togetherness. The structural set-up of the facility and safe operating procedures, underpinned

by the expertise and altruism of the charity, established direct and indirect opportunities for social interaction. Service-users had a trusted space to share and reinvent illness stories and discuss SEI&L issues through meaningful interactions; a practice that could help adjustment to living with loneliness and improve well-being (Bradshaw et al. 2021; Frank 2013). Moreover, the PA equipment provided a renewed possibility and joy for movement in a supportive environment for populations typically marginalised within traditional physical activity settings, including the elderly, as well as individuals with disabilities and chronic health conditions (e.g. Brittain, Biscaia, and Gérard 2020; Jin and Harvey 2020; Raymond 2019). These findings support the work of Phoenix and Orr (2014) who highlighted the pleasures that can be generated through exercise in the non-elite ageing body and advocated moving beyond the dominant 'exercise is medicine' (EIM) discourse; emphasising the problematic nature of a focus on performance and health outcomes for older adults (see also Hudson, Day, and Oliver 2015).

To be clear, we recognise the strong evidence base associated with the concept of EIM and physical activity/exercise's role in the management and prevention of numerous chronic health conditions (Pedersen and Saltin 2015). However, framing exercise as solely a tool to achieve 'best' health is a practice grounded in morality and neoliberal discourses of health that place the onus on individual self-management at the expense of excluding certain bodies, obscuring social and physical ability and downplaying the intrinsic value and enjoyment of exercise (Cairney, McGannon, and Atkinson 2018). The current narratives showcased a therapy centre grounded in the dominant discourse of EIM, as alluded to by the CEO Jack, and the traditional exercise referral review processes, such as assessment of physical functionality. Despite this, the narratives also emphasised fundamental social connections mediated by the facility and the advantages of the adaptable PA exercise which helped create a body/ability/age inclusive space. This supports research by Pickett and Cunningham (2017) who outlined key components of body-inclusive physical activity facilities which included: recognition of individuals as unique and valuable, development of strong leadership towards inclusive practices, accessibility of physical spaces with adaptable equipment and fostering a sense of community and participant empowerment. Within the therapy centre community, diverse bodies were welcomed, and the narratives represent older adults' experiences of living and exercising with chronic health conditions; for which there were no cures. While the physical review processes enhanced self-efficacy and physical health for some individuals at the centre, others used the facilities to reduce SEI&L, to enjoy movement and to improve well-being whilst living with a debilitating and often deteriorating illness. These narratives might be interpreted as having commonalities with Williams et al. (2018) who found that individuals living with spinal cord injury and arthritis revealed multiple experiences with exercise beyond solely a 'restitution' from chronic illness, and called for health professionals, academics and policy makers to 'prescribe to more ethical forms of exercise promotion that may lead to more efficacious, person-sensitive interventions' (p. 441). By integrating ethnography and narrative inquiry in the current research we believe we were able to enhance the richness of qualitative analysis and representation of the topic area, thereby providing a vivid window into the emerging field of community-based PA exercise. Consistent with our research aims this work showcases older adults' embodied experiences of SEI&L and we have interpreted the data to highlight the utility of PA exercise facilities in creating accessible modes for movement and opportunity to support the dynamic processes of coping with SEI&L in later life.

Conclusion

In developing the narratives presented here, we have attempted to embrace the complexity of SEI&L and older adults nuanced behaviours, emotions, and social interactions within a community PA exercise setting. As such, we hope the narratives assist in understanding the complexities of physical activity in later life through a psycho-socio-cultural resource that can give substance to the texture of older adult's lives (Phoenix, Smith, and Sparkes 2010).

A principal strength of representing older adults storied lives is opening up deeper insights into SEI&L using emotive transferable language to engage multiple audiences. As such, these narratives could be used as a tool to reflect and interpret experiences, supporting self-reconstruction and renewal, thereby promoting the likelihood of listening and responding to individuals experiencing SEI&L and instigating personal and social change (Frank 2013; Smith and Monforte 2020). For instance, previous literature representing key research findings through CNF have used stories to engage sports practitioners (e.g. coaches) and athletes in important conversations to enhance practice (e.g. Palmer and Cavallerio 2022). The narratives presented here could be similarly used as a pedagogical tool within the health and fitness industry with the aim of raising awareness of SEI&L in later life, changing the ideological positions of exercise instructors, and advocating for body, ability, and age inclusive PA exercise facilities. Practical strategies to foster inclusion could include provision of accessible exercise equipment (e.g. power assisted options); leadership commitment to inclusion (e.g. physical activity leaders who mandate inclusive exercise and health messages through modelling inclusive behaviours); peer support (e.g. volunteers as role models); community-oriented physical cultures fostering enjoyment (e.g. development of social connections); and bottom-up participatory approaches in community-based exercise design (e.g. listening to the needs and desires of older adults) (Buffey et al. 2021; Lim et al. 2022; Pickett and Cunningham 2017). In order to further extend the present CNF, we call on researchers to develop imaginative and effective ways of using these stories to instigate change. In doing so, researchers might consider how these stories could be disseminated within communities and what impact they may have on the exercise industry regarding the support of older adults living with SEI&L.

In our view, exercise should not be viewed exclusively through a health and performance lens; nor should this lens be considered sacrosanct. Rather, we wish to highlight through this work the role of PA community-based exercise in fostering a sense of well-being and enjoyment and facilitating social engagement in later life (Palmer, Tulle, and Bowness 2018). While the present narratives might be used to raise awareness of innovations in PA exercise opportunities, and directed towards elderly service users, it is important to point out that older adults are not a homogenous group. Practitioners should therefore be offering and promoting a range of diverse modalities which encourage physical activity – helping to foster increased understanding and respect for ageing as a natural process associated with both challenges and opportunities (Hausknecht et al. 2020). In consideration of these issues, the wider exercise industry should meet the challenge of recognising and supporting diversity – ensuring their facilities offer service-users more ability, body, and age inclusive spaces which challenge the associated social stigma and stereotype 'baggage' that older adults and other marginalised groups are often burdened with. We call for more research which engages with older adults, particularly those who are vulnerable, in methodologically vibrant ways to represent their lived stories. We believe this will aid in the development and support of inclusive physical activity initiatives which help support older adults experiencing SEI&L and in doing so, contribute to wider initiatives such as the campaign to end loneliness in the UK (Campaign to End Loneliness 2020).

Disclosure statement

No potential conflict of interest was reported by the author(s).

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