LINK MEDICAL JOURNAL
of Health and Community Research | LMJHCR

Volume 4, Issue 2, 2026
e-ISSN: 3007-3448
Open Access | CC BY 4.0
DOI: 10.61919/ez6s3848

Original Article

Patients' Experiences and Perceptions of Multidisciplinary Rehabilitation Services Following Stroke: A Qualitative Study

Feng Yu[1], Chrismis Novalinda Ginting[1], Gilbert Lister[1]

[1] Faculty of Medicine, Dentistry, and Health Sciences, Universitas Prima Indonesia, Medan, Indonesia

Corresponding Author: Chrismis Novalinda Ginting, chrismis@unprimdn.ac.id

Received: 22 September 2026 | Revised: 18 October 2026 | Accepted: 20 October 2026 | Published: 22 October 2026

How to Cite: Feng Yu et al. 2026. Patients' Experiences and Perceptions of Multidisciplinary Rehabilitation Services Following Stroke: A Qualitative Study. Link Medical Journal. 4, 2 (Oct. 2026), 1–17.

ABSTRACT

Background: Multidisciplinary stroke rehabilitation addresses interacting physical, communicative, psychological, and social needs. Survivors' accounts can clarify whether professional contributions are experienced as coordinated, personally relevant, and continuous across care settings. Objective: To explore stroke survivors' experiences and perceptions of multidisciplinary rehabilitation, focusing on coordination, communication, involvement in goal setting, and continuity between institutional rehabilitation and everyday recovery. Methods: A qualitative descriptive study examined rehabilitation experiences in Medan, Indonesia. The sample comprised 15 adult stroke survivors with experience of rehabilitation involving at least three professional disciplines. The sampling strategy was maximum-variation purposive sampling. The author team conducted semi-structured individual interviews and undertook reflexive thematic analysis through familiarisation, coding, identification of patterns across accounts, and theme development and refinement. Results: Participants included eight men and seven women aged 39–76 years; ten had experienced ischemic stroke and five hemorrhagic stroke. Three interconnected themes described their experiences: "One Team, Many Voices"—coordination shaped confidence in rehabilitation; "Recovery Became Meaningful When the Goals Became Mine"—communication, autonomy, and individualized rehabilitation; and "The Hardest Part Began After Discharge"—continuity, accessibility, and rebuilding everyday life. Participants valued complementary professional expertise when roles and recommendations formed an understandable plan. Meaningful goals connected therapeutic activities with household tasks, family responsibilities, and employment. Preferences for involvement varied, and clinician guidance could be reassuring. Returning home could make rehabilitation more relevant while exposing environmental barriers, fatigue, financial and transportation difficulties, increased reliance on family, and uncertainty about further support. Conclusion: Participants experienced multidisciplinary rehabilitation positively when professional contributions were coherent, goals reflected valued activities, emotional concerns were recognised, and support remained understandable and accessible across settings. Their accounts suggest priorities for service organisation and further evaluation rather than evidence of comparative treatment effectiveness. Keywords: stroke; multidisciplinary rehabilitation; patient experience; qualitative research; person-centred care; goal setting; continuity of care.

INTRODUCTION

Stroke remains a major cause of death and long-term disability worldwide. Successive World Stroke Organization fact sheets describe a substantial global burden, with pronounced inequalities between settings. Survival may be accompanied by motor impairment, communication difficulties, cognitive changes, fatigue, emotional distress, and restrictions in family, work, and community participation. Rehabilitation therefore concerns both bodily functioning and the activities and relationships through which people understand recovery (1, 2).

Specialist stroke rehabilitation brings together complementary professional contributions. Physiotherapists address mobility, balance, strength, and gait; occupational therapists support self-care, domestic activities, cognition, and participation; speech and language therapists address communication and swallowing; rehabilitation physicians integrate medical and functional management; and nurses support daily practice and self-management. Psychology, dietetics, and social support may address additional needs. Guidance recommends multidisciplinary planning, personally meaningful goals, accessible information, appropriate family involvement, and review across the recovery pathway. Guidance for intracerebral hemorrhage also recognises the importance of organised rehabilitation, although its recommendations concern a specific stroke population (3, 4).

The presence of several professions does not necessarily produce a coherent experience of care. Patients may encounter unclear roles, recommendations whose differences are unexplained, limited involvement in decisions, or uncertainty about which service remains responsible after discharge. A qualitative systematic review of rehabilitation satisfaction identified professional–patient relationships, service delivery, autonomy, expectations, and culture as important dimensions. A separate synthesis of embodied recovery showed how survivors negotiated disconnection and reconnection with themselves, others, and everyday life (5, 6).

Patient experience complements functional outcomes by identifying whether rehabilitation is understandable, relevant, and manageable. Qualitative evidence on early supported discharge, chains of care, and hospital-to-home

transition describes continuing information needs, variable participation in planning, and difficulties accessing longer-term support. More recent syntheses identify unmet rehabilitation needs and barriers to shared decision-making involving emotional state, information, family circumstances, and service resources (7, 8, 9, 10, 11).

Context matters when interpreting these experiences. An Indonesian study of caregivers in Yogyakarta identified communication responsibilities, limited knowledge, service constraints, and practical and emotional demands. Recent Philippine research involving survivors, household carers, and organisational stakeholders describes geographical and financial barriers alongside the importance of family support. These studies provide relevant regional comparisons, but their findings cannot establish the organisation of services or the prevalence of difficulties in Medan (12, 13, 14).

The present study explored stroke survivors' experiences of multidisciplinary rehabilitation in Medan, Indonesia. It examined how participants understood professional coordination, communication, involvement in goals and decisions, and continuity between institutional rehabilitation and subsequent everyday recovery. The research question concerned what made rehabilitation feel coherent and personally meaningful from the survivor's perspective.

LITERATURE REVIEW

Multidisciplinary Rehabilitation and the Meaning of Recovery

Multidisciplinary rehabilitation responds to interacting needs rather than treating stroke recovery as a single impairment problem. NICE recommends goals that are meaningful, activity- and participation-focused, challenging but achievable, and reviewed over time. This emphasis complements appropriate management of impairments; it does not replace it. Coordination concerns how professional inputs contribute to a plan that the person can understand and use (3).

Lo and colleagues synthesised 34 qualitative studies and described recovery through experiences of disconnection, transition and negotiation, and reconnection. Sun and colleagues synthesised 28 papers involving 468 participants, identifying physical adaptation, psychological experiences, multidimensional motivations, and unmet needs. Together, these reviews situate rehabilitation within changing identities, relationships, and practical circumstances, while highlighting the importance of individualized guidance, feedback, social interaction, and accessible services (6, 10). Fatigue and psychological health further illustrate the breadth of rehabilitation needs. Zhan and colleagues documented the prevalence of post-stroke fatigue. Larsson and colleagues found evidence of a weak association between greater fatigue and poorer physical fitness, while the pooled association with physical activity was uncertain and supported by very low-certainty evidence. These observational associations do not establish that exercise treats fatigue. Zhao and colleagues reported benefits of psychological interventions for patients with post-stroke anxiety and depression. By contrast, Song and colleagues found promising quality-of-life effects from longer multicomponent exercise sessions but no significant pooled effect on depression or anxiety (15, 16, 17, 18).

Communication, Goals, and Participation in Decisions

Guidance recommends that goal-setting discussions involve the person after stroke, provide accessible information, and support participation in decisions. However, the ability and desire to participate may vary with uncertainty, symptoms, confidence, and circumstances (3, 11).

Notkin and colleagues identified misalignment between rehabilitation plans and survivors' needs across a hospital-to-municipality transition. Vieira and colleagues, drawing on survivors, caregivers, and physiotherapists, described goal setting as frequently clinician-led despite recognition of the importance of patient involvement. Their findings locate participation within individual, professional, organisational, and policy conditions rather than treating it solely as patient willingness (19, 20). Zang and colleagues similarly identified patient, family, professional, and environmental influences on shared decision-making. Vingerhoets and colleagues showed that relationships, communication, and organisational priorities shaped whether survivors and families felt understood beyond the diagnosis. These studies suggest that person-centred care involves eliciting values and preferences while providing professional guidance that makes participation possible (11, 21).

Information, Self-Directed Activity, and Unmet Needs

Information requirements extend beyond discharge instructions. Helbach and colleagues identified needs concerning treatment, etiology, prognosis, rehabilitation, discharge, support, and life changes; information was sometimes provided too early, and direct professional communication was preferred. Wang and colleagues identified information

as a prominent supportive-care need alongside psychological, social, rehabilitation, practical, physical, emotional, and spiritual needs (22, 23).

In broader rehabilitation settings, Dorward and colleagues found that encouragement, feedback, programme flexibility, familiar activities, and the environment shaped engagement in self-directed activities. This evidence provides context for rehabilitation delivery rather than a stroke-specific estimate. In stroke-specific research, Shao and colleagues described interacting personal, cognitive, emotional, family, and environmental influences on home exercise. Tan and colleagues' meta-analysis further showed that unmet needs remain common in community-dwelling survivors across several domains (24, 25, 26).

Transitions, Family Support, and Access

Early supported discharge is a defined service model and should not be equated with discharge alone. Connor and colleagues' qualitative synthesis found that it could ease transition home while leaving difficulties with subsequent community support. Fors and colleagues described variable support, limited involvement in planning, and repeated information needs across a different chain of care. Liu and colleagues' hospital-to-home review reinforces the importance of examining transition as a process rather than a single event (7, 8, 9).

Quantitative evidence requires separate interpretation. Jee and colleagues did not find statistically significant pooled differences for several outcomes, including activities of daily living, modified Rankin Scale, length of stay, and mortality; these findings neither establish superiority nor demonstrate equivalence. Interview studies by Carlsson and colleagues and Törnbom and colleagues describe the relevance of well-planned, flexible home support, family involvement, fatigue, emotional experiences, and a sense of control in specific very early supported discharge programmes (27, 28, 29).

Family assistance may connect services and everyday rehabilitation while also changing carers' roles and valued activities. Qualitative reviews by Jammal and colleagues and Wang and colleagues describe adjustment, emotional demands, practical difficulties, and support needs. Return-to-work research identifies additional challenges involving employment, professional support, and caregiver responsibilities. Professional perspectives on peer support suggest possible social, emotional, and informational contributions, alongside concerns about resources, implementation, and unrealistic expectations (30, 31, 32, 33).

Telerehabilitation may provide another route to support, but functional outcomes and experiences of access should be distinguished. Sharififar and colleagues reported functional benefits or comparable outcomes in several domains and variable satisfaction. Alwadai and colleagues found insufficient evidence to draw conclusions about satisfaction, adherence, and cost across reviews. The qualitative F@ce 2.0 study concerned a specific person-centred, SMS-supported intervention and emphasised trusting relationships and personal meetings alongside technology (34, 35, 36).

MATERIAL AND METHODS

Study Design and Context

A qualitative descriptive design was used to explore stroke survivors' experiences and perceptions of multidisciplinary rehabilitation. The study concerned rehabilitation medicine services in Medan, Indonesia, encompassing inpatient, outpatient, and community-based rehabilitation pathways. The qualitative approach addressed how participants understood professional involvement, communication, goal setting, and continuity of rehabilitation within their recovery experiences. The focus was on participants' interpretations of care rather than the measurement of treatment effectiveness.

Participants and Sampling

The sampling strategy was maximum-variation purposive sampling, intended to include adults with differing rehabilitation experiences. The sample comprised 15 stroke survivors. Eligibility criteria included age of at least 18 years, ischemic or hemorrhagic stroke, and rehabilitation involving at least three professional disciplines. Participants were expected to be able to reflect on both institutional rehabilitation and subsequent recovery, with an interval of 2–12 months specified for inclusion.

Medical instability or cognitive impairment that prevented meaningful participation in an interview was an exclusion criterion. Mild or moderate communication impairment was not an automatic exclusion criterion, recognising the importance of including the perspectives of stroke survivors with communication difficulties.

Participants included eight men and seven women aged 39–76 years. Ten participants had experienced ischemic stroke and five had experienced hemorrhagic stroke. Their rehabilitation experiences included physiotherapy, occupational therapy, rehabilitation medicine, nursing, speech and language therapy, psychology, and nutritional, vocational, or social support. Participant characteristics and rehabilitation disciplines and services are presented in Table 1.

Data Collection

The author team conducted semi-structured individual interviews. The interview guide addressed four domains corresponding to the rehabilitation literature discussed in the study: experiences of different rehabilitation professionals; communication and coordination across disciplines; involvement in decision-making and goal setting; and post-discharge and longer-term rehabilitation experiences. These domains provided a focus for exploring participants' accounts of care and recovery.

Open-ended questions included: "What was it like to be in rehabilitation after a stroke?"; "How do the various professionals collaborate, in your view?"; "How were the rehabilitation goals determined?"; "Did you at times get conflicting or confusing advice?"; "What did you see change as you went home?"; and "What would have been more helpful to you in rehabilitation?" Follow-up prompts were used to explore specific examples and clarify participants' accounts. The interview plan envisaged approximately 35–60 minutes per interview. Potential communication supports included additional response time, written keywords, visual cues, and speech and language therapy support strategies, where appropriate.

Data Analysis

The author team analysed the interview material using reflexive thematic analysis informed by Braun and Clarke. Analysis involved repeated familiarisation with transcripts, development of initial codes, identification of patterns across participants' accounts, construction and refinement of candidate themes, and development of written interpretations. Coding combined attention to participants' explicit descriptions with interpretation of the meanings attached to their rehabilitation experiences. This focus on patterned meaning is consistent with methodological accounts distinguishing themes from interview topics (37, 38).

Initial codes included "professionals not providing different instructions," "feeling safe when supported by a team," "not knowing why I took therapy," "my goals being decided by my therapist," "wanting to go back to family role," "therapy prematurely ends," "transport problem," "becoming a therapist," "fatigue not manifesting," and "making my goals real at home."

Initial codes were grouped into candidate themes through consideration of related meanings across accounts. Patterns concerning professional advice, perceived coordination, and reassurance contributed to the theme "One Team, Many Voices"—Coordination Shaped Confidence in Rehabilitation. Patterns concerning explanations of therapy, clinician-directed goals, personal priorities, and meaningful everyday activities contributed to "Recovery Became Meaningful When the Goals Became Mine"—Communication, Autonomy, and Individualized Rehabilitation. Patterns concerning the ending of formal therapy, access barriers, rehabilitation roles at home, fatigue, and everyday recovery contributed to "The Hardest Part Began After Discharge"—Continuity, Accessibility, and Rebuilding Everyday Life.

The interview domains and the themes served related but distinct purposes. The domains organised the topics explored during interviews, whereas the three interconnected themes expressed patterns of meaning across participants' accounts. Theme development focused on the relationships between experiences and on why particular aspects of rehabilitation were perceived positively or negatively.

Contrasting accounts were also considered, including participants who preferred clinicians to guide goal setting and those who experienced discharge as empowering rather than threatening. These accounts qualified the interpretation of autonomy and transition: preferences for involvement could differ, and returning home could represent progress alongside uncertainty or reduced professional support.

Rigor

Credibility was addressed through systematic comparison of patterns across participants, attention to accounts that challenged an emerging interpretation, and maintenance of an analytic record connecting codes and themes. The analysis distinguished descriptions of services received from interpretations of why participants found particular experiences reassuring, meaningful, confusing, or difficult. Contrasting accounts were considered alongside shared patterns to retain variation within the three themes.

Table 1. Participant characteristics and rehabilitation disciplines and services

Participant	Age (years)	Sex	Stroke type	Reported interval (months)	Rehabilitation disciplines and services
P1	58	Male	Ischemic	4	PT, OT, rehabilitation medicine, nursing
P2	67	Female	Ischemic	7	PT, OT, SLT, nursing, rehabilitation medicine
P3	49	Male	Hemorrhagic	5	PT, OT, psychology, rehabilitation medicine
P4	71	Female	Ischemic	9	PT, OT, nursing, rehabilitation medicine
P5	55	Male	Ischemic	3	PT, SLT, OT, rehabilitation medicine
P6	62	Female	Hemorrhagic	6	PT, OT, psychology, nursing
P7	39	Male	Ischemic	8	PT, OT, psychology, vocational advice
P8	76	Female	Ischemic	11	PT, OT, nursing, nutritional support
P9	64	Male	Hemorrhagic	4	PT, OT, SLT, rehabilitation medicine
P10	46	Female	Ischemic	6	PT, OT, psychology, rehabilitation medicine
P11	69	Male	Ischemic	10	PT, OT, nursing
P12	52	Female	Hemorrhagic	5	PT, OT, SLT, rehabilitation medicine
P13	60	Male	Ischemic	7	PT, OT, rehabilitation medicine
P14	44	Female	Ischemic	3	PT, OT, psychology, SLT
P15	73	Male	Hemorrhagic	8	PT, OT, nursing, rehabilitation medicine

Abbreviations: P, participant identifier; PT, physiotherapy; OT, occupational therapy; SLT, speech and language therapy.

FINDINGS

Participant Characteristics and Overview of the Themes

The study included 15 stroke survivors: eight men and seven women aged 39–76 years. Ten participants had experienced ischemic stroke and five had experienced hemorrhagic stroke. Their rehabilitation experiences involved different combinations of physiotherapy, occupational therapy, rehabilitation medicine, nursing, speech and language therapy, psychology, and additional support services. Individual characteristics and rehabilitation exposure are presented in Table 1. Three interconnected themes described participants' experiences: "One Team, Many Voices"—Coordination Shaped Confidence in Rehabilitation; "Recovery Became Meaningful When the Goals Became Mine"—Communication, Autonomy, and Individualized Rehabilitation; and "The Hardest Part Began After Discharge"—Continuity, Accessibility, and Rebuilding Everyday Life.

Table 2. Themes, subthemes, and interpretive focus

Theme	Subtheme	Interpretive focus
1. Coordination shaped confidence in rehabilitation	Complementary expertise within a shared recovery plan	Different professional contributions were valued when participants understood how they fitted together.
Theme 1	Understanding changing or conflicting advice	Unexplained differences in recommendations created uncertainty about safe activity and progression.
Theme 1	Making professional roles understandable	Multiple professional contacts did not necessarily provide clarity about responsibilities.
Theme 1	Being known across rehabilitation encounters	Familiar clinicians provided continuity through knowledge of previous abilities, concerns, and priorities.
2. Communication, autonomy, and individualized rehabilitation	Professional guidance and negotiated involvement	Participants differed in their readiness and preference for involvement in goal setting.
Theme 2	Connecting clinical gains with everyday purposes	Rehabilitation became meaningful when activities related to household tasks, family roles, and employment.
Theme 2	Receiving explanations that could be understood and revisited	Participants valued accessible explanations and opportunities to return to information.

Theme	Subtheme	Interpretive focus
Theme 2	Recognising emotional experiences alongside physical impairment	Fear, frustration, embarrassment, and concerns about dependence could remain less visible than physical difficulties.
3. Continuity, accessibility, and rebuilding everyday life	Discovering the demands of rehabilitation at home	Everyday environments exposed difficulties that were less apparent in institutional settings.
Theme 3	Navigating reduced support and uncertain next steps	Changes in therapy availability could leave participants unsure about continued rehabilitation and whom to contact.
Theme 3	Managing fatigue and the demands of self-directed rehabilitation	Fluctuating energy and other symptoms complicated the use of home programmes.
Theme 3	Family assistance and the redistribution of rehabilitation responsibilities	Family support enabled daily rehabilitation while prompting concern about dependence and burden.
Theme 3	Accessing ongoing care and considering remote support	Travel, finances, and individual support needs influenced the practical usefulness of available services.

Participants valued the complementary expertise of rehabilitation professionals, but their accounts distinguished access to several disciplines from experiencing those disciplines as a coherent team. They also described differences between achieving clinical milestones and regaining activities that mattered in their everyday lives. Accounts of returning home brought these concerns together: participants encountered practical demands while navigating changes in professional support, family assistance, and responsibility for rehabilitation. Participants retrospectively described changing priorities during recovery. Initial concerns about survival, walking, and basic self-care were accompanied or followed by concerns about family roles, employment, confidence, social participation, and living with persistent symptoms. These experiences were not uniform. Professional guidance could be reassuring, greater involvement in decisions could become more important over time, and discharge could represent both progress and uncertainty. Table 2 presents the thematic structure.

Theme 1: "One Team, Many Voices"—Coordination Shaped Confidence in Rehabilitation

Complementary Expertise Within a Shared Recovery Plan

Participants associated different rehabilitation professionals with different aspects of recovery. Physiotherapy was linked with standing, walking, balance, strength, and transfers. Occupational therapy was described in relation to applying developing abilities to dressing, bathing, food preparation, writing, household tasks, and community activities. Speech and language therapy was valued in accounts involving communication difficulties, while rehabilitation medicine was associated with bringing medical and functional concerns together. The value of multidisciplinary rehabilitation therefore extended beyond receiving several forms of treatment. Participants appreciated the different perspectives professionals brought to a shared recovery process:

"The physiotherapist helped me stand and walk, but the occupational therapist asked what I needed to do when I reached home. They were looking at the same recovery from different sides."

Professional differences were reassuring when their relationship to a common purpose was apparent. Participants did not necessarily expect every professional to give identical advice or perform similar activities. Rather, they valued an understandable connection between those contributions.

"When they all knew what the target was, I felt safer. The doctor, therapist, and nurse were saying different things, but they were different parts of the same plan."

Perceived coordination gave rehabilitation a sense of direction. Accounts of professionals understanding one another's priorities were accompanied by confidence that someone was attending to the broader recovery process. This distinguished a coherent rehabilitation experience from a succession of appointments whose purposes were difficult to connect.

Understanding Changing or Conflicting Advice

Differences between recommendations became problematic when participants could not understand their reasons. Accounts included uncertainty about walking aids, the amount of assistance family members should provide, and how vigorously activities should be practised.

"One person told me not to walk without someone holding me. Later another person told me I should try to do more by myself. I did not know which instruction I should follow."

The difficulty concerned both the advice itself and the participant's ability to interpret it. A recommendation for greater independence might reflect changing abilities, but without an explanation it could be experienced as a contradiction. Participants' accounts therefore did not establish that apparently inconsistent advice necessarily represented disagreement or inappropriate care. They showed how unexplained changes could leave the person receiving rehabilitation uncertain about what was safe or expected. Confidence depended partly on understanding how recommendations related to current abilities and recovery priorities. Professional adaptation was easier to make sense of when its rationale was communicated.

Making Professional Roles Understandable

Having several professionals involved did not always clarify who was responsible for particular concerns. Physiotherapy and medical roles were relatively familiar within the accounts, while distinctions involving occupational therapy, psychology, rehabilitation nursing, and social support could be less clear.

"There were many people helping me, but at the beginning I did not understand who was responsible for what. Sometimes I repeated the same story to different people."

This uncertainty affected how participants understood the organisation of rehabilitation. Repeatedly describing the same difficulties could make care feel fragmented, even when multiple services were available. Participants distinguished professional presence from integration: the former concerned the number and variety of contacts, while the latter concerned understandable responsibilities, connected advice, and continuity of priorities.

Being Known Across Rehabilitation Encounters

Continuity with individual clinicians carried relational significance. Familiar professionals were valued for knowing previous abilities, anxieties, and personally meaningful goals. This knowledge could make small changes more visible and reduce the need to explain the recovery story repeatedly.

"A new therapist can read the notes, but the therapist who knows you notices the small things—how afraid you were before, what you could not do last week, and why something matters to you."

Changes in clinicians could temporarily make rehabilitation feel less personal. The concern was not simply about seeing a different professional; it involved whether knowledge of the person's recovery and priorities continued across encounters. Within this theme, confidence was associated with complementary expertise, understandable recommendations, clear responsibilities, and relationships through which participants felt known.

Theme 2: "Recovery Became Meaningful When the Goals Became Mine"—Communication, Autonomy, and Individualized Rehabilitation

Professional Guidance and Negotiated Involvement

Participants described different relationships with professional guidance. In early recovery, fear, uncertainty, and limited knowledge could make clinician direction reassuring. Accepting professional goals did not necessarily mean that a participant was dissatisfied or wanted greater responsibility at that point.

"At first, I did whatever they said because I just wanted to survive and walk again. I did not know enough to say what my goal should be."

Other accounts distinguished agreement with a proposed goal from meaningful participation in choosing it. Participants could accept goals because they trusted professional expertise while recognising later that their own concerns had not been explored.

"They told me the goals, and I agreed because I thought they knew best. Later I realized nobody had asked which activities worried me most at home."

The contrast qualified the meaning of autonomy. Participants did not uniformly seek to determine clinical treatment independently. Their accounts instead emphasised understandable advice, opportunities to express preferences, and involvement suited to their confidence and circumstances. Collaborative goal setting was experienced differently from being informed of goals that had already been selected.

Connecting Clinical Gains With Everyday Purposes

Participants described a gap between improvements recognised within rehabilitation and the activities through which they understood recovery in daily life. Walking performance, shoulder movement, and structured tasks acquired greater meaning when linked to an identifiable purpose.

"I wanted to prepare food again. When the exercise was connected to holding a knife, opening a container, or carrying something safely, then I understood why I was doing it."

"Everyone was happy when I could walk independently. I was happy too, but I kept thinking, 'Can I go back to my job? Can I support my family?' That question came much later in rehabilitation."

Personally meaningful goals included cooking, household activities, parenting, employment, supporting family members, and participating in community life. These priorities did not necessarily replace concerns about walking or self-care. They changed what those gains meant and how participants evaluated their usefulness. Participants retrospectively described becoming more aware of these concerns as recovery progressed. Clinical achievements could be welcomed while leaving important questions unresolved. Rehabilitation felt more relevant when professionals asked which activities participants wanted to regain and connected therapeutic tasks with those activities.

Receiving Explanations That Could Be Understood and Revisited

Communication influenced participants' understanding of rehabilitation and their ability to participate in it. They valued explanations of why an activity was being practised, how it related to recovery, and what they were expected to do beyond supervised sessions. Information provision was also experienced in relation to its timing. Participants described difficulty retaining explanations during the early post-stroke period, when uncertainty and competing concerns could limit their ability to process information.

"They may have explained it the first time, but after the stroke my mind was full. I needed someone to explain again later without making me feel that I should already know."

The account distinguished receiving information from being able to use it. Repeated explanations were valued when they allowed participants to revisit concerns without embarrassment. Communication was therefore described as an ongoing part of rehabilitation, through which the purpose of activities and the meaning of progress could become clearer.

Recognising Emotional Experiences Alongside Physical Impairment

Participants described fear of another stroke, frustration with slow improvement, embarrassment associated with communication difficulties, and concern about becoming a burden. These experiences could be less visible to others than weakness or difficulties with movement.

"People could see that my hand was weak. They could not see that I was afraid to sleep because I thought another stroke might happen."

Accounts of psychological support described the value of having space to discuss such concerns. Participants also recalled encouragement and emotional reassurance from other rehabilitation professionals. Support was valued when it acknowledged uncertainty and remained realistic about recovery. The distinction between visible physical impairment and less visible emotional distress shaped how participants experienced being understood. Within this theme, personally meaningful rehabilitation involved more than selecting activities: it also involved explanations, recognition of emotional concerns, and a negotiated relationship between professional expertise and the person's priorities.

Theme 3: "The Hardest Part Began After Discharge"—Continuity, Accessibility, and Rebuilding Everyday Life

Discovering the Demands of Rehabilitation at Home

Returning home could represent progress and the recovery of familiar surroundings, while also exposing difficulties that had been less apparent in institutional rehabilitation. Participants described bathing, preparing meals, carrying items, negotiating stairs and uneven surfaces, moving through narrow spaces, and organising daily activities around fatigue.

The difference between a controlled rehabilitation environment and the home could alter the meaning of independence. An activity achieved in one setting was not necessarily straightforward in another.

"At home the therapist saw why I was struggling. In the hospital I could walk in a clear corridor. At home there were steps, furniture, and the bathroom was completely different."

Home-based professional input was valued when it connected rehabilitation with these specific circumstances. Seeing the environment could make difficulties understandable in a way that practising an activity away from home had not. Participants' accounts therefore included both the challenges of returning home and the increased relevance rehabilitation could acquire there.

Navigating Reduced Support and Uncertain Next Steps

Participants described different experiences of continuity after discharge. Some accounts involved relatively straightforward movement into outpatient or home-based rehabilitation. Others described a marked reduction in scheduled therapy and uncertainty about what should follow.

"I understood that I could not have therapy forever, but I did not understand what the next stage was. One week I had regular appointments and then suddenly I was mostly doing it myself."

The concern was not necessarily an expectation of indefinite professional treatment. It involved understanding the next stage of recovery, what could be managed independently, and how further assistance could be obtained. The ending of scheduled sessions could be interpreted as an indication that recovery was complete, even when participants continued to experience limitations. The transition also changed how difficulties were addressed. Problems that had previously prompted an immediate professional response could become matters for participants and their families to manage.

"In hospital, if I could not do something, somebody knew what to do. At home, the same problem became my family's problem."

An identifiable professional contact was important within accounts of ongoing support. Participants valued knowing whom to approach when function changed, equipment became unsuitable, new symptoms arose, or progress seemed to stall.

"I did not expect the hospital to follow me forever. I just wanted to know who was still connected to my recovery."

Continuity was therefore described through access to advice, information, review, and a continuing connection with rehabilitation services. Its meaning extended beyond the frequency of appointments.

Managing Fatigue and the Demands of Self-Directed Rehabilitation

Participants' accounts of rehabilitation at home included variation in confidence, knowledge of exercises, and ability to fit activities around daily demands. Written or online instructions could provide guidance, but generic programmes were not always easy to apply in the presence of fatigue, pain, fear of falling, or environmental obstacles. Fatigue was described as particularly difficult because energy could fluctuate and the reasons for reduced activity were not always apparent to other people.

The account distinguished willingness to practise from the capacity to do so at a particular time. Participants could experience pressure to appear motivated while dealing with symptoms that were not externally visible. Managing rehabilitation independently therefore involved more than remembering an exercise programme; it also involved interpreting symptoms and deciding how activities could be undertaken within everyday circumstances.

"Some days I wanted to exercise but my body felt empty. It was difficult because I looked normal sitting in a chair, so people thought I just needed to try harder."

Family Assistance and the Redistribution of Rehabilitation Responsibilities

Family members provided practical and emotional support after discharge. Participants described assistance with exercises, transport, medication, communication, personal care, and attendance at appointments. This support helped rehabilitation continue within daily life.

"My wife became the person who reminded me about everything, watched me walk, helped me exercise, and took me to appointments. Rehabilitation continued, but much of it moved onto her."

Participants valued this assistance while expressing concern about dependence and the demands placed on relatives. Their accounts showed how responsibilities previously supported by professionals could become embedded in family relationships. These were survivors' perceptions of family involvement. They conveyed gratitude, reliance, and concern about burden, rather than a direct account of caregivers' own experiences. Within participants' narratives, the availability of family assistance shaped what could be managed at home and how independent recovery felt.

Accessing Ongoing Care and Considering Remote Support

Financial and transportation difficulties affected the practical accessibility of rehabilitation. Repeated outpatient visits involved travel costs, physical effort, and coordination with family members. Accounts also described reduced earnings and difficulties returning to work. Consequently, the existence of a service did not necessarily mean that participants could use it consistently.

Remote follow-up was viewed as potentially helpful for reviewing exercises, discussing progress, and obtaining answers to questions. Its perceived usefulness depended on confidence with technology, communication abilities, disability, and the nature of the support required. Participants did not describe remote contact as meeting every rehabilitation need; their accounts distinguished opportunities for advice and follow-up from situations in which hands-on assessment or practical assistance was valued.

Across these experiences, accessibility involved the relationship between available services and the person's circumstances. Transport, finances, symptoms, family assistance, and the type of professional input required shaped whether ongoing rehabilitation could be incorporated into daily life.

Variation and Connections Across the Themes

The three themes described connected dimensions of the rehabilitation experience. Understanding professional roles and recommendations helped participants make sense of their care. Connecting rehabilitation with personally meaningful activities gave that care a purpose. Returning home placed both understanding and purpose within an environment where professional contact, resources, and practical support could change.

Table 3. Contrasting experiences and their contribution to interpretation

Dimension	Experiences described in the accounts	Contribution to interpretation
Professional recommendations	Different professional contributions could form an understandable shared plan; unexplained differences could create uncertainty.	Coherence depended on how recommendations were connected and explained, rather than on all professionals saying the same thing.
Involvement in goal setting	Clinician guidance could be reassuring; agreement with professional goals could also coexist with unexpressed personal concerns.	Preferred involvement varied, and acceptance of a goal did not necessarily demonstrate that it had been negotiated.
Meaning of progress	Walking and self-care gains were valued, while employment, family responsibilities, and household activities could remain unresolved.	Clinical achievement and personally meaningful recovery were related but not interchangeable.
Returning home	Home could represent progress and make rehabilitation more relevant; it could also reveal environmental obstacles and reduced professional availability.	The meaning of discharge depended on both the opportunities of home and the support available there.
Family involvement	Relatives enabled exercises, appointments, and daily care; participants also expressed concern about reliance and burden.	Family support was experienced as valuable while changing the distribution of rehabilitation responsibilities.
Continuing professional support	Participants recognised limits to scheduled therapy while still wanting guidance about the next stage and a contact for concerns.	Continuity involved an understandable route to advice and review as well as the provision of treatment sessions.

The accounts also qualified interpretations of what constituted a positive experience. Professional direction could be valued without eliminating the importance of patient involvement. Different recommendations could reflect progression rather than disagreement, while still creating uncertainty if their reasons were unclear. Discharge could signify achievement and a return to familiar life while exposing unmet support needs. Family assistance could enable rehabilitation while prompting concern about dependence. These variations are summarised in Table 3. Figure 1 illustrates the connections among the three themes.

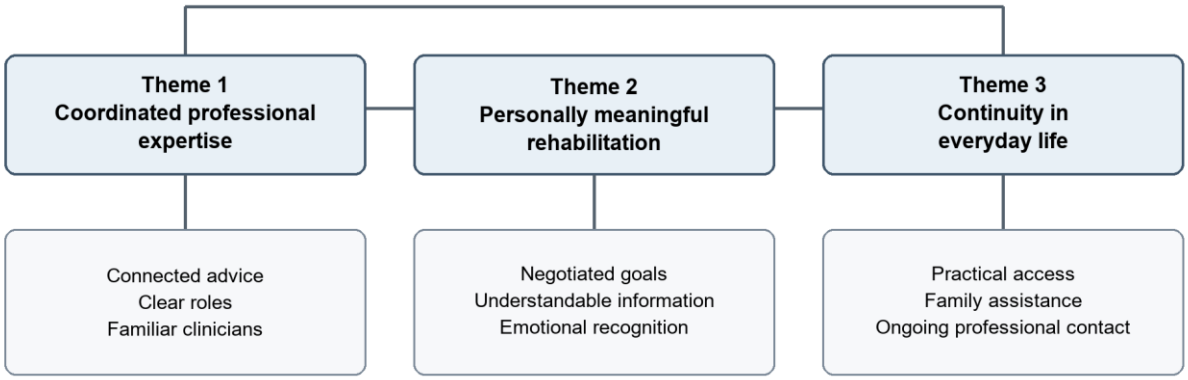


Figure 1. Thematic map of stroke survivors' experiences of multidisciplinary rehabilitation. Undirected links represent connections among the three themes. Professional coordination, personally meaningful rehabilitation, and continuity in everyday life were connected through participants' accounts of understanding care, pursuing valued activities, and managing recovery across settings.

DISCUSSION

Interpreting Multidisciplinary Rehabilitation Through the Patient Experience

This study identified three connected aspects of rehabilitation experience: whether professional contributions formed a coherent plan, whether rehabilitation reflected personally meaningful priorities, and whether support remained understandable and accessible when everyday recovery moved beyond institutional care. These findings concern perceived quality and meaning rather than comparative treatment effectiveness. They align with qualitative reviews that place relationships, autonomy, expectations, and participation alongside functional restoration, while showing how these dimensions were connected within the present accounts (5, 6, 10).

The distinction between multidisciplinary presence and perceived integration is particularly relevant. Participants valued different forms of expertise, but several professional contacts did not automatically provide clarity about responsibilities or a shared purpose. This supports guideline recommendations for coordinated multidisciplinary planning. It also corresponds with Connor and colleagues' synthesis, in which organisational and interprofessional factors were central to early supported discharge, and Fors and colleagues' findings concerning variable information and involvement across a chain of care (3, 7, 8).

The present accounts add a qualification to the interpretation of conflicting advice. Participants could experience uncertainty without the accounts establishing that professionals actually disagreed or delivered inappropriate treatment. Recommendations might change because abilities or priorities had changed. The practical issue was whether that change was explained. Thus, internal coordination and its communication to the patient are related but distinct: a shared plan may be clinically appropriate while remaining difficult for its intended recipient to understand. This interpretation is consistent with evidence identifying communication, professional relationships, and patient understanding as central to rehabilitation experience (5, 8, 21).

Relational continuity further shaped the experience of being understood. Familiar clinicians were valued for recognising earlier abilities, anxieties, and goals. Vingerhoets and colleagues similarly found that survivors and families wanted professionals to understand the person beneath the diagnosis. Their study included family perspectives and used a different analytical approach, whereas the present analysis concerns survivors' accounts. The convergence supports the relevance of personal knowledge in care, but does not show that the same clinician must provide every encounter or that familiarity alone improves clinical outcomes (21).

Meaningful Goals and Responsive Involvement

Participants linked the meaning of therapeutic activities with cooking, household responsibilities, employment, and supporting family members. This resembles Lo and colleagues' account of recovery as reconnection with self and everyday life and Sun and colleagues' identification of individualized guidance, motivation, and unmet needs. The present findings therefore support an interpretation in which functional gains acquire personal significance through the activities they enable, rather than suggesting that impairment-focused treatment has no value (6, 10).

The concern about returning to work illustrates this distinction. Walking independently could be an important achievement while leaving questions about employment and family provision unanswered. Nuccio and colleagues' meta-synthesis likewise identified professional support, employment perspectives, and practical challenges in return to work. Its inclusion of both survivors and caregivers offers a broader view than the present survivor-only accounts. These findings suggest that work-related concerns merit discussion within rehabilitation, but the present study cannot identify predictors of successful return to employment (32).

The accounts also challenge a simple opposition between clinician direction and patient autonomy. Professional guidance could be reassuring during uncertainty, while unquestioned agreement could coexist with concerns that had not been elicited. Notkin and colleagues reported misalignment between rehabilitation plans and patient needs, and Vieira and colleagues described clinician-led practices within a wider lack of preparedness for collaborative goal setting. The present findings are compatible with those concerns while retaining the contrasting experience that guidance itself could be valued (19, 20).

Shared decision-making therefore appears better understood as supported and responsive involvement than as a fixed expectation that every patient should take equal responsibility for every decision. Zang and colleagues' synthesis identifies stage-specific needs, emotional state, self-efficacy, family circumstances, information, and service resources as interacting influences. In the present study, preferences were recalled within recovery narratives; they were not measured repeatedly. A prospective account of how individual preferences change would require longitudinal research (11).

Communication and Recognition of Less Visible Needs

Participants' requests for repeated explanations distinguish information delivery from usable understanding. Helbach and colleagues found that information was sometimes offered too early and that people preferred direct professional communication. Wang and colleagues' scoping review identified information as a prominent supportive-care need. Together with the present accounts, this supports revisiting explanations as questions and circumstances evolve, while tailoring their format to the person rather than assuming that a previous explanation has resolved an information need (22, 23).

Fear of recurrence, frustration, embarrassment, and concerns about dependence could be less visible than physical impairment. These accounts support attention to emotional experience within routine rehabilitation conversations. They do not establish psychiatric diagnoses or the effectiveness of psychological treatment in this sample. Zhao and colleagues' review provides separate intervention evidence for psychological approaches in people with post-stroke anxiety and depression. Song and colleagues' exercise review, however, found no significant pooled effects on depression or anxiety despite promising quality-of-life findings. Exercise and psychological support should therefore not be represented as interchangeable evidence-based solutions to the same outcome (17, 18).

Fatigue raised a related concern about the interpretation of participation. Reduced activity could be understood by others as poor motivation even when participants wanted to practise. Zhan and colleagues' prevalence review situates fatigue as an important post-stroke problem. Larsson and colleagues found a weak association with poorer physical fitness, but the pooled physical-activity association was uncertain and causality could not be established. The present accounts support recognising fatigue when interpreting difficulty with home programmes; they do not show that a particular pacing or exercise intervention would improve fatigue (15, 16).

Discharge and the Continuity of Everyday Recovery

Returning home combined opportunities with practical vulnerability. Participants described the relevance of real environments while also recalling reduced professional availability and uncertainty about the next stage. This parallels Connor and colleagues' distinction between an easier transition home and a more difficult transition into longer-term community support. Liu and colleagues' transition review and Fors and colleagues' chain-of-care study similarly show why discharge should be interpreted within a continuing pathway rather than as an isolated event (7, 8, 9).

The comparison with very early supported discharge requires attention to context. Carlsson and colleagues interviewed participants shortly after discharge within a defined programme, predominantly following minor stroke; Törnbom and colleagues examined a Swedish programme involving mild or moderate stroke. Those studies describe the value of flexible home support, security, and control. The present accounts span different professional exposures without establishing equivalence to those service models. Similar experiences may therefore indicate shared concerns about transitions rather than identical programmes or implementation conditions (28, 29).

Patient experience should also remain separate from comparative effectiveness. Jee and colleagues' meta-analysis did not demonstrate statistically significant pooled differences for several clinical and service outcomes. Lack of statistical significance is not proof of equivalence, and positive accounts of home support are not evidence of superiority. The present contribution is to identify how access to advice, an understandable next stage, and an identifiable professional contact could influence the experience of continuity (7, 27). Tan and colleagues' recent meta-analysis reported that unmet needs remained common among community-dwelling survivors, including information, fatigue, and cognitive and emotional concerns. This helps explain why an apparent clinical milestone or the completion of scheduled therapy need not coincide with the end of rehabilitation needs. However, its pooled estimates should not be applied to the present sample, and the present interviews cannot estimate the prevalence of unmet needs in Medan (26).

Family Responsibilities and Regional Comparisons

Family assistance sustained exercises, appointments, communication, and everyday care in participants' accounts. Survivors also expressed concern about reliance and burden. Jammal and colleagues' synthesis describes changes in carers' roles, identities, and valued activities, while Wang and colleagues identify emotional struggles and practical support needs. These sources provide caregivers' perspectives that the present study does not directly capture. The current findings should therefore be interpreted as survivors' perceptions of family involvement, not a substitute for assessing caregivers' own preferences or capacity (30, 31).

Muhrodji and colleagues' study in Yogyakarta offers a relevant Indonesian comparison. Its seven caregivers described communication responsibilities, limited knowledge, service constraints, and physical and emotional demands. The sample included family and other caregiving roles, and its focus differed from the present survivor interviews. The convergence supports attention to how rehabilitation responsibilities are distributed at home, while differences in participants, setting, and study focus prevent conclusions about a uniform Indonesian experience (12). Recent Philippine evidence broadens the regional comparison. Buckingham and colleagues' qualitative study involved 24 people with stroke and 20 household carers across several sites, identifying financial and geographical barriers, family support, knowledge gaps, and unmet service needs. These concerns resemble aspects of the present findings, but the Philippine study also identified culturally specific meanings that cannot be assumed to apply in Medan. Similarities support further contextual comparison; they do not establish shared cultural mechanisms or comparable national service provision (13). A Philippine mixed-methods study involving government officials and organisational leaders identified resource, staffing, infrastructure, and policy constraints. These system-level perspectives provide a possible context for access problems but cannot determine why an individual participant in the present study experienced reduced therapy or unclear follow-up. Combining patient, caregiver, clinician, and organisational perspectives in future research could distinguish communication problems from capacity and referral constraints more clearly (14).

Self-Directed Rehabilitation and the Role of Technology

Participants' interest in remote contact concerned exercise review, questions, and continued connection rather than a demonstrated replacement for practical assessment. The F@ce 2.0 study similarly located SMS-supported goal achievement within trusting relationships and personal meetings. Its specific intervention and mild-to-moderate stroke sample limit generalisation, but the comparison supports evaluating technology through how it contributes to meaningful rehabilitation relationships and activities (36). Functional telerehabilitation evidence provides a separate basis for evaluation. Sharififar and colleagues reported benefits or comparable findings in several functional domains, while satisfaction varied. Alwadai and colleagues found insufficient evidence for conclusions about satisfaction, adherence, and cost. Accordingly, the present findings support considering tailored combinations of in-person and remote support, but do not establish that a hybrid model is optimal, acceptable, or cost-effective for most patients (34, 35). Self-directed rehabilitation also depends on more than access to instructions. Dorward and colleagues identified encouragement, feedback, familiarity, flexibility, and environmental conditions in broader rehabilitation services. Shao and colleagues' stroke-specific study described interacting personal, cognitive, emotional, and family influences on home exercise. These findings are compatible with the present accounts of fluctuating confidence and capacity, but do not justify interpreting difficulties with exercise solely as lack of motivation (24, 25).

Implications for Rehabilitation Practice and Research

The findings suggest several priorities for service evaluation: making professional roles and changes in recommendations understandable; revisiting goals and information; recognising emotional concerns and fatigue alongside visible impairment; clarifying the next stage of rehabilitation; identifying a route to advice and review; and

discussing the support available from relatives. These priorities accord with guideline recommendations and qualitative evidence, but their implementation and effects should be evaluated within the local service context (3, 5, 7, 22, 26).

Peer support may be relevant to social and informational needs, although it was not an established theme or tested intervention in this study. Corbin and colleagues found that rehabilitation professionals anticipated possible benefits while identifying resource barriers, weak hospital–community links, and concerns about false hope. Peer support therefore represents a candidate for collaborative development and evaluation rather than a service recommendation demonstrated by the present data (33). Future studies could follow survivors across settings and repeated time points, include accessible approaches for people with substantial communication difficulties, and incorporate caregiver and professional perspectives. Such work could test whether the relationships described here persist across recovery stages and explain how service organisation influences experience. Methodological transparency and coherence remain important when using reflexive thematic analysis to interpret these perspectives (8, 11, 38).

Limitations

The findings are context-specific and offer interpretive understanding rather than statistical generalisability. Eligibility required experience of at least three rehabilitation disciplines; survivors with more restricted access may have different experiences that are not represented. Selection of people able to participate meaningfully in interviews may also underrepresent those with severe communication difficulties, major cognitive impairment, or profound disability. The accounts were retrospective and cannot establish prospective changes in priorities or preferences. Descriptions of coordination and changing recommendations reflect survivors' perceptions rather than independent observation of professional practice. They cannot determine whether apparent contradictions represented disagreement, appropriate progression, communication difficulties, or a combination of these factors. Caregiver and professional perspectives were not directly examined. Survivors' concerns about family burden therefore cannot establish caregivers' own experiences or support capacity. Similarly, suggestions about remote contact cannot establish its acceptability after use, comparative effectiveness, or cost. The findings should be interpreted in relation to the service context and the range of experiences represented, rather than extended to all stroke survivors or rehabilitation systems.

CONCLUSION

Stroke survivors' accounts described multidisciplinary rehabilitation as meaningful when complementary professional contributions formed an understandable plan, therapeutic goals connected with valued activities, and support remained accessible across institutional and everyday settings. Confidence was associated with clear roles, explanations of changing advice, and relationships in which participants felt known. Preferences for involvement differed. Professional guidance could be reassuring, while agreement with a goal did not necessarily mean that personal concerns had been explored. Returning home could make rehabilitation more relevant while exposing environmental barriers, fatigue, financial and transportation difficulties, reliance on relatives, and uncertainty about further support. These findings suggest priorities for making rehabilitation coherent, personally relevant, and continuous from the survivor's perspective. They support local evaluation of communication, goal review, transition planning, and routes to ongoing advice. They do not establish comparative treatment effectiveness or a single preferred model of rehabilitation. Longitudinal and multi-perspective research could clarify how these experiences vary across recovery stages and service contexts.

DECLARATIONS

Authors' Contributions:	Concept and Design: FY, CNG; Data Collection: FY, CNG, GL; Analysis: FY, CNG, GL; Drafting: FY; Critical Revision: CNG, GL.
Ethical Approval:	The institution responsible for ethical review was Universitas Prima Indonesia, Medan, Indonesia.
Informed Consent:	Written informed consent was obtained from all participants before enrolment.
Conflict of Interest:	The authors declare no conflict of interest.
Funding:	No external funding was received for this study.
Data Availability:	De-identified data may be available from the corresponding author on request, subject to participant consent and institutional confidentiality requirements.
Acknowledgments:	None.
AI Declaration:	Generative AI tools were used solely for language and grammatical refinement. The authors verified the final manuscript and remain fully responsible for its accuracy, integrity, and scientific content.

REFERENCES

1. Feigin VL, Brainin M, Norrving B, Martins S, Sacco RL, Hacke W, et al. World Stroke Organization (WSO): Global Stroke Fact Sheet 2022. Int J Stroke. 2022;17(1):18-29. doi:10.1177/17474930211065917.
2. Feigin VL, Brainin M, Norrving B, Martins SO, Pandian J, Lindsay P, et al. World Stroke Organization: Global Stroke Fact Sheet 2025. Int J Stroke. 2025;20(2):132-144. doi:10.1177/17474930241308142.
3. National Institute for Health and Care Excellence. Stroke rehabilitation in adults. NICE guideline NG236 [Internet]. London: NICE; 2023 [cited 2026 Oct 15]. Available from: https://www.nice.org.uk/guidance/ng236
4. Greenberg SM, Ziai WC, Cordonnier C, Dowlatshahi D, Francis B, Goldstein JN, et al. 2022 Guideline for the Management of Patients With Spontaneous Intracerebral Hemorrhage: A Guideline From the American Heart Association/American Stroke Association. Stroke. 2022;53(7):e282-e361. doi:10.1161/STR.0000000000000407.
5. Abu Saydah H, Turabi R, Sackley C, Moffatt F. Stroke Survivor's Satisfaction and Experience with Rehabilitation Services: A Qualitative Systematic Review. J Clin Med. 2023;12(16):5413. doi:10.3390/jcm12165413.
6. Lo TLT, Lee JLC, Ho RTH. Recovery beyond functional restoration: a systematic review of qualitative studies of the embodied experiences of people who have survived a stroke. BMJ Open. 2023;13(2):e066597. doi:10.1136/bmjopen-2022-066597.
7. O Connor E, Dolan E, Horgan F, Galvin R, Robinson K. A qualitative evidence synthesis exploring people after stroke, family members, carers and healthcare professionals' experiences of early supported discharge (ESD) after stroke. PLoS One. 2023;18(2):e0281583. doi:10.1371/journal.pone.0281583.
8. Fors S, Brråndal A, Pessah-Rasmussen H, Lindgren I. Experiences of chain of care and rehabilitation after stroke: a qualitative study of persons discharged to skilled nursing facilities before returning home. J Rehabil Med. 2024;56:jrm35240. doi:10.2340/jrm.v56.35240.
9. Liu S, Liu X, Yang X, Huang S, Xie W, Xiao W, et al. Exploring Experiences and Perceptions of Stroke Survivors in Hospital-To-Home Transition Care: A Qualitative Systematic Review. J Clin Nurs. 2025;34(2):592-624. doi:10.1111/jocn.17564.
10. Sun X, Shi Y, Liu C, Wang S, Li D, Zhu X, et al. Experience and needs of stroke patients in physical rehabilitation: a systematic review and meta-synthesis. BMC Health Serv Res. 2025;25(1):1062. doi:10.1186/s12913-025-13213-7.
11. Zang S, Ye M, Qi W, Wu Z, He M, Lou Q, et al. Factors influencing participation of patients who had a stroke in rehabilitation shared decision-making: a qualitative meta-synthesis. BMJ Open. 2026;16(1):e103985. doi:10.1136/bmjopen-2025-103985.
12. Muhrodji P, Wicaksono HDA, Satiti S, Trisnantoro L, Setyopranoto I, Vidyanti AN. Roles and Problems of Stroke Caregivers: A Qualitative Study in Yogyakarta, Indonesia. F1000Res. 2022;10:380. doi:10.12688/f1000research.52135.2.
13. Buckingham SA, Anota E, Barba MM, Boac V, Estrada M, Faeldon L, et al. 'Pagbangon at Pag-Asa' (Resurgence and Hope): A Qualitative Study of the Lived Experiences of People With Stroke and Household Carers in the Philippines. Health Expect. 2026;29(1):e70537. doi:10.1111/hex.70537.
14. Buckingham S, De Vera JA, Faeldon L, Kent B, Logan A, Ong A, et al. A Multi-Sector Mixed Methods Study of Stroke Services in the Philippines: Insights From Government Officials and Organisational Leaders. Int J Health Plann Manage. 2025;40(5):1033-1047. doi:10.1002/hpm.3939.
15. Zhan J, Zhang P, Wen H, Wang Y, Yan X, Zhan L, et al. Global prevalence estimates of poststroke fatigue: A systematic review and meta-analysis. Int J Stroke. 2023;18(9):1040-1050. doi:10.1177/17474930221138701.
16. Larsson P, Bidonde J, Olsen U, Gay CL, Lerdal A, Ursin M, et al. Association of post-stroke fatigue with physical activity and physical fitness: A systematic review and meta-analysis. Int J Stroke. 2023;18(9):1063-1070. doi:10.1177/17474930231152132.

17. Zhao B, Yao Y, Gao T. The effect of psychological intervention on the quality of life and rehabilitation outcome of stroke patients with anxiety and depression: A systematic review. Medicine (Baltimore). 2024;103(45):e40439. doi:10.1097/MD.0000000000040439.

18. Song YY, Sun WJ, Wang C, Tian YM, Liu H, Jiang Y. Effects of multicomponent exercise on quality of life, depression and anxiety among stroke survivors: A systematic review and meta-analysis. J Clin Nurs. 2023;32(21-22):7677-7690. doi:10.1111/jocn.16853.

19. Notkin GT, Molsted S, Jensen MB, Lind L, Bove DG. How do stroke survivors experience rehabilitation goal setting and plans to support their rehabilitation? A qualitative study. Disabil Rehabil. 2026;48(1):108-116. doi:10.1080/09638288.2025.2499578.

20. Vieira A, Pereira CM, Goes AR. Exploring readiness to patient-centered goal-setting in stroke Rehabilitation-A qualitative study. Disabil Rehabil. 2026. Epub ahead of print. doi:10.1080/09638288.2026.2716825.

21. Vingerhoets C, Hay-Smith J, Graham F. 'Beyond the surface': a qualitative study exploring the experiences of stroke survivors and their families in sharing their values, preferences, and circumstances in inpatient rehabilitation. Disabil Rehabil. 2026;48(17):5551-5566. doi:10.1080/09638288.2026.2627995.

22. Helbach J, Hoffmann F, Hecht N, Heesen C, Thomalla G, Wilfling D, et al. Information needs of people who have suffered a stroke or TIA and their preferred approaches of receiving health information: A scoping review. Eur Stroke J. 2025;10(1):5-21. doi:10.1177/23969873241272744.

23. Wang S, Li D, Zhu S, Guo X, Xu M, Wang H, et al. The supportive care needs of stroke patients: A scoping review. Res Nurs Health. 2024;47(5):532-550. doi:10.1002/nur.22406.

24. Dorward E, Devlin A, Brusco NK, Dulfer F, Whittaker SL, Reeder S, et al. Patients' perceptions of participating in self-directed activities outside supervised occupational and physiotherapy within inpatient and home-based rehabilitation settings: a qualitative study. Disabil Rehabil. 2025;47(3):592-600. doi:10.1080/09638288.2024.2341872.

25. Shao J, Wang Q, Zhang X, Liu K, Sha L, Shi H, et al. This is a personal journey: a qualitative study on the influencing factors of home-based exercise rehabilitation behavior among stroke survivors. Front Neurol. 2026;17:1736073. doi:10.3389/fneur.2026.1736073.

26. Tan K, Thayabaranathan T, Purvis T, Wang Y, Kilkenny MF, Nelson MR, et al. Unmet needs poststroke and associated factors: A systematic review and meta-analysis. Rehabil Psychol. 2026. Epub ahead of print. doi:10.1037/rep0000675.

27. Jee S, Jeong M, Paik NJ, Kim WS, Shin YI, Ko SH, et al. Early Supported Discharge and Transitional Care Management After Stroke: A Systematic Review and Meta-Analysis. Front Neurol. 2022;13:755316. doi:10.3389/fneur.2022.755316.

28. Carlsson GE, Törnbom K, Nordin Å, Sunnerhagen KS. Coming home in the context of very early supported discharge after stroke - An interview study of patients' experiences. J Stroke Cerebrovasc Dis. 2024;33(9):107869. doi:10.1016/j.jstrokecerebrovasdis.2024.107869.

29. Törnbom K, Carlsson GE, Nordin Å, Sunnerhagen KS. Patients' experiences of very early supported discharge after stroke: safety, emotional support and feelings of control in everyday life. Disabil Rehabil. 2025;47(12):3100-3107. doi:10.1080/09638288.2024.2415332.

30. Jammal M, Kolt GS, Liu KPY, Dennaoui N, George ES. The impact of caregiving on the roles and valued activities of stroke carers: A systematic review of qualitative studies. PLoS One. 2024;19(5):e0304501. doi:10.1371/journal.pone.0304501.

31. Wang L, Liu J, Wu L, Zhang J, Fang H. Caregiving experiences of stroke caregivers: A systematic review and meta-synthesis of qualitative studies. Medicine (Baltimore). 2023;102(13):e33392. doi:10.1097/MD.0000000000033392.

32. Nuccio E, Petrosino F, Simeone S, Alvaro R, Vellone E, Pucciarelli G. The needs and difficulties during the return to work after a stroke: a systematic review and meta-synthesis of qualitative studies. Disabil Rehabil. 2024;46(21):4901-4914. doi:10.1080/09638288.2023.2287016.

33. Corbin S, Damiolini E, Termoz A, Huchon L, Rode G, Schott AM, et al. Rehabilitation professionals' views on individual peer support interventions for assisting stroke survivors with reintegration into the community: a qualitative study. Disabil Rehabil. 2023;45(26):4413-4423. doi:10.1080/09638288.2022.2152115.

34. Sharififar S, Ghasemi H, Geis C, Azari H, Adkins L, Speight B, et al. Telerehabilitation service impact on physical function and adherence compared to face-to-face rehabilitation in patients with stroke: A systematic review and meta-analysis. PM R. 2023;15(12):1654-1672. doi:10.1002/pmrj.12988.

35. Alwadai B, Lazem H, Almoajil H, Hall AJ, Mansoubi M, Dawes H. Telerehabilitation and Its Impact Following Stroke: An Umbrella Review of Systematic Reviews. J Clin Med. 2025;14(1):50. doi:10.3390/jcm14010050.

36. Söderhielm K, Tistad M, Ytterberg C, Guidetti S. Experiences of F@ce 2.0: a person-centred intervention for home-based rehabilitation after stroke supported by digital technology - a qualitative study. BMJ Open. 2025;15(7):e089147. doi:10.1136/bmjopen-2024-089147.

37. Braun V, Clarke V. Thematic analysis: a practical guide. London: SAGE; 2022.

38. Braun V, Clarke V. Supporting best practice in reflexive thematic analysis reporting in Palliative Medicine: A review of published research and introduction to the Reflexive Thematic Analysis Reporting Guidelines (RTARG). Palliat Med. 2024;38(6):608-616. doi:10.1177/02692163241234800.