

“MORE THAN JUST A PATIENT” Experiences of High-Intensity Resistance and Impact Training in Men with Prostate Cancer and Bone Metastases – A Qualitative Study

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Abstract

Purpose

To explore how men with prostate cancer and bone metastases experienced participating in a supervised high-intensity resistance and impact training (HiRIT) programme, including perceived benefits, challenges, and influence on physical and mental wellbeing.

Methods

This qualitative study was embedded within a randomised controlled trial investigating the effect of a 32-week supervised HiRIT programme. Individual semi-structured interviews were conducted with men who had completed or discontinued the programme. Twenty-two consecutive participants were invited to participate, and all accepted, resulting in 22 interviews, which were analysed using reflexive thematic analysis.

Results

Four themes were generated: *Resistance Training: A New Way to Gain Physical Strength to Support Daily Life with Cancer*, describing visible progress that reached into everyday life; *More Than Just a Patient*, a shift from being defined by illness towards feeling recognised as a person; *Support and Obligation Through a Sense of Community Among Peers*, grounded in a shared diagnosis; and *Safety Through Professional Supervision*, where trust in skilled physiotherapists allowed the men to train without fear of harm. Rather than fearing the demanding training, the men welcomed being challenged, particularly when it was framed as part of their treatment.

Conclusion

Supervised HiRIT was experienced as acceptable and meaningful, helping the included men feel capable, supported, and connected. These findings underscore the importance of exercise delivery and professional supervision for men with prostate cancer and bone metastases.

Trial registration

The trial was registered at ClinicalTrials.gov (NCT06259279) on 24 February 2024.

Introduction

Prostate cancer is one of the most prevalent cancer diagnoses among men worldwide (1). As the disease progresses, a large number of patients develop bone metastases, which can be associated with significant burden, including pain, fatigue, reduced physical function, and increased risk of skeletal-related events, substantially affecting daily functioning and quality of life (QoL) (2).

Exercise is increasingly recognised as an important part of supportive care across the cancer trajectory, including in advanced cancer (3). Structured exercise has been shown to improve physical function, fatigue, and QoL (4), and resistance training additionally counteracts treatment-related side effects such as loss of muscle mass, reduced bone density, and functional decline, particularly in relation to androgen deprivation therapy (ADT) (5).

High-intensity resistance and impact training (HiRIT) programmes combine progressive, multi-joint resistance exercises with impact loading under professional supervision, specifically targeting muscular strength and skeletal health (6). Within exercise oncology, high-intensity training marks a shift from traditionally conservative approaches, particularly in patients with bone metastases, where exercise has historically been considered contraindicated because of concerns about skeletal fragility, pathological fractures, and other skeletal-related events (7). However, emerging evidence supports the feasibility and safety of supervised exercise for selected patients with bone metastases (8).

Patients' decisions regarding exercise participation may be influenced by their perceptions of the risk of exercising with bone metastases, the safety of the training setting, and their confidence in their own ability to participate (9). While qualitative studies have explored experiences of supervised exercise among men with prostate cancer (10–12), studies focusing on men with bone metastases remain limited. A recent qualitative study found that patients with bone metastases from various cancer diagnoses perceived an individually tailored, moderate-intensity supervised exercise programme to be safe and beneficial (9). However, to our knowledge, no studies have explored how men with prostate cancer and bone metastases experience high-intensity resistance and impact training, in which the skeleton is deliberately loaded. Knowledge about how this patient group experiences such training is essential to challenge this cautious approach and to support clinicians in translating high-intensity training into clinical practice. Against this background, this study aimed to explore how men with prostate cancer and bone metastases experience participating in a hospital-based supervised HiRIT programme, to provide insight into how this patient group perceives the benefits and challenges of participating in HiRIT, and how they perceive the influence of their training on their physical and mental wellbeing.

Methods

To explore how men with prostate cancer and bone metastases experience participating in a supervised HiRIT programme, this study applied a qualitative design. The study was embedded within the High Impact Training to Patients with Prostate Cancer and Bone Metastases (HIP) study, a randomised controlled exercise intervention trial.

The HIP study

The HIP study was conducted at the Department of Oncology, Copenhagen University Hospital, Herlev and Gentofte, Denmark, with participants recruited from the urology outpatient clinic when ADT was due to commence. Participants randomised to the intervention group took part in a 32-week, twice-weekly, supervised programme centred on progressive, barbell-based resistance exercises (deadlift, squat, and overhead press) combined with an impact-loading exercise (jumping). Sessions were led by physiotherapists experienced in cancer care and conducted in small groups of up to six in a hospital facility. Details on eligibility criteria, study design, and the HIP programme can be found at [ClinicalTrials.gov](https://clinicaltrials.gov/ct2/show/study/NCT06259279) (NCT06259279) and in the study protocol (13).

Participants and Recruitment

For this qualitative study, all men in the intervention group who completed or discontinued the programme during a specified recruitment period were invited to take part in an interview, allowing perspectives on barriers to continued participation to be included. Recruitment was consecutive and continued until the sample was considered to hold sufficient information power to address the research aim, given the narrow inclusion criteria and the focused aim of the study (14).

Data Collection

Individual semi-structured interviews were conducted shortly after each participant completed or discontinued the intervention. An interview guide (Table 1) ensured consistency while allowing flexibility to follow up on topics raised by the participants. The guide was developed from the team's clinical experience and existing evidence (10). Two versions with the same overall structure were used, for those who completed and those who discontinued. Two of the 22 interviews were conducted virtually via Microsoft Teams, the remainder face-to-face in a private room at the hospital. All interviews were audio-recorded. Interviews were conducted and analysed in Danish. Quotations were translated by AMR, staying close to participants' wording, and checked by a bilingual colleague independent of the study. The interviews were conducted by MKM and AL. MKM is a researcher with a nursing background and extensive experience in qualitative research; AL is a clinical nurse specialist with experience in prostate cancer care. The interviewers were not involved in delivering the exercise intervention and had no previous contact with the participants.

Table 1
Semi-structured interview guide

Theme	Questions and prompts
Opening question	To begin, could you tell me a little about why you chose to take part in HIP?
Experiences of the training	How has your experience of the training been? How has your physical condition changed since you started training?
Positive aspects	How are you doing in your everyday life since you started training? – <i>fatigue</i> – <i>mood</i> – <i>energy</i> – <i>appetite</i>
Challenges and barriers	Have you experienced any challenges in connection with the training? – <i>How have you handled these challenges?</i> Before you started, did you have any concerns that you might get injured?
Motivation and support	What has motivated you to train during your participation? What thoughts do you have about continuing the training? What support have you received from family, friends, or health professionals in connection with your training? – <i>How has this support affected your participation?</i> How has it been to train in a group? – <i>same diagnosis</i> – <i>group size</i>
Suggestions for improvement	Do you have any suggestions for how the training could be improved? Is there anything you think could make the training more effective or more accessible for other participants?

Note: The table shows the interview guide used with participants who completed the programme. A second version was used with participants who discontinued. The two versions shared the same overall structure and thematic content; the version for participants who discontinued opened by exploring the reasons for stopping (“What was the reason you stopped attending the group?”, with follow-up on any other reasons and on the considerations made before stopping) and included additional questions on what might have supported continued participation (“What could have been done for you to continue training at the hospital?”) and on whether the participant had continued with other forms of training.

Theme	Questions and prompts
Closing question	Is there anything else you would like to add about your experiences with the training that we have not covered in the interview?
Note: The table shows the interview guide used with participants who completed the programme. A second version was used with participants who discontinued. The two versions shared the same overall structure and thematic content; the version for participants who discontinued opened by exploring the reasons for stopping (“What was the reason you stopped attending the group?”, with follow-up on any other reasons and on the considerations made before stopping) and included additional questions on what might have supported continued participation (“What could have been done for you to continue training at the hospital?”) and on whether the participant had continued with other forms of training.	

Data Analysis

The audio recordings were transcribed verbatim by AMR, which supported early familiarisation with the data. The interviews were analysed following the analytic phases from Braun and Clarke's reflexive thematic analysis (15–17). An inductive approach was applied, with codes and themes derived from the data, and coding was conducted primarily at the semantic level, staying close to the explicit meanings expressed by participants (15). Coding was managed in NVivo (version 15).

Coding of the full dataset produced 22 codes, each with a written description. The codes were clustered into candidate themes in a working document linking every cluster to the codes and extracts it rested on, so the developing themes could be checked against the data. Through discussion between AMR, MKM, and AL, theme boundaries were reconsidered and subthemes integrated, and four themes were generated. Rather than seeking coder agreement, these discussions drew on the team's differing professional backgrounds to challenge the interpretation, with the researchers remaining attentive to how their own positions shaped their reading of the data.

Ethical Considerations

This qualitative study was conducted in accordance with the Declaration of Helsinki. The Regional Health Research Ethics Committees in the Capital Region of Denmark waived the need for ethical approval of the interview study (no. F-24052638) and approved the HIP study (ref. no. H-23015286). The study was registered in the region's record of data processing activities for research (ref. no. P-2024-17384). All participants received written and oral information and provided written informed consent before their interview. Interviews were pseudonymised at transcription, and quotations are reported so that individual participants cannot be identified.

Results

Twenty-two men participated in the interview study between November 2025 and April 2026 (Table 2; Fig. 1). Interviews lasted a mean of 31 minutes (range 15–45). Only three had previous experience with

resistance training, all machine-based. One participant had discontinued the HIP programme; 21 completed it. The analysis generated four main themes capturing how they experienced taking part in the HIP programme (Fig. 2). Illustrative quotes are presented with participant numbers (e.g. ID01).

Table 2
Participant characteristics

ID	Age, years, mean (range)	Treatment	ECOG PS	Living status	Working status	Attendance, %, mean (range)	Previous exercise experience*
Group (n = 22)	69 (52–82)	ADT only: 11 ADT + CT: 11	0: 17 1: 5	Alone: 8 Co-living: 12 w./ children: 2	Retired: 7 Sick leave: 9 Part time: 5 Self-employed: 1	88 (16–100)	None: 5 Resistance training: 3 Other exercise: 14
01	67	ADT	0	Alone	Retired	95	None
02	78	ADT	0	Alone	Retired	100	Resistance
03	66	ADT	0	Living with partner	Partial sick leave	89	Golf
04	61	ADT	0	Living with partner	Partial sick leave	91	Cycling, Yoga
05	68	ADT + CT	0	Alone	Working part time	84	Cycling
06	68	ADT + CT	0	Living with partner	Partial sick leave	95	Running, Rowing
07	80	ADT	1	Living with partner	Retired	84	Cycling, Golf
08	82	ADT	1	Living with partner	Working part time	80	Tennis
Abbreviations:							
ADT (androgen deprivation therapy), CT (chemotherapy), ECOG PS (Eastern Cooperative Oncology Group Performance Status). Attendance is calculated as the percentage of completed sessions out of 64 scheduled sessions. Values in the group row are n unless otherwise specified.							
*Previous exercise experience refers to regular, structured exercise prior to programme entry. Resistance training refers to machine-based resistance training.							

09	80	ADT	1	Living with partner	Working part time	94	None
10	64	ADT + CT	0	Alone	Partial sick leave	97	Running, Martial arts
11	60	ADT + CT	0	Living with partner	Partial sick leave	98	Cycling
12	76	ADT + CT	0	Alone	Working part time	81	Ice skating, Roller blades
13	74	ADT + CT	1	Alone	Retired	97	None
14	58	ADT	0	Living with partner	Partial sick leave	100	Cycling
15	67	ADT	0	Alone	Retired	77	None
16	81	ADT	0	Living with partner	Working part time	94	Resistance
17	52	ADT + CT	0	Children biweekly	Partial sick leave	84	None
18	62	ADT + CT	0	Children biweekly	Partial sick leave	95	Running, Cycling
19	69	ADT	1	Alone	Retired	100	Tennis
20	75	ADT + CT	0	Living with partner	Retired	88	Tennis, Golf
21	59	ADT + CT	0	Living with partner	Self-employed	94	Resistance
22 (dropout)	62	ADT + CT	0	Living with partner	Partial sick leave	16	Running

Abbreviations:

ADT (androgen deprivation therapy), CT (chemotherapy), ECOG PS (Eastern Cooperative Oncology Group Performance Status). Attendance is calculated as the percentage of completed sessions out of 64 scheduled sessions. Values in the group row are n unless otherwise specified.

*Previous exercise experience refers to regular, structured exercise prior to programme entry. Resistance training refers to machine-based resistance training.

THEME 1: RESISTANCE TRAINING: A NEW WAY TO GAIN PHYSICAL STRENGTH TO SUPPORT DAILY LIFE WITH CANCER

For most participants, resistance training was something they had never imagined would suit them, and trying it in a supervised setting changed that view:

ID11: *"As I said, I've never been to a fitness centre. I've sometimes passed by, and people were standing there with those weights, and you think, well, that wasn't something I would have come up with myself. So now you've sort of tried it and found out that it's actually quite fun in some way."*

Alongside the novelty, the experience of surprisingly quick, visible progression, beginning with minimal loads and gradually increasing, was described as a powerful source of motivation to keep training.

For many, the strength gained from training reached beyond the exercise facility into everyday life. They described more energy, better mobility, and a greater ability to manage ordinary daily tasks. Physical strength was rarely a goal in itself; it was valued because it restored a degree of ordinary daily functioning:

ID06: *"I have more energy now, compared to what I had. The training has helped with that. Definitely. Because now I have that strength, in a way. I mean, I can do things now. Now I can lift, I can walk. Before, I could barely drag myself along. So it's really been good."*

Subtheme 1a: Intentions to continue, dependent on structure and support

Most participants expressed concrete intentions to continue resistance training after the programme ended: by joining a local fitness centre, acquiring weights at home, or training with family members, colleagues, or fellow participants. For some, the continuation was already underway. Other participants doubted their plans would hold once the programme's structure was gone. They pointed to professional supervision as the hardest part to replace. Without this, some were unsure whether training on their own would happen:

ID08: *"We still talk about continuing ours. I mean, the four boys there. ... I'm not sure it'll actually happen. Also because the training has been fun and good, after all. But we won't have that staff with us. Which has meant a great deal, being there to lift the weight up and put plates on and take them off."*

THEME 2: MORE THAN JUST A PATIENT

Participants described how supervised exercise let them experience themselves as being more than their illness. In a treatment trajectory otherwise dominated by their diagnosis, the training facility was a setting where they were seen as capable rather than sick. Being met as a whole person, and being challenged rather than spared, stood out from the rest of their care:

ID03: *"It has definitely been really great for us. ... This team here. ... That you are met there. As a human being. And challenged. In an incredibly good way."*

For several participants, being challenged in this way contrasted with a perception of their body as fragile that had developed earlier in the illness. As the disease and its treatment set in, physical weakness came to feel natural and unavoidable. The HIP programme appeared to unsettle this assumption: the training showed participants that they could still affect their own physical state. This often came with a sense of personal responsibility: a recognition that something had to be done, and that it was theirs to do:

ID19: *"I've been on this [the medication] for six years now. ... It eats away your body and soul. It just goes downhill. You have to be very aware of it. And that's what I've become now. That something has to happen. There's no such thing as saying: 'It's raining, so I'm staying indoors today.' That won't do."*

Part of what made this shift possible was that the training stood apart from the rest of the treatment. Even though the sessions took place inside the hospital, they were experienced as something distinct from illness and medical care. They offered a break from the tests, appointments, and treatments that otherwise filled participants' time there. This interpretation was not shared by everyone. For one participant, the hospital setting carried the opposite weight, and returning to it kept him in the role of patient:

ID04: *"You feel very hospitalised by continuing to come into a hospital environment ... I've damn well been at the hospital a lot, I don't mind that it [the programme] is stopping now."*

THEME 3: SUPPORT AND OBLIGATION THROUGH A SENSE OF COMMUNITY AMONG PEERS

A central part of the training experience was the community that formed among participants. Sharing the same diagnosis created an immediate understanding between them, sparing participants the effort of explaining or justifying their situation. One participant likened the group to a platoon at the front, facing the same enemy and sharing the same hope of survival. For several participants, encouragement concerning their life situation and illness carried more weight coming from fellow patients, who spoke from experience rather than expertise:

ID21: *"It carries a different weight when it's people who have been through it themselves who say it, than when it's a doctor or a physiotherapist ... When you talk to those who have been through it themselves, it just feels much, much stronger."*

For one participant, these exchanges changed how he related to the illness, moving from avoidance towards seeking out information he had previously kept at arm's length.

The community offered more than shared understanding and encouragement. For many, it also became a source of enjoyment and, at times, genuine friendship. Seeing others in the same situation was described as a lift, and visible progress in the weights added an extra pull to attendance. Alongside this, belonging to the team came with a sense of obligation. Participants did not want to let the group down, and this pulled them to the sessions even on days when they felt unwell from treatment. Turning up became a way of honouring others as much as themselves:

ID01: *"Actually, there were a couple of guys on the group who weren't feeling very well one day. One of them had had chemotherapy the day before, but he still came anyway, and he preferred to sit there and be part of it rather than stay at home. And [as he said], 'I probably didn't have the strength to take part anyway.' And that just showed that motivation we all had."*

THEME 4: SAFETY THROUGH PROFESSIONAL SUPERVISION

Trust in the physiotherapists' supervision was central to participants' sense of safety. This trust went beyond instruction in correct technique, resting on a more basic sense of being looked after throughout the session, which allowed participants to train without fear. As fatigue set in over the course of a session, movements became harder to control, and the physiotherapists' watchful presence caught the changes that participants could not manage on their own:

ID18: *"There's some technique they keep an eye on. Partly in general that you do it correctly, but when you get tired, your technique also changes ... It's difficult to do alone, because you get tired."*

Participants rarely expressed concern about injury during training; only one described some initial nervousness. For several participants, the sense of safety was tied to the training taking place in a hospital. They preferred it to municipal alternatives, describing the programme as more targeted and specialised than the municipal rehabilitation they had previously encountered. For some, this preference reflected how closely the training was bound to their wider treatment, experienced as part of the same course of care. Even the one participant who had discontinued the programme described it in these terms:

ID22: *"It's a complete package. ... Chemo kills you, and the training, it revives you."*

Some participants said they would have taken up comparable high-intensity training had it been offered in their municipality. Information from health care professionals also shaped how participants entered the programme. Several described how advice from their treating doctors, presenting exercise as important and evidence-based, gave them the confidence to take part.

Discussion

A recent meta-synthesis of qualitative studies concluded that exercise can positively influence all four dimensions of well-being in people with advanced cancer: physical, psychological, social, and spiritual

(18). Our findings speak to three of these, the physical, psychological, and social, and add a fourth dimension that the synthesis does not cover: safety. This may reflect the population and the training itself, as across the studies synthesised the site of metastases was never specified, and none involved high-intensity or impact loading.

Regaining physical strength was central to how the men experienced the programme. Like participants in the meta-synthesis, who revised the physical limits they thought their illness had set (18), the men in our study came to see decline as less inevitable, but they tied this shift specifically to heavy, progressive loading. Although exercise in this group has long been approached with caution (7), Galvão et al. (19) showed that supervised exercise could preserve physical function without causing skeletal complications, though their programme was deliberately protective and avoided loading the metastatic sites. Most existing supervised programmes for men with prostate cancer have also relied on exercise machines (20). The programme studied here departs from both conventions, applying heavy free-weight resistance and impact loading directly. Rather than finding this daunting, the men found the training worthwhile and valued being challenged. This echoes Murphy et al. (10), who found that men with prostate cancer preferred the more demanding parts of supervised training and cautioned against overprotecting them. Our findings suggest this preference holds even in men with bone metastases, provided the training feels safe.

A second dimension concerned a shift in how the men saw themselves: from being defined by illness to feeling like people again. Adamsen et al. (21) described a similar process, in which participants regained bodily control and reshaped their identity through supervised exercise during chemotherapy. Their participants, however, were much younger women and men with an athletic background returning to a familiar identity, whereas the men in our study were mostly meeting resistance training for the first time. That they took to it nonetheless may reflect the format itself: previous research suggests that practical, action-oriented approaches resonate with how many men prefer to engage with health and exercise (12, 22). In our study, advice from the men's treating doctors also seemed to play a part. Once training began, quick and visible progress kept them engaged.

A third dimension concerned the community that formed among the men. Where the meta-synthesis described exercise as easing isolation and fostering a sense of belonging (18), here that belonging took a sharper form: a shared diagnosis created an immediate, intuitive understanding that removed the need to explain or justify their situation to one another. One participant's image of the group as a platoon at the front captures how a common threat created solidarity. The same military metaphor appears in Adamsen et al. (23), who described how men with cancer bonded quickly through their shared situation. In both studies, this togetherness was geared towards action: the men came together to do something, not to dwell on their suffering. For one participant, this stance reached beyond the training itself, prompting more questions and a more active part in his own treatment. This sense of community formed among men in their seventies and eighties, several of whom described unexpected friendships late in life. This suggests that the social pull of supervised group training is not limited to younger people, or to those who were physically active before their illness.

A fourth dimension concerned safety, which in the men's accounts rested on skilled supervision. Despite living with bone metastases, they rarely voiced concern about injury, which may reflect the trust they placed in the physiotherapists. This sense of safety may have been part of what allowed them to embrace being challenged. Supervised, hospital-based exercise has been described as a safe learning environment, whereas the move to unsupervised community training can feel like a confrontation with the real world (20). For high-intensity and impact loading in men with bone metastases, the margin for error is smaller, and qualified supervision and individualised exercise prescription are not only reassuring but a precondition for delivering this training safely (24). The setting, expertise, and resources this requires must be considered when translating such programmes into practice.

Taken together, the findings point to components that may support delivery of a HiRIT programme into routine cancer care (Table 3).

Table 3

Suggested components to support successful delivery of a HiRIT programme into routine cancer care for men with prostate cancer and bone metastases

Dimension of well-being in patients with advanced cancer	Experiences of participating in a HiRIT programme	Suggested components
Physical	• Strength that reached into everyday life • Greater independence in daily tasks • Intentions to continue, but doubts without the programme's structure	• Make progress visible from the start • Prepare the transition to independent training • Gradually hand over management of loading and progression
Psychological	• Being met as a person, not a patient • Being challenged rather than spared • A sense of being able to affect their own body	• Let treating clinicians present exercise as important and evidence-based • Progress loading according to individual capacity, not assumptions about frailty • Challenge within a safe setting
Social	• Immediate understanding through a shared diagnosis • Enjoyment and friendship • Obligation towards the group	• Deliver training in groups • Group by shared diagnosis rather than mixed • Provide time and a simple setting for informal socialising after sessions
Safety	• Trust in skilled physiotherapists • Training without fear of harm	• Supervision by physiotherapists experienced in cancer care • Qualified assessment and progression of loading

Strengths and limitations

To our knowledge, this is the first qualitative study of how men with prostate cancer and bone metastases experience high-intensity resistance and impact training. Embedding it within a randomised controlled trial gave a clearly defined sample and a systematic recruitment pathway. The participants shared the same diagnosis and treatment setting by design, and varied in age and life circumstances, giving the accounts reasonable breadth. All invited men agreed to be interviewed, lowering the risk that only the most engaged took part. Although the study was designed to include the perspectives of men who discontinued, only one participant had discontinued, after 11 of 64 sessions, when a pre-existing hand injury, unrelated to the prostate cancer or bone metastases, was aggravated during training. The low number of discontinuations reflects well on the programme but limits what this study can say about

men who do not complete such an intervention. In line with reflexive thematic analysis, we treated the analysis as an interpretation shaped by the research team, not a neutral pulling-out of themes. Several researchers were involved in the analysis, not to confirm a single reading but to deepen the interpretation through different perspectives, with their own preunderstandings treated as part of the work (17).

Conclusion

This study showed that men with prostate cancer and bone metastases experienced supervised HiRIT as acceptable and meaningful. Beyond physical benefits, participants described feeling recognised as more than just patients, finding a sense of community with peers, and feeling safe through professional supervision. These findings suggest that professionally supervised HiRIT may offer more than physical rehabilitation: it may provide a setting in which men with bone metastases gain confidence in their bodies. Further research is needed to establish its clinical effects and determine how such programmes can best be delivered within cancer care.

Declarations

Funding

No specific grant was received for this study. The authors' work was supported by their employing institutions as part of their salaried positions.

Competing interests

The authors declare no competing interests.

Ethics approval

The Regional Health Research Ethics Committees in the Capital Region of Denmark waived the need for ethical approval of the interview study (no. F-24052638) and approved the HIP study (ref. no. H-23015286). The study was registered in the Capital Region of Denmark's record of data processing activities for research (ref. no. P-2024-17384) and conducted in accordance with the Declaration of Helsinki.

Consent to participate

All participants received written and oral information about the study and provided written informed consent before their interview.

Consent to publish

All participants consented to the publication of pseudonymised anonymised quotations.

Data availability

The datasets generated and analysed during the current study are not publicly available because the interview data contain information that could compromise participant confidentiality, but are available from the corresponding author on reasonable request.

Author contributions

Conceptualisation and study design: AMR, MLKS, MKM.

Data collection: MKM, AL. Transcription: AMR. Formal analysis: AMR, MKM, AL. Writing, original draft: AMR. Critical revision of the manuscript for important intellectual content: MLKS, KL, AL, MKM. Other revisions made by PBØ, AV, CBJ, DN. All authors read and approved the final manuscript.

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Figures

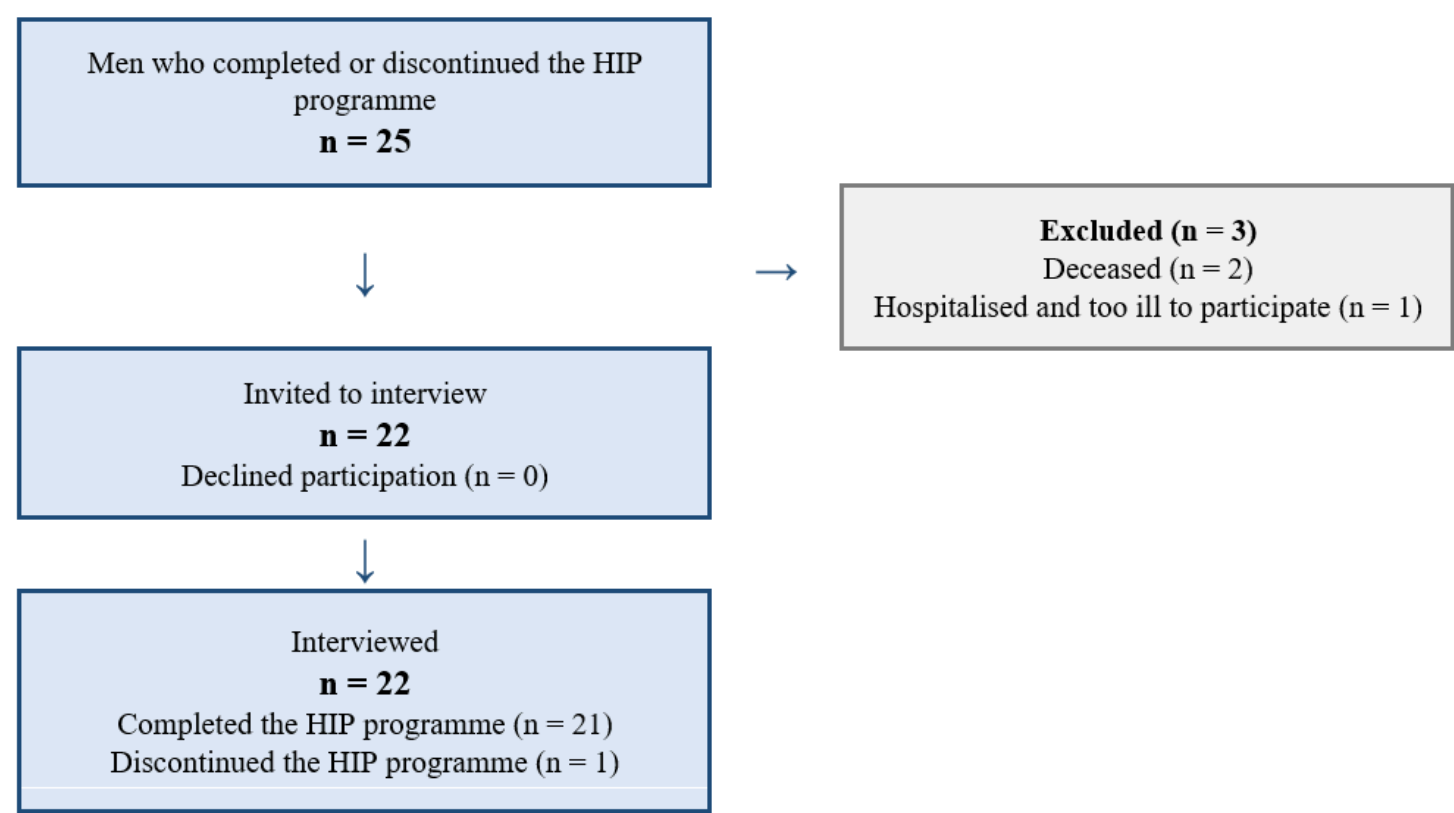


Figure 1

Flow diagram of participant inclusion in the interview study.

Figure 2

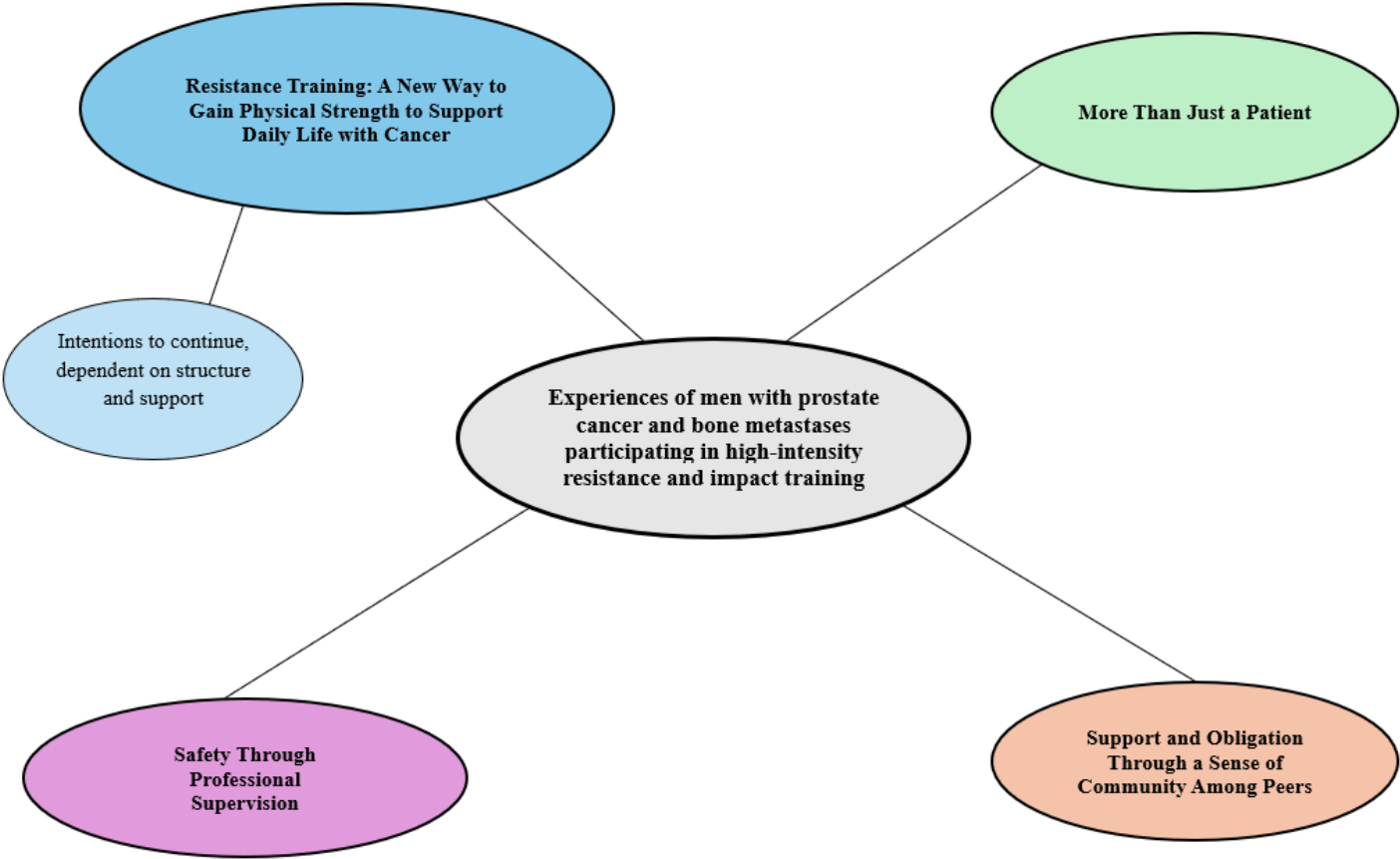


Figure 2

Thematic map of themes and subtheme.