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Living with falls: house-bound older people's experiences  
of health and community care

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## **ABSTRACT**

Despite world-wide emphasis on falls prevention, falls and their consequences remain a major health issue for older people, and their health care providers. Many systematic reviews have been undertaken to evaluate the impact of intervention programmes on falls reduction, however relatively little research provides a voice for older people's own perceptions of such programmes. To readdress this imbalance the current research aimed to investigate the experiences of a hard to reach group of older people who had received a post-fall health and social care programme. Semi-structured interviews with eight house-bound people aged over 65 were undertaken, and data analysed using interpretative phenomenological analysis. Four themes were identified: Losing independence; losing confidence; losing social identity; managing a changed self. Despite a tailored intervention programme minimal improvement in participants' psychological adjustment to falls was noted. Outcomes from this study are of interest to health and social care staff who deliver falls prevention programmes. Staff need to enhance constructive adjustment to the older person's altered circumstances and ensure their behaviours do not exacerbate their clients' loss of independence. This should assist older people's ability to positively manage their sense of self, allowing them to find continuing meaning in their daily lives.

Keywords: Older people, Community care, Qualitative research, Rehabilitation, falls

## **Introduction**

Accidental falls and fall related injuries are major public health concerns for individuals aged 65 years and over, with women being at greatest risk (Campbell et al 1990; Tinetti and Speechley 1989). It is estimated one third of community dwelling people in this age group fall at least once a year (Berg, Alessio, Mills and Tong 1997; Campbell et al 1990), whilst the prevalence of falls in hospitals and nursing homes is considerably higher than for people living in the community (American Geriatrics Society, British Geriatrics Society and American Academy of Orthopaedic Surgeons Panel on Falls Prevention 2001). While such high prevalence rates already a cause for concern, it appears the actual incidence of falls among the over 65 year age group is underestimated (Hill and Schwarz 2004). All evidence points to a major health risk for older individuals posed by falls, which increases further into older age.

The physical consequences of falling have been widely reported and can be severe, including the leading cause of accidental death in the over 75 age group (Lilley, Arie and Chilvers 1995). Other physical consequences include bruising, abrasions, pain, and fractures (Berg et al. 1997; Campbell et al 1990), with osteoporosis substantially increasing the risk of serious falls related injuries and costs resulting from hip fractures (Department of Health 2001). With projected demographic changes indicating that the over 60 age group will double globally between 2000 and 2025, costs are expected to rise dramatically in the coming years.

However, consequences of falling of course are by no means limited to physical injuries. Falls are associated with a range of psychological measures, including fear of falling (Kressig et al 2001; Lach 2005; Lee et al. 2008; Scheffer et al 2008; Tinetti, Richman and Powell 1990); loss of confidence (Myers et al 1996); depression (Gagnon et

al 2005); reduced self-efficacy (Tinetti et al 1994); social isolation; and an increase in dependency and disability (Tinetti and Powell 1993).

Against this background, considerable attention worldwide has been directed toward the implementation of prevention programmes that can identify risks at an early stage and thus effectively address the problem of falls (American Geriatrics Society, British Geriatrics Society and American Academy of Orthopaedic Surgeons Panel on Falls Prevention 2001; Gillespie et al 2009; Hill and Schwarz 2004; Swift 2001). Multi-disciplinary input targeting multi-factorial risk factors has been identified as an effective approach to falls prevention (Gillespie et al 2009). However, indications to date are mixed. While it has been reported that programmes can reduce the incidence of falls by up to 30% (Swift 2001), Gates, Lamb, Fisher, Cooke and Carter (2008) found multi-factorial interventions offered only limited ability for reducing falls risk.

Qualitative research provides an understanding of people's lived experience, and in the context of falls, a history of falls and potential susceptibility to further falls come to form part of how people make sense of future possibilities. Concerns over future life are especially salient at the point of hospitalization following a fall. Ballinger and Payne (2000) in a qualitative study of older people who had been hospitalized following a fall found a major concern of those interviewed was to present themselves as competent and able. By doing so they reduced the possibility of being viewed by others as likely to fall again, thus distancing themselves from being seen as frail and vulnerable. Perceptions of safety, independence and quality of life remain central concerns of everyday living, and have been regarded as a dynamic tension between two opposing life forces; one of striving for independence and the second for exercising precaution (Ward-Griffin et al 2004). These findings point to the debilitating psychological consequences of falling that persist over and above the immediate physical injuries sustained. Prevention programmes that reduce the

incidence and severity of falls, as noted above, are to be welcomed; the challenge however of addressing the non-physical consequences of falling remains.

In order to rehabilitate older people following a fall and reduce the risks of further falls, a number of initiatives have been introduced within the United Kingdom aiming to combine National Health Service (NHS) and Local Authority (social work) community services in delivering tailored rehabilitation interventions that encompass health and social-care for older community dwelling people. These initiatives are based on a multi-professional approach to prevent further falls, drawing on teams of professionals from disciplines, including physiotherapy and occupational therapy as well social work services. Accordingly, the aims of such programmes are drawn widely: to improve physical and functional abilities of older community-living individuals, while enhancing the individuals' confidence, allowing them to continue living in the community. As the psychological consequences of these programmes are largely unknown, the present study aims to examine the experiences of eight housebound, community living older people, a group that appears to be under-represented in the research literature, following their involvement in one such multi-disciplinary programme.

## **Methods**

### **Design**

A qualitative research design, using an interpretative phenomenological analysis (IPA) approach, was used to understand and explore how participants made sense of their experiences post fall. IPA is based on a philosophical tradition acknowledging the multiple approaches to human understanding, where experiences of the world come to have meaning for the individual through dynamic constructs such as beliefs, perceptions, attitudes and values (Holstein and Gubrium 1998).

### **Sample and setting**

The study was conducted within a large health authority in Scotland, UK, with ethical approval for the study being granted by the local NHS research ethics committee. Twenty letters were sent to potential participants, identified by their community physiotherapist, who had been discharged from the service within the previous six weeks. Eight people replied, comprising seven women and one man, aged between 67 and 89 years (mean age 84 years). All had sustained a serious fall or falls requiring medical treatment, and subsequently received a multi-professional intervention programme specifically tailored to their physical and functional needs. Four participants sustained fractures as a result of the fall requiring hospitalization, and had returned to their own homes by the time the interviews took place. All participants were of Scottish (European) background and lived in lower socio-economic areas within a west of Scotland city. Six participants were widowed, one was single, and one divorced, and all but one participant lived alone. Two participants lived in privately-owned accommodation; three lived in council housing within a high rise building; and three participants lived in a sheltered housing complex. At the time the interviews took place, seven participants used walking aids for mobility at all times, whilst one participant only used a walking aid when outdoors, and always accompanied by another person.

Each intervention was specific to the individual's physical and functional needs, and therefore details of each programme cannot be provided. Available elements of the multi-disciplinary programme comprised physiotherapy; nursing; occupational therapy; podiatry; dietetics; pharmacy; optometry; continence; social-work; and social-care provision. Medical care was provided by the participants' general practitioner, and specialist hospital services. Although not all participants will have required access to all services, they had all received physiotherapy and occupational therapy aimed at improving physical function and

confidence. Interventions followed the local NHS falls prevention protocol (Strategy for Osteoporosis and Falls Prevention 2006).

#### Data generation

Recruitment and interviews took place over autumn and winter of 2006. Informed consent was obtained from each participant prior to the commencement of their interview. All interviews lasted approximately one hour and were conducted by the first author in participants' own homes. At the time the interviewer worked within community-based health services and was accordingly familiar with the health status and concerns of those who agreed to take part in the study. This knowledge allowed the establishment of easy rapport between interviewer and interviewees in the research process, allowing interviewees to talk openly about their experiences. Interviews were conducted using a semi-structured format within which questions focused on five main areas, namely participants' general health; experience of falls; rehabilitation experiences, which encompassed their social-care input and health interventions; whether they felt there had been any physical change as a result of the intervention; and perceived overall effectiveness of the intervention programme. Interviews were audio-recorded with the consent of the participants and later transcribed. To ensure confidentiality, participants' names were changed to pseudonyms.

#### Data analysis

Interview transcripts were analyzed manually using interpretative phenomenological analysis (Smith and Osborn 2008). This method requires immersion in the data by the researcher, and results in the identification of themes, or patterns of lived experience, that reflect participants' own understandings of the phenomena being studied. The present analysis began with a close examination of individual transcripts on a case-by-case basis, following the order in which the interviews took place. An initial reading was undertaken with preliminary observations

and any pertinent issues being noted. This process was repeated a number of times. Descriptive labels were used to identify issues, while emerging relationships between issues were noted. The above process was repeated for each transcript. Thereafter connections between similar issues were perceived, resulting in the identification of emerging conceptual themes. As themes emerged, they were checked against all transcripts in the data set, to ensure relevance to the original data. Emerging themes were repeatedly checked for fit against further instances, with themes being further developed as necessary. This initial analysis was conducted by the first author. Thereafter both authors checked the emerging themes against instances occurring in the data set. At this stage, the authors discussed what appeared to be negative cases and agreed how these cases should inform further analysis of the data and further development of the analytic themes. In the course of this process, both authors re-read the relevant passages of the interview transcripts. Particular attention was paid to the extension and refinement of themes and on the grounding of themes in the participants' own understandings as demonstrated in the data themselves in order to establish the relevance of the final themes for the participants themselves. Analysis continued on an iterative basis until finally agreed by both authors. Given the emphasis that interpretative phenomenological analysis places upon the rich understanding of personal and individual experience, the useful conclusion of analysis arrives at a point where recurrent patterns within the data have been identified and analysed, and no further claims can be made in respect of the data. Data saturation as commonly understood thus is not a direct goal of those who adopt the interpretative phenomenological approach. In the present study, data analysis concluded at a time when 'no new properties, dimensions, conditions, actions/interactions, or consequences [were] seen in the data' (Strauss and Corbin, 1998, p.136) and the categories could be treated as saturated to this extent. At this stage no further themes were emerging,

and the developed themes could be shown to be most relevant in accounting for participants' understandings as reflected in the transcripts.

## **Results**

Analysis of the interviews resulted in four major themes, signifying the collective experiences of the participants. These were losing independence, losing confidence, losing social identity, and managing a changed self. Each theme is discussed in detail below.

### ***Losing independence***

A main theme for the participants was the impact falling had had on their daily activities. Participants referred to constraints on their lives directly resulting from falls, and for seven people this had not improved following their tailored programmes. These constraints included limiting ordinary activities to safe areas, and the need to use walking aids to improve safety and minimize the risk of falling. The use of walking aids did seem to increase the range of possible activities available for six participants, as seen below.

Mary: Yes, it would make me more independent ... I could go round with my zimmer (walking frame) to C, get my milk and come back.

Although walking aids might allow a greater range of choices, five participants perceived the aids as unwelcome, despite the assistance they afforded, and to be markers of a loss of independence. For example, Sarah viewed her walking stick as a nuisance, getting in the way when she was doing chores, whereas for Catherine it was a reminder of her altered state and abilities. Catherine, now dependent on a three-wheeled walking frame, had initially refused to use a zimmer walking frame, which was first given to her, as it made her feel old, and socially identified as infirm.

Catherine: Mm, I just watched them using them. They walked bent up. I mean I'm bent up myself using that (referring to her wheeled walking aid), but not as bad as – maybe I look the same as somebody else, not as far as I could see, with people using a zimmer.

Similar concerns with public appearance were evident for four other participants. Mary stated she wanted to be able to walk without using her stick “Just for show”. Thus, aids designed to facilitate activities were viewed as indicators of lesser abilities and of changed status. Conversely, being involved in daily activities without using these aids, although potentially riskier in health and safety terms, allowed more possibilities for claiming independence.

An inevitable consequence of losing full independence was a reliance on others for activities and tasks all the participants were no longer able to manage themselves. The following are typical examples:

Helen: For instance my home help does all the shopping, but you dearly want sometime to do your own shopping, things you need yourself.

Mary: Now, I'm feeling I'm depending a lot on my daughter and it's a lot on her shoulders because her husband died 2 years ago with cancer, and, and she's had cancer, and I really feel she's had an awful lot on her plate, and now to be landed with me.

In the extract above Mary clearly describes how her loss of independence has led to feelings of being a burden on her daughter.

### *Losing confidence*

As well as the loss of physical capacities and consequent loss of independence, participants described ongoing psychological changes resulting from their falls. An overwhelming response to the falls was a fear of future falls and their consequences, a fear that remained with the participants. Throughout the interviews fear was explicitly stated, and often voluntarily divulged without specific questioning. Fear was mostly articulated as an affective reaction, as the following response indicates:

Thomas: Er, it gives you an awful fright. You could land and hit your head. If you hit your head you'd be finished, aye, yes I do worry. Yes, yes, cos anything can happen.

Fear was also manifested in the participants' loss of confidence in their abilities to live as they had prior to their falls. As a result, a common response was for individuals to avoid, or explicitly rule out, the possibility of engaging in a range of activities they had previously pursued.

Betty: Well, when I was able I was a very busy lady, so many things to do, so many – treasurer of this, secretary of that and of course now I can't do anything like that – well, sometimes when you think of the things you use to do and can't do them now, well that's a bit disappointing.

In the quotation above we clearly see Betty's perception that all of these roles are now beyond her capabilities. Four participants expressed rather stronger feelings toward the consequences of their falls. Helen became tearful on a number of occasions when speaking

about her fall, Betty stated she did not wish to mention the word “fall”, while Annie articulated frustration and anxiety:

Annie: No, it's just really frustration. I wanted to get up and give my son his breakfast before he went out in the morning. And I also wanted – I was very anxious to get the tea ready for when he came in because we have our dinner at tea time and er I was anxious to get it done ...

The psychological impact of falling is clear in the above extract from Annie, an 89 year old woman who had fallen and broken her hip. Annie's frustration was directly connected with her role of providing a mother's responsibility for her son, with whom she lives. Mary, an 88 year old woman who had fallen and fractured her hip, expressed even stronger frustration at the restrictions resulting from her fall.

Mary: *I want to be well.* This is the thing that really annoys me. I mean I'm not enjoying being a semi-invalid. This is ridiculous. Really ridiculous.

Prior to the fall, Mary had been living a confident and independent life, in spite of blindness. The fall in itself, and fear of any further falls, had led to a loss of confidence in her abilities to do many of the things she had been previously, and routinely, engaged in. For Mary therefore, the fall led her to doubt her abilities to overcome her blindness, and led to extreme frustration with her housebound life. She, as with all of the participants, described a loss of confidence as a major impact of the fall, which had continued despite their rehabilitation programme.

### ***Losing social identity***

A loss of independence and confidence commonly resulted from falling. However, five of the participants reported an even greater loss in their lives, in the form of losing identity. Implications for identity, as a result of falling, became particularly apparent in the participants' dealings with primary (community) and secondary (hospital) care health staff, and their home care workers, following their falls. For the most part interactions with health staff in hospitals were negative, while negative experiences with home care workers was also a concern.

Catherine, a 75 year old woman with severe osteoporosis described encounters with home help workers, on whom she was totally reliant for meals and personal care. In describing these encounters, she made clear a lack of attention afforded to her as a person.

Interviewer: But this rushing in and out, what does that make you feel like?

Catherine: You're just a number – Say for instance, if you were able to make your coffee, you'd maybe have your sandwich and have your coffee later, well everything's put in front of you. It's like being in a home 'There's your meal, take it. Eat it or lump it'.

Catherine's perception is of being treated simply as a 'case' in a busy social-care provider's workload. Notwithstanding these dealings occurred in her own home, it seems Catherine viewed herself as being unable to assert any control or re-establish her own identity in this social encounter.

Four other participants similarly described instances of being undermined in their dealings with health staff. Mary repeatedly requested a physiotherapy referral from her GP, which took three months to achieve. Mary discussed feelings of frustration at not being listened to throughout this period, stating: "Because, honestly, I felt neglected, absolutely brushed aside. Not worth bothering about." It was only at the stage of receiving individual

contact from the rehabilitation team that Mary's feelings of being ignored gave way to a sense of being important in health-care terms.

Interactions with health professionals, mostly medical staff, often left participants feeling invisible, with few resources available to them to sustain a meaningful sense of their own identities in such contexts. Indeed, four participants reported being simply ignored, either in terms of not receiving information about their care, or not being listened to when requesting other services. Two participants reported that health professionals were prepared to discuss their care with others, especially family members.

Mary: And two days before I was due to leave they had said to E, my daughter ... 'Your mum will be going to a convalescent home', because I'm on my own and 'will that be alright?' and E had said 'Yes, that will be fine'.

Interviewer: But no-one had asked you?

Mary: *Nobody had said to me.*

Not all interactions were negative, however, with involvement by health and social-care personnel often providing sources of comfort. The following quotations were in response to being asked whether they benefitted from the COPT involvement, and although only two of the participants felt they physically improved, the feeling of being worthwhile and no longer invisible was deemed of greatest benefit:

Interviewer: Has it been useful do you think, the physiotherapy programme?

Betty: I would say so

Interviewer: Can you tell me how?

Betty: Just the fact that someone was taking an interest in me.

Interviewer: What was the best part of having S come out and, you know, having some rehabilitation?

Helen: The fact that someone was caring enough to do it.

### *Managing a changed self*

In the three themes above, we have seen the negative impact the ongoing consequences of falls had on participants' lives. Taken together, these consequences necessitated many changes in the participants' everyday lives and activities. It is noteworthy that such adverse changes occurred despite the delivery of individually-tailored health and social-care programmes, designed to address individual needs and minimize the ongoing effects of previous falls. Contact with social-care and health staff were not always perceived as empowering the participants in living their lives, and, as noted, in some instances added to the sense of loss of meaningful identity. The participants however did not totally accept their lives had been negatively transformed, but rather sought to make sense of themselves in changed circumstances. Part of this process of coming to terms involved attributing the possibility of future falls to circumstances beyond their control:

Catherine: Not really. If you fall you fall, no matter where you are.

Annie: Oh, it doesn't bother me. It's just kind of accidental (referring to falls).

Interviewer: Uh, huh. Is there anything you think you can do to prevent them?

Annie: I don't think so. Mm.

It should be noted here that part of their rehabilitation programme included the management of modifiable antecedents of falls, such as environmental factors. Notwithstanding the aims and delivery of such programmes, participants regarded falls almost as risks of life that had to be accepted. This perceived lack of control however should not be taken to indicate participants had given up a sense of control over their lives. By way of contrast, the participants at other points of the interviews explicitly described abilities they could exercise in their daily lives. Annie described how she managed her routine domestic tasks, even though her abilities to do so were considerably less than her pre-fall state. Six other participants similarly described themselves as having come to terms with their lives, subsequent to their falls.

Thomas: You mean how I live myself? Oh, I'm quite contented, you know. Yes, oh, aye, you've got to do that way, you know, if you want to keep going.

Interestingly, the participants often described themselves as "lucky", either for what they still had, in terms of their current abilities, or for the good fortune they had experienced in the past.

Despite viewing the impact of falling as overwhelmingly negative and denying a sense of control over any future possibility of recurrence, the participants retained a strong sense of their own agency in many aspects of their day-to-day life. By making sense of their everyday experiences in ways that emphasized the positive aspects of these experiences, the participants were able to maintain personal identity and quality of life. For the participants in the current study, it seems recovering from falling had less to do with aiming to return to their previous states than with the management of a changed self in response to the negative events they had experienced.

## **Discussion**

The present study provides a unique insight into the experiences of a group of housebound older people who have experienced multiple falls as they negotiated their lives with significant physical disability. Despite the provision of tailored programmes specifically aimed at maintaining independence and allowing older people to remain in their own homes, loss of independence and confidence were main themes. For these community dwelling participants, a loss of independence was an ongoing reality of their lives, and although this loss has been identified as a major concern for older people in hospital following a fall (Ballinger and Payne 2000; Kong et al 2002; Tinetti and Powell 1993), and returning to community-living thereafter (Health Education Board Scotland [HEBS] 2003; Ward-Griffin et al 2004; Yardley and Smith 2002), it is the interactional experiences of the majority of participants in some of their dealings with health and social care staff, and how this impacted on them, that is of interest here.

Whilst the majority of interactions the participants had with health and social care professionals were positive, some of these interactions post fall resulted in feelings of frustration, disappointment, and anger, which were sometimes directed at themselves. The absence of personal attention from health and social care staff, disempowering effects of having staff discuss their care with family and others, and the relative invisibility of the participants themselves, are consistent with findings that on occasions health professionals continue to treat older people as being compliant, passive and submissive (Fineman 1994). This also indicates continuing discrimination towards older people by NHS and social-care staff (Bunn et al 2008), despite awareness and discussion of this as an important issue (Lothian and Philp 2001). The subjective experience of being involved in negative

interactions appears to go beyond simply a feeling that decisions are being made for patients, as has been suggested (Coyle 2000), to a more extensive loss of social identity, in becoming invisible.

In order to draw out the meaning of this theme for the participants and its effects upon their experiences, let us make explicit what we refer to by use of the term 'social identity'.

Numerous writers use descriptions such as 'self', 'identity', 'personal identity', 'social identity' and others, either interchangeably or in somewhat divergent ways, leading to lack of clarity in what is under discussion (see McKinlay and McVittie, 2011, for a discussion). Here, we take the term social identity to refer to the interactions that a person has with others in a social world, and the outcomes of those interactions, for how the individual makes sense of who he or she is in social terms. Social identity, so defined, can usefully be contrasted with personal reflection upon experience and how one makes sense of who one is as an individual (often referred to as 'self' or personal identity')(for a discussion of this distinction, see Owens 2006). Although the potential consequences of falling on social identity have been noted in previous studies (Ballinger and Payne 2002; Yardley and Smith 2002), identity is often treated as being synonymous with other individual attributes, such as independence, confidence and fear. Loss of social identity, as discussed in relation to social embarrassment, is a further example. It is perhaps more appropriate to discuss these elements of experience as reflecting damage to personal identity. In the present study five of the participants did indeed experience a loss of social identity, however they did so as a consequence of poor interactions with health and social-care staff, that is, in interactional terms. This occurred when information was provided to family members, rather than to the older person, and ignoring requests by participants for further assistance, with the effect of disempowering them. One participant had tried to have her medicines delivered directly to her home, but was only successful once her nephew had intervened on her behalf. By

ignoring their concerns, and providing information in such a way, professionals appear to treat older people, if not as invisible, certainly as incapable of understanding and making meaningful decisions in their own lives. The effect of undermining autonomy in this way further emphasizes the extent of older people's possible dependency on their families, while minimizing any degree of independence. In social terms, participants perceived themselves as being objects of talk rather than autonomous persons with their own identity.

The participants in the present study had all received interventions by way of a multi-disciplinary programme intended to promote physical and psychological recovery from falling. Despite this, the rehabilitation programmes were unable to address the participants' loss of independence and confidence, while additional interactions with health and social-care systems introduced further instances of delays in the provision of services. What is very concerning however, is that the experience of care following a fall, particularly for those who sustained a fracture and required hospitalization, appeared in some respects to have exacerbated psychological issues relevant to the participants, with interpersonal interactions often impacting negatively on the identities of the older people involved.

Loss of confidence, in relation to further falls, continued to impact on the participants' ability to go outdoors alone, leaving them housebound. Previous studies have also pointed to a loss of confidence and a fear of future falls (Lee et al 2008; Myers et al 1996; Yardley and Smith 2002) that commonly result from a fall. Published reports suggest 50% of older people who fall admit to a fear of further falls (Arfken et al 1994; Howland et al 1998; Kressig et al 2001; Myers et al 1996), and it has been noted many older people do not admit to this fear for a number of reasons, including concern over loss of personal freedom being imposed by others (Kong et al 2002; Li et al 2003). Instead, in the present study all but one participant openly admitted to this fear. While an individual might be housebound due to the constraints of their physical limitations, fear of further falls might also be limiting

those who could be physically capable of venturing beyond their door. While systematic reviews of interventions to ameliorate fear of falling have recently been undertaken (Zijlstra et al 2007; Jung et al 2009), there is limited evidence for successful reduction of this debilitating condition. Further research should aim to identify the incidence of fear of falling in the housebound population, and is certainly required to inform tailored rehabilitation programmes that aim to counteract the long term social and functional consequences for housebound older people.

Although the rehabilitation programmes in the current study were not able to address the participants' loss of independence and confidence, for the majority of participants the benefit they felt they had received from the multi-disciplinary programme was a re-affirmation of their worth, of having someone take an interest in them. This goes some way in overcoming the loss of social identity as a consequence of their dealings with other hospital and social-care staff.

The findings from the current study also point to more positive experiences for those who have fallen, than has been suggested elsewhere. Previous work on managing self-concept in later life has identified "immunizing" responses in identity-threatening situations, whereby perceived reality becomes manipulated by processes such as denial, or the re-interpretation of evidence towards more favourable views (Greve and Wentura 2003). Older people who work to minimize the consequences of falls might be viewed as employing a coping strategy enabling them to ward-off challenges to identity that might otherwise result. Yet, in the present study the participants voluntarily described changes in their experiences of domestic tasks and everyday life, and were openly acknowledging their limitations. The present findings therefore provide insight into the subjective experiences of these circumstances. The adjustment to life changes can be seen as part of a process of managing self, moreover an individual self that is positively evaluated, in terms of ongoing

abilities, good fortune and contentment with life. Viewing subjectively experienced outcomes in this light offers a more comprehensive understanding than is commonly provided by constructs such as self-efficacy, self-esteem or similar, that appears to have questionable relevance on an individual level.

The present findings come from a purposive sample of participants. Interpretative phenomenological analysis as a method seeks to provide rich insights into the lived experiences of individuals rather than to derive findings that are equally applicable to other groups or populations; the current findings therefore cannot readily be generalised to all elderly people who fall or live in fear of falling. Nonetheless, this study does provide important insights for health and social-care professionals working in the area of falls prevention. Issues such as loss of independence and loss of confidence appear to be highly intractable, which continue despite the efforts of initiatives intended to address these matters, alongside other falls prevention measures. Dealing with individual experiences of this sort poses considerable challenges for future initiatives designed to promote physical and psychological well-being following a fall. Any such intervention must, in addition to addressing physical consequences of a fall, be designed so as to ameliorate psychological difficulties, not add to them; delayed and impersonal delivery of even the most carefully designed service is unlikely to be experienced as satisfactory by those on the receiving end. Identifying and addressing the prime concerns of older people themselves is fundamental, whilst promoting their ability to manage their sense of who they are will thereby allow older people to find continuing meaning in their everyday lives.

### **References:**

American Geriatrics Society, British Geriatrics Society, American Academy of Orthopedic Surgeons Panel on Falls Prevention (2001) Guideline for the prevention of falls in older persons. *Journal of the American Geriatric Society* 49:664-672

Arfken C, Lach H, Birge S, Miller P (1994) The prevalence and correlates of fear of falling in elderly persons living in the community. *American Journal of Public Health* 84:565-70

Ballinger C, Payne S (2000) Falling from grace or into expert hands? Alternative perspectives about falls in older people. *British Journal of Occupational Therapy* 63:573-579

Ballinger C, Payne S (2002) The construction of the risk of falling among and by older people. *Ageing and Society* 22:305-324

Berg W, Alessio H, Mills E, Tong C (1997) Circumstances and consequences of falls in independent community-dwelling older adults. *Age and Ageing* 26:261-268

Bunn F, Dickinson A, Barnett-Page E, McInnes E, Horton K (2008) A systematic review of older people's perceptions of facilitators and barriers to participation in falls-prevention interventions. *Ageing & Society* 28:449-472

Campbell A, Borrie M, Spears G, Jackson S, Brown J, Fitzgerald J (1990) Circumstances and consequences of falls experienced by a community population 70 years and over during a prospective study. *Age and Ageing* 19:136-141

Coyle J (2000) Exploring the meaning of 'dissatisfaction' with health care: the importance of 'personal identity threat'. *Sociology of Health & Illness* 22:95-124

Department of Health (2001) National service. Framework for older people. Department of Health: London

Fineman N (1994) Health care providers' subjective understandings of old age: implications for threatened status in late life. *Journal of Aging Studies* 8:255-270

Gagnon N, Flint A, Naglie G, Devins G (2005) Affective correlates of fear of falling in elderly persons. *The American Journal of Geriatric Psychiatry* 13:7-13

Gates S, Lamb S, Fisher J, Cooke M, Carter Y (2008) Multifactorial assessment and targeted intervention for preventing falls and injuries among older people in community and emergency care settings: systematic review and meta-analysis. *British Medical Journal* 336:130-138

Gillespie LD, Robertson MC, Gillespie WJ, Lamb SE, Gates S, Cumming RG, Rowe BH (2009) Interventions for preventing falls in older people living in the community. *Cochrane Database of Systematic Reviews*, Issue 2. DOI: 10.1002/14651858.CD007146.pub2

Greve W, Wentura D (2003) Immunizing the self: self-concept stabilization through reality-adaptive self-definitions. *Personality and Social Psychology Bulletin* 29:39-50

Health Education Board for Scotland (2003) The construction of the risks of falling in older people: lay and professional perspectives. <http://www.healthscotland.com/documents/browse/352/0.aspx> Accessed 12 November 2005

Hill K, Schwarz J (2004) Assessment and management of falls in older people. *Internal Medicine Journal* 34:557-564

- Holstein J, Gubrium J (1998) Phenomenology, ethnomethodology, and interpretive practice. In: Denzin N, Lincoln Y (eds) *Strategies of qualitative enquiry*. Sage, London, pp 137-157
- Howland J, Lachman M, Walker Peterson E, Cote J, Kasten L, Jette A (1998) Covariates of fear of falling and associated activity curtailment. *The Gerontologist* 38:549-555
- Jung D, Lee J, Lee S (2009) A meta-analysis of fear of falling treatment programs for the elderly. *Western Journal of Nursing Research* 31:6-16
- Kong K, Lee F, Mckenzie A, Lee D (2002) Psychosocial consequences of falling: the perspective of older Hong Kong Chinese who had experienced recent falls. *Journal of Advanced Nursing* 37:234-242
- Kressig R, Wolf S, Sattin R, O'Grady M, Greenspan A, Curns A, Kutner M (2001) Associates of demographic, functional, and behavioural characteristics with activity-related fear of falling among older adults transitioning to frailty. *Journal of the American Geriatrics Society* 49:1456-1462
- Lach H (2005) Incidence and risk factors for developing fear of falling in older adults. *Public Health Nursing* 22:45-52
- Lee F, Mackenzie L, James C (2008) Perceptions of older people living in the community about their fear of falling. *Disability and Rehabilitation* 30:1803-1811
- Li F, Fisher K, Harmer P, McAuley E, Wilson N (2003) Fear of falling in elderly persons: association with falls, functional ability, and quality of life. *The Journals of Gerontology* 58B:283-290
- Lilley J, Arie T, Chilvers C (1995) Accidents involving older people: a review of the literature. *Age and Ageing* 24:346-365
- Lothian.K, Philp I (2001) Care of older people: maintaining the dignity and autonomy of older people in the healthcare setting. *British Medical Journal* 322:668- 670
- McKinlay A, McVittie C (2011) *Identities in context: Individuals and discourse in action*. Wiley-Blackwell, Oxford
- Myers A, Powell L, Maki B, Holliday P, Brawley L, Sherk W (1996) Psychological indicators of balance confidence: relationship to actual and perceived abilities. *Journals of Gerontology* 51A:37-43
- Owens T (2006) Self and identity. In: Delamater J, (ed) *Handbook of social psychology*. Kluwer Academic / Plenum Publishers, New York, pp 205-232
- Scheffer A, Schuurmans M, Van Dyk N, Van Der Hooft T, De Rooij S (2008) Fear of falling: measurement strategy, prevalence, risk factors and consequences among older persons. *Age and Ageing*, 37:19-24

Smith J, Osborn M (2008) Interpretative phenomenological analysis. In: Smith J (ed) Qualitative psychology. A practical guide to research methods, 2nd ed. Sage, London, pp 53-80

Strategy for Osteoporosis and Falls Prevention (2006) NHS Greater Glasgow Strategy for Osteoporosis and Falls Prevention 2006 – 2010.  
[http://library.nhs.uk/mediaAssets/library/nhs\\_ggc\\_strategy\\_osteoporosis\\_falls\\_prevention\\_2006-2010.pdf](http://library.nhs.uk/mediaAssets/library/nhs_ggc_strategy_osteoporosis_falls_prevention_2006-2010.pdf) Accessed 25 June 2007

Strauss A, Corbin J (1998) Basics of qualitative research: Techniques and procedures for developing grounded theory, 2nd ed. Thousand Oaks, CA, Sage.

Swift C (2001) Falls in late life and their consequences-implementing effective services. British Medical Journal 322:855-857

Tinetti M, Mendes de Leon C, Doucette J, Baker D (1994) Fear of falling and falls-related self-efficacy in relationship to functioning among community living elders. The Journals of Gerontology 49A:140-147

Tinetti M, Powell L (1993) Fear of falling and low self-efficacy: a cause of dependence in elderly persons. The Journals of Gerontology 48A:35-38

Tinetti M, Richman D, Powell L (1990) Falls efficacy as a measure of fear of falling. The Journals of Gerontology 45B:239-243

Tinetti M, Speechley M (1989) Prevention of falls among the elderly. The New England Journal of Medicine 320:1055-1059

Ward-Griffin C, Hobson S, Melles P, Klooseck M, Vandervoort A, Crilly R (2004) Falls and fear of falling among community-dwelling seniors: the dynamic tension between exercising precaution and striving for independence. Canadian Journal on Aging 23:307-318

Yardley L, Smith H (2002) A prospective study of the relationship between feared consequences of falling and avoidance of activity in community-living older people. The Gerontologist 42:17-23

Zijlstra G, van Haastregt J, van Rossum E, van Eijk J, Yardley L & Kempen G (2007) Interventions to reduce fear of falling in community-living older people: A systematic review. Journal of the American Geriatrics Society. 55:603-615.