GENDER AND FALLS: PERCEPTIONS OF OLDER PEOPLE AND THEIR KEY FAMILY MEMBERS

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ABSTRACT

This thesis explores the ways in which gender impacts upon the construction of the meaning and risk of falling among older people who have had recurrent falls, and their key family members. Older people aged 65 and over, who have had two or more falls in the past 12 months were studied. In depth interviews were conducted with 40 older people, consisting of twenty older men and twenty older women, and 35 key family members. The family members consisted of mainly sons (n=11) and daughters (n=17); the remainder comprised wives (n=4), a brother (n=1), and nieces (n=2). All interviews were tape-recorded, fully transcribed and analysed using NUD*IST.

The social meaning of falls constructed by older people who have had falls revolves around three inter-related components: the language of falls, gendered stigma associated with private and public falls, and gendered disruption. Risk perception of falls by older people is linked to gendered notions of how ‘at risk’ they were, their awareness of risk, and the responsibilities attached to risk taking. Older men were more likely than older women to see themselves as rational individuals who would not deliberately put themselves at risk.

The subsequent actions taken by older people to prevent future falls were gendered; older men were not only more pro-active in that they initiated more actions but were more often encouraged by family members to make decisions. Older men drew upon their gender identity and social position within the family, to exert control over what should or ought to be done, in order to minimise their risk of falling. In contrast, older women’s exertion of control was less evident.

The gender of the older person and their key family member influenced their respective actions. The power imbalance between men and women resulted in the younger male within the older female/younger male dyads undertaking ‘protective’ actions and ‘coercive’ actions. Within the older male/younger female dyads, the power imbalance
resulted in daughters undertaking ‘engaging’ and ‘negotiating’ actions. Similarly ‘negotiating’ as well as some ‘engaging’ actions were taken by the younger female member within the younger female/older female dyads, but these were explained as reflecting feminine sensitivity among women. The presence of ‘mutual respect’ within father/son and brother/brother dyads resulted in minimal actions being taken by both members of the dyad, due to the potential conflict arising from each trying to retain power and control.

This study indicates that gender impacts upon the meaning of falls and the risk of falling with more older men perceiving falls to be discrediting. This, in turn, impacts upon the subsequent actions taken by older people and their key family members. However, older men who had had falls continue to retain their power resulting in more empowering types of actions taken by their key family members.
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Chapter 1

Falls Among Older People: An Introduction

This introductory chapter provides a background to the proposed study, and sets the context for the purposes of the study. An outline of the thesis is provided in the second section of the chapter.

1.1. Background to the Study

My experience working as a nurse and registered nurse tutor for twenty years has alerted me to the needs of older people and their family. I have met many older patients on my visits to hospitals whilst working with my students, and I became more aware of the perennial problems faced by older people who were admitted to hospital wards because of falls. I began to wonder how these falls might impact upon them and their family members; what it means to fall, and what these older people and their family members do to prevent future falls.

Preliminary reading of the literature indicated that falls among older people are common events. Since the extensive review by Askham et al (1990) of research on falls among older people substantial developments have taken place; these included a study of accident prevention and risk taking by older people (Wright, 1994), a review of the effectiveness of health promotion interventions to prevent accidents in older people (Oakley et al, 1995), and a study of the social construction of the risks of falling among older people (Martin, 1999).

The impact of falls and accidents by older people upon the use of health services has been recognised. The Department of Health (1998:65) acknowledges that ‘accidents, particularly falls, are a major cause of death and disability in older people’. Half of those in the oldest age group - 85 and over - who sustain a serious injury following a fall have a
hip fracture. Other injuries following falls by older people may result in the need for medical or hospital treatment, or social care services at home. Even with minor injuries, older people can lose their self-confidence, and if they curtail their daily activities of living, their independence can be compromised, necessitating more support services (McIntyre, 1999). Further, fear of falling and the fear of undertaking tasks might lead an older person to be disempowered. It is not surprising, therefore, that one of the targets set by the Department of Health (DOH, 1992) was to reduce deaths from accidents among those aged 65 and over, by a third by the year 2005. Recently, the 1999 White Paper Saving Lives: our Healthier Nation (DOH, 1999), has maintained this overall theme to reduce accidents. Targets were set to reduce the death rate from accidents by at least one-fifth, and the rates of serious injury by at least one-tenth by 2010; a significant concern being accidents in the home amongst those aged over 65.

During the course of my study, the Department of Health developed short-term strategies to tackle falls and injuries following falls, as indicated in the National Service Framework (NSF) for Older People (DOH, 2001). For example, Standard 6 of this NSF sets out the health and social care services required to respond to the needs of those who have already fallen, and Standard 8 of the NSF aims to reduce the number of falls resulting in serious injury and to ensure effective treatment and rehabilitation for those who have fallen. Whilst the NSF may be considered a key timely vehicle for ensuring that the needs of older people are at ‘the heart of the reform programme for health and social services’ (DOH, 2001:90), it is stressed that it is necessary to involve or engage older people in consultation so that policy can be developed and met appropriately. In particular, despite the evidence of an extensive body of research on falls among older people, little is done to address the issue of how older people who have had falls perceive the meaning of falls and their falling experiences, and how these perceptions might influence the subsequent actions taken by older people and their family members. Little is also known about the extent to which gender impacts on the meaning of falls, or on actions taken by older people and their family members to prevent future falls. These issues will be addressed in this thesis, by interviewing older people and their key family members separately.
1.2 Outline of The Thesis

The thesis consists of an introduction, followed by three literature review chapters and one methodology chapter. There are four analysis chapters, and the final chapter evaluates how the findings relate to the theoretical literature and addresses the implications for policy and future research.

Chapter 2 examines research literature relating to falls among older people. The first section takes a biomedical approach, examining the medical definition of falls, the risk of falling and the impact of falls on older people. The second section examines the literature on falls from a sociological perspective, and explores the ways in which falls may be construed. Included in the discussion are the theoretical concepts of ‘preferred identities’ (Charmaz, 1987), stigma (Goffman, 1968), ‘status passage’ (Glaser and Strauss, 1971), and ‘biographical disruption’ (Bury, 1982).

Chapter 3 draws on the perspectives of symbolic interactionism and initially examines the social construction of risk. Concepts of risk, safety, and hazards are examined, as are the theoretical approaches to risk. The key issues identified in current research on risk and risk taking are explored in relation to the way older people who have had falls might perceive risk and take risks. Issues related to this are that of dependency and interdependency, control and autonomy, since these are considered influential in the construction of the meaning of falls.

Chapter 4 focuses on gender as a construct and discusses how gender might influence the identities of older men and women, as well as the nature of gender and age relations. Meanings of masculinity and femininity are explored, with reference to how ‘gender display’ (Goffman, 1976) and ‘doing gender’ (West and Zimmerman, 1987), might provide theoretical underpinning to the study. Particular aspects of gendered identities, such as that of gendered responsibility and dependence, control and power, are explored.
The chapter also explores the nature of family caring relationships; with specific focus on the negotiations and the gendered aspects of caring within the family.

Chapter 5 discusses the methodology and research design of the study. The chapter describes how the research was carried out, and its limitations. Particular attention is paid to the issue of gaining access and to conducting interviews with older people and their key family members.

Chapters 6 and 7 are linked, examining the meaning of falls and of risk among older people. The first of these chapters focuses on the meaning of falls from the older person’s perspective. It discusses the particular language used by older people to talk about their falls, and examines how the notions of stigma and that of biographical disruption impact upon their social construction of falls. The chapter also distinguishes between public and private falls, and examines the impact these have on the self and social identity of older men and women. Where appropriate, the impact is gleaned from the perspective of key family members. Chapter 7 makes links with Chapter 6 by initially examining the construction of the meaning of the risk of falling from the older person’s perspective. Older people were asked what they thought made them fall and about their risk of future falls. It further discusses how key family members perceive risk, in relation to their older relative’s risk of falling. Key issues such as ‘trade-offs’ and maintaining independence by older people are raised in relation to how they might influence older people and their key family members’ subsequent actions to prevent the older person’s future falls. Chapter 7 also examines the extent to which older people’s experience of falls impacts upon their recognition of the risk associated with falling.

Chapter 8 explores the subsequent actions taken by older people who have had falls to prevent future falls. It examines how falls involve a disruption of normal taken-for-granted activities of daily living, resulting in older people making decisions about what actions to take or avoid. The chapter examines the ways in which gender impacts upon
the types of actions taken by older people, and how these actions are influenced by the older person’s notion of the causes of falls, and their notions of control and power.

Chapter 9 examines the actions taken by key family members to prevent an older relative falling. The extent to which the nature of the gender and generational relationship impacts upon the types of actions taken by key family members is examined. In particular, it discusses how the types of actions differ between older father/adult daughter, older mother/adult son, and older mother/adult daughter dyads. How the gender of the older person and the gender of the key family member interact and influence the nature of the dyad relationship in terms of control, autonomy and power is another focus.

Chapter 10 draws together the emerging conceptual themes that relate to the theoretical literature, and evaluates the contribution of the thesis to existing work. Recommendations for health policy are outlined, and a reflection of the strengths and limitations of the study is included.
Chapter 2

Falls among Older People: A Sociological Perspective

This chapter will review primarily sociological literature that discusses falls among older people. This body of work is limited, and discussion will focus on the work of McKee et al., (1999), Borkan et al., (1991), Martin (1999) and Kingston (1998, 2000) who all contribute to the discourse on falls. In particular, Kingston’s (1998) work drew on the theoretical framework of status passage (Glaser and Strauss, 1971) and Charmaz’s (1987) theory of preferred identities. The concept of stigma (Goffman, 1963) is also examined due to the negative connotation associated with falls. Because the bulk of the literature on falls among older people derives from the biomedical domain, this chapter first provides an overview of this literature, with a particular focus on recurrent falls. Definitions of falls are examined, as are the impact of falls among older people.

Charmaz (1983) indicates that the onset of chronic illness represents an assault both on the person’s physical self, and the person’s sense of identity, leading to doubts about the person’s self-worth. It is suggested that like chronic illness, falls may result in the older person experiencing a loss of confidence, representing threats to the person’s self identity. Within this context, work on chronic illness, in particular Bury (1982) and Charmaz (1987, 1995) is discussed, illustrating the usefulness of the literature on chronic illness in providing a sociological understanding of the construction of the meaning of falls by older people.
2.1 Falls Amongst Older People: Biomedical Approach

2.1.1 Medical Definition of Falls

Generally the lack of accuracy in falls terminology (Steinmetz and Hobson, 1994) impedes ‘conceptual development in falls research’ (Martin, 1999:14). Several reviewers (Askham et al., 1990; Oakley et al., 1995; Gillespie et al., 1998; Dowswell et al., 1999) have noted the lack of consistency in definitions of falls. Kingston (1998) noted the lack of standardisation in the literature concerning the definitions of falls, with different terms used interchangeably to describe events or misadventures that encroach upon individuals. Given such disarray, Isaac’s (1987:14-15) definition has been used for the purpose of this study, which is:

A fall is an event which results in a person coming inadvertently to rest on the ground.

Isaac (1987) suggested that exclusion of falls resulting from loss of consciousness, onset of paralysis, or an epileptic attack is desirable for the purpose of research and prognosis. This exclusion was supported by the Kellog International Working Group (1987). Isaac’s (1987) definition has been used by Kingston (1998) in his study of older women who had fallen and consequently attended the Accident and Emergency department because of their injuries.

Cwikel and Fried (1992) noted that few studies have tried to determine the definitions of falling from the older person’s subjective perspective. Wright et al.’s (1998) small study of the psychological factors which contribute to the high risk of falling among nursing home residents found that the residents who were identified as frequent fallers by the nurses ‘did not see themselves as persons who repeatedly fall’. Many felt they “slipped”, “tripped” or “slid” but did not really “fall” (Wright et al., 1998:16), supporting Tideiksaar and Kay’s (1986) evidence that patients tend to state they slipped or tripped, but did not fall.
2.1.2 Defining Older People Who Fall

Overstall (1992) classifies older people who have had falls into two groups: 'true-fallers' and 'non-fallers'. According to his definition, a 'non-faller' is one who had fallen only once in an index year, while 'true fallers' are those who fall more frequently. He argues that such distinction should enable researchers to know 'what turns a non-faller into a faller' (Overstall, 1992:32). This classification has since been used by Forster and Young (1995) in their study of the incidence and consequences of falls due to stroke. The authors defined 'fallers' as those who had two or more falls, and 'nonfallers' included those who had fallen only once in an index year. By using this classification, the characteristics of both groups at discharge could be compared (Forster and Young, 1995).

Some researchers use the term 'recurrent fallers' and distinguish them from 'non-recurrent fallers'. Recurrent fallers are defined as those who had two or more falls in the past year (Clemson et al., 1996). In relation to Overstall's classification, recurrent fallers would be defined as 'true fallers'. In other studies, fallers are known as single or multiple fallers; the latter being those who had more than one fall in the past 12 months (Gaebler, 1993). It can be seen that there are diverse ways of viewing falls. The classification offered by Overstall (1992) aids simplicity. For the purpose of this study, an older person who has had two or more falls in the past 12 months is referred to as having 'recurrent falls'.

2.1.3 Biomedical Perspective on Falls Among Older People

Older people, compared with the rest of the population, are most likely to experience falls, and injuries and fatalities resulting from falls (DTI, 1999). About 30% of older people living in the community are likely to fall one or more times in a year (Lord et al., 2001). The risk of experiencing a fall increases with age, with those in the oldest age group, aged 85 and over, at greatest risk of falling (Dowswell et al., 1999).
The location of falls varies according to age and gender (Lord et al., 2001). With increasing age more falls occur inside the home on level surfaces (Lord et al., 1994). Men were more likely than women to fall outside and at greater levels of activity; that is, when engaged in activities such as carrying or climbing rather than merely standing or walking (Campbell et al., 1990; Lord et al., 2001). Women are more likely to fall inside their home (Lord et al., 2001).

**Falls and the risk of falling**

A range of physical and psychological factors associated with falls have been identified, including postural hypotension (Skelton and Dinan, 1999), balance, gait or mobility problems such as degenerative joint disease, stroke and Parkinson's Disease (Thornby, 1995; Lord et al., 2001), impaired vision (Wahl et al., 1999)), and polypharmacy (Tinetti et al., 1994; Monane and Avorn, 1996; Age Concern England, 1998). Other risk factors include having already experienced a fall (Luukinen et al., 1995: Wallace et al., 1993), cognitive impairment, such as the various forms of dementia (Feder et al., 2000) and a lack of confidence (Myers et al., 1996). Fear of falling (Tinetti and Powell, 1993; Franzoni et al., 1994), and the degree of confidence that people have regarding their activities of daily living (Franzoni et al., 1994) can be seen as both a risk and consequence of falls. Franzoni et al. (1994) noted that those with a fear of falling were found to have fallen more often than those with no fear.

**Impact of falls on older people**

Whilst a number of studies focus on the prevention of falls (Brody et al., 1984; Cummings et al., 1991; Studenski et al., 1994), there are also a number that examine the consequences of falls for older people (for example, Hornbrook et al., 1991; Graham and Firth, 1992; McIntyre, 1999). The vast majority of falls do not result in hospitalisation or serious injury (Lilley et al., 1995). Lord (1990) asserts that 10-15% of falls are associated with serious injury, 2-6% with fractures and around 1% with hip fractures.

Other consequences of falls among older people include depression (Morse et al., 1985), restricted mobility and pain (Hornbrook et al., 1991; Vellas et al., 1987), restricted
activity (Vellas et al., 1987), and a move into residential care institution (Tinetti and Williams, 1997). The fear of falling, and the fear of undertaking tasks or activities that might lead to a fall can result in older people becoming disempowered, more isolated, and with a reduced quality of life (Tinetti and Powell, 1993). In addition, if informal or family carers fear that their older relative may fall, they may be less willing to support or enable the older person to take part in activities perceived as risky (Tinetti and Powell, 1993).

Reviews of research on falls among older people (Askham et al., 1990; Lilley et al, 1995) highlight the use of a dominant biomedical and individualistic approach, such approach tends to focus upon ‘determining physiological and biological explanations’ and does not acknowledge psychological or social factors influencing older people’s experiences of falls (Victor, 1999:9). Some studies acknowledge the impact that the consequences of falls can have upon family members, including spouses (Liddle and Gilleard, 1995). My study attempts to bridge this gap by examining the construction of the meaning of falls and the risk of falling by older people who have had falls, and by their key family members, as well as the subsequent actions undertaken to prevent future falls experienced by older people.

2.2 Falls Among Older People: Sociological Approaches

This section examines the sociological approaches relevant to the study of falls by briefly exploring how a sociology of falls might be a broader perspective, compared to the biomedical approach to study falls among older people. The metaphoric use of the term ‘fall’ is explored. It also examines recent sociological studies on falls.
2.2.1 A Sociology of Falls

In her discussion of the sociology of accidents, Green (1995:2) observes that the medical and the legal profession have developed bodies of knowledge about accidents yet ‘there has been little sociological research on how these classifications [the range of misfortunes] are made’. A sociology of falls has been advocated by Kingston (1998:107) because of ‘the inability of the medical model to offer insights beyond the purely biomedical’. He further claims that a sociology of falls would provide complementary knowledge and insights into falls and the impact of falls, particularly as the biomedical approach is reductionistic with a disease-driven focus.

Social construction of falling

Falls are important events that hold varying degrees of significance depending on the context or way they occur. A person’s previous experience could influence the way they talk about their falls (Martin, 1999; Kingston, 1998). This supports Sneldon’s (1948:98) early observations through case reports, for example:

A woman aged 70 says “she easily catches her foot and trips over”. She recently tripped over an irregularity in the pavement and fell headlong, injuring her knee. Says that when she trips “she feels herself going but cannot help it”.

It also implies that if a person perceives her/his fall as an accident, unintentional and unpredictable, s/he may talk about that fall as accidental. However, Kingston (1998:147) argues that even though individuals can describe the circumstances and offer an explanation on most occasions, ‘their interest does not always lead them to an analysis of whether the misadventure was accidental or not’. It begs a range of questions: whether older people consider if their falling was preventable, whether they consider themselves at risk of falling, and what subsequent actions should be taken. This research will explore how the construction of the meaning of falls might impact upon older people’s perceptions of their risk of falling, and their subsequent actions to prevent future falls.

From the lay and professional perspectives, Martin’s (1999) study illuminates that similar language has been utilised to describe falling events. Using a qualitative approach, she
undertook in-depth interviews and group interviews involving both those from professional groups (such as therapists and nurses), and older people aged 60 years, in Scotland. The study comprised of two phases. In the first phase, five group and individual interviews were conducted. Of the 39 respondents, 14 were male and 25 female, aged 60 and over. In the second phase a total of 50 respondents, aged less than 75 years, of whom 40 were female, participated in focus groups. In her study, lay people used words like ‘trips’ or ‘stumbles’ to depict faltering steps and these tended to be attributed to external or environmental causes. The word ‘fall’ was used to describe an event more ‘linked with poor physical health or extreme old age’ (Martin, 1999:30), although the language used to talk about the latter was frequently varied and inconsistent as ‘trips’ and ‘stumble’ and ‘falls’ were used interchangeably. Nonetheless, Martin’s (1999:31) study found that the two kinds of falling events (that is, trips/stumbles versus falls) had ‘different meanings and implications’. The attempt by her older respondents to feel the need for their fall to have been caused by tripping over something suggests that falls convey important meanings for people. Trips or stumbles were linked with an external factor such as loose carpet or an uneven pavement, whereas falls could happen without obvious warning, such as ‘blackouts’ that the older person had no control over. In other words, unlike falls, trips or stumbles were perceived as having an external ‘trigger’ (Martin, 1999:30). Older respondents also perceived a diminished physical ability as a cause of falls that was largely associated with old age. Because of the negative connotations associated with falls, older people felt the need to maintain an identity ‘which is not construed solely in terms of socially stereotyped notions of older age’ (Martin, 1999:32). Hence, they may be anxious not to admit to having fallen, as illustrated by one of Martin’s respondents who did not want her daughter to know what had happened.

Kingston (2000) suggests that the term ‘fall’ has metaphorical meaning. Referring to the North America usage of fall (for autumn), he argues that it symbolises decline. Other metaphors can be found in everyday usage where ‘falling apart’, ‘flat out’ or ‘prostrate’ denote negative connotations of falls while ‘standing firm’ provides a positive aspect of not being liable to fall.
2.2.2 Recent Sociological Studies on Falls

There have been very few studies that specifically examine falls in older people from a sociological perspective. Just over a decade ago, Askham et al.’s (1990) review of research on falls among elderly people highlighted that one of the neglected areas was the contribution of social and psychological risk factors to the likelihood of having falls. However, the last ten years has seen a great increase in epidemiological and clinical research literature on falls among older people (Martin, 1999), yet offers little in the way of critical analysis and discourse about falls from other disciplines apart from medicine (Kingston, 2000). Kingston also noted that the closest contribution from a sociological perspective has been the work of Yardley (1997) who has taken ‘an intense interest in disorientation’ (Kingston, 2000:216). Yardley (1997) suggests that disorientation can be seen as a loss of control and even a weakness, which may explain why older people may be reluctant to talk about falls.

One of the areas in sociological research that has been developed more recently concerns older people’s health needs and health promotion issues. This has relevance for falls among older people because health impinges upon many aspects of the lives of older people, their lifestyle and behaviour. Martin (1999:9) maintains that ideas of personal responsibility for health are implicitly ‘embedded within health promotion theory and practice’, and Watson et al. (1996:161) argue that health promotion should respond to ‘everyday embodied lay experiences’.

Efforts have been made to respond to this need; for example, Fee et al.’s (1999) work has contributed to a wider knowledge and understanding of the social factors influencing older people’s health beliefs and health-promoting behaviours. Findings of this study (which used focus groups and in-depth interviews with people aged 55 and over) include: the majority of older people perceive they have little control over their health, that ‘people are less likely to make changes in their health-related behaviour if they feel they are receiving contradictory or confusing information’ (Fee et al., 1999:73), and that
'being able to take an active role in the family and the community is an indicator of 'good' health' (Fee et al., 1999:13).

Martin’s (1999) study also addresses the limitations of health promotion in responding to everyday embodied lay experiences. As mentioned earlier, Martin’s study is one of few which specifically focuses on falls in older people from a sociological perspective. By focusing on the ways in which risk is felt to be shaped by various social factors and contexts, Martin (1999) was able to examine how older people compared with health professionals perceive and construct risks of falling.

According to Martin (1999:65) risk perceptions are not clearly defined, and ‘may be very difficult to articulate’. She found that some older participants were more cautious and had a clear sense of which activities would be more ‘difficult’ (rather than dangerous) for example, changing a light bulb, and which they might seek help with. These perceptual changes were related to physical health problems, as opposed to being age-related.

Martin’s (1999:70) study also indicated that some older people made great efforts to conceal falls or health problems from family members ‘whom they feared would see this as an opportunity to intervene (interfere) in their life’. This reflects the independence valued by older people. However, this fiercely guarded independence may inhibit older people from seeking help and advice from their relatives, for example, help with shopping (Martin, 1999). It also may deter older people from seeking help and advice from health professionals, for example, advice on choice and use of walking aids (ibid.).

Both of these British studies (Fee et al., 1999; Martin, 1999) have implications for the way older people respond to the falls they have experienced. They raise questions of whether older people feel they have any control over their falls, and whether they feel their falls could have been prevented, as well as how their meaning of falls impacts upon their subsequent actions. In particular, none of the above studies examined gender differences.
Kingston’s (1998) study of falls among older women adds another dimension to the discussion. His randomised control trial sets out to test the hypothesis that ‘post accident and emergency discharge assessment, intervention and referral within five working days by a Health Visitor would improve the medium term functional status of elderly female fallers’ (Kingston, 1998:186-7). In his discussion of falls among older people, he argued for a sociology of falls. Drawing attention to the potential usefulness of the theoretical framework of status passage (Glaser and Strauss, 1971), Kingston (1998) argues that it could offer insights into questions about what privileges, influence, or power do older people who fall gain or lose, and what impact a fall may have on an individual’s sense of self-identity and behaviour. His work will be discussed in greater detail in section 2.3 and 2.4.

McKee (1998) maintains that the inability to control our body has to do with the failure of the social self and the physical self. Citing accidents as an example, he suggests that the person who experiences falls would be familiar with the sense of embarrassment which is the outcome of being unable to control one’s body. McKee (1998) maintains that recovery ‘post-fall’ may be influenced by the older person’s sense of physical self and self-identity. He and his colleagues examined the effect that psychosocial factors may have on an older person’s recovery from a fall (McKee et al., 1999). Their study adopted a longitudinal two-phased, multi-factorial design that involved a convenience sample of 40 people aged 65 and over (33 females and 7 males) admitted to a large hospital following a fall. In phase one, questionnaires were used to ‘explore the correlates of patients’ beliefs about the cause of their fall and their beliefs about their recovery, when assessed in hospital’ (McKee et al., 1999:556). The second phase of the study involved the development of a questionnaire to determine whether ‘such causal and recovery beliefs predict variances in perceived recovered activity at home, two months after the initial fall’ (ibid.).

Where causal beliefs were concerned, McKee et al. (1999) found that sixteen (40%) participants attributed their falls to an external cause, while 19 (47.5%) identified an internal cause for their fall. Five participants (12.5%) could not identify a cause of their
fall. Only seven participants (17.5%) believed they could have prevented their fall. This could imply that their subsequent actions would be to take measures in order to prevent falls from recurring. The fear of falling was found to be associated with perceived risk of falls, which was associated with having fallen since leaving hospital. Of the forty who participated in the follow-up questionnaire, a quarter had fallen again. As acknowledged by the authors the limitations of their sample made it difficult to generalise the findings to the wider population, for example, in relation to gender differences.

Borkan et al. (1991) focused on hip fracture rehabilitation and examined the meanings presented in the narratives of elderly patients who had hip fractures. Participants were interviewed during the initial hospital admission with follow-up interviews conducted at 3 and 6 months intervals. The authors categorised the participants into two groups. The first group included those patients who viewed their fracture as disease/illness, whilst the second group believed their fracture was caused by an external factor, such as the environment. Borkan et al. (1991:947) reported that:

> Those individuals who perceive their problems in a more external or mechanical fashion (caused by the environment) show greater improvement in ambulation at 3 and 6 months relative to those who show no evidence of this thinking or who perceive it as an internal or organic problem (in terms of disease or illness).

In other words, those who perceived they were in hospital because of a fracture that they believed to be caused by external influences such as the environment, showed greater improvements in terms of their activities of daily living. Those who perceived that their fracture was associated with an illness or disease did less well in recovery. Borkan et al. (1991) suggestion that the recovery process from a fracture is influenced by whether it is perceived as an illness or disease, or caused by external factors such as the environment, has a bearing in relation to how older people might construct their meaning of falls. It also has implications for the way older people took actions to prevent future falls, with the assumption that different cause(s) of falls lead to different approaches to preventing falls. This study will examine the extent to which the meaning of falls impacts upon the subsequent actions of older people and of their key family members.
What is striking in the studies discussed above is that none of the above-mentioned studies have focused on how gender might have influenced the meaning of falling, the older person’s risk perception or their self-identity.

### 2.3 Falls as ‘Preferred Identities’ and ‘Stigma’

The following theoretical concepts, ‘preferred identities’ (Charmaz, 1987), and ‘stigma’ (Goffman, 1968), are examined in detail to consider their relevance to an understanding of how falls might impinge upon the identities of older people who have had recurrent falls.

#### 2.3.1 Preferred Identities

The following discussion is drawn from the work of Kingston (1998, 2000) who first identified the usefulness of ‘preferred identities’ (Charmaz, 1987) in explaining how older people who have had falls maintain their identity. With respect to Charmaz’s (1987) ‘preferred identities’, individuals’ effort to find valued lives and selves and to maintain their identity can be seen as part of the rehabilitative process and coping by individuals with a chronic illness; such attempts may be essential for someone making sense of life after a falling event (Kingston, 1998).

Preferred identities relate to individuals’ attempts to find valued lives and selves (Charmaz, 1987). Corbin and Strauss (1988) refer to them as individuals’ efforts to define and maintain a valued identity. These efforts could be considered as part of the rehabilitation process for people with chronic illness, and are essential to ‘making sense of life after a fall’ (Kingston, 2000:219). Preferred identities offer a theoretical perspective in terms of how the ageing process, impairment, disability and falls might be viewed by older people.

Charmaz (1983:138) refers to the process of ‘the loss of self’ which is not a permanent feature and demonstrates the way in which people move beyond this state and are able to create new ‘reconstituted identities’. As the earlier discussion indicates, falls among older
people have physical, psychological and social consequences. It is suggested here that older people who have had falls may experience the process as a loss of self; for example, having to rely on others because of their fear of falling, be seen as being more dependent on others to assist them in their activities of daily living, or having to curtail activities that they think might cause them to fall again. According to Charmaz (1983:172), this could lead to ‘social isolation’ which in turn ‘leads someone to live a restricted existence, both of which limit possibilities for positive validation of self’. She also notes that illnesses that people experience which pose ‘identity problems often are left entirely to them and their significant others’ (Charmaz, 1983:283).

Charmaz’s (1987) description of the concept of identity has been influenced by Goffman (1968). The concept of identity refers to ‘attributes, actions, and appraisals of self’ (Charmaz, 1987:284). The distinction between personal identity and social identity is made, the former derives from identifications the individuals make, while social identity derives from identifications others make (Charmaz, 1987). In relation to falls among older people, falls might result in older people being concerned with their personal and social identity since falls can have psycho-social impacts such as fear of falling (Franzoni et al., 1994), a lack of confidence (Myers et al., 1996), and greater dependency (McIntyre, 1999).

Identity levels are defined by Charmaz (1987:286) as ‘implicit or explicit objectives for personal and/or social identity that chronically ill people aim to realise’. She suggests that the types of preferred identities can be seen as representing particular identity levels. The kind of selves people wish to shape or select are reflected in these identity levels which are collectively known as the hierarchy of preferred identities: these include the supernormal identity, the restored self, the contingent personal identity, and the salvaged self (Charmaz, 1987).

The person with the ‘supernormal identity’ attempts to participate more diligently in her activities than other ‘nonimpaired’, despite the illness and its symptoms (Charmaz, 1987). In relation to an older person who has had falls, this level may be reflected in his/her
attempts to maintain independence and take on extra activities despite some residual restriction in mobility following the falls. At this level the older person is also aware of the risks involved in doing so.

The person with a 'restored self identity' expects to return to their former lives, with the aim to 'reconstruct' a similar physical self as before and return to their former self (Charmaz, 1987:287). To an older person who has had falls, a restored self identity would mean reconstructing the same sense of self before the fall events, that is, falling did not affect the person's self identity.

At the 'contingent personal identity' level, from the start, the person defines 'risk and possible failure', believing that their 'hopes, aspirations, and plans are fragile and tentative' (Charmaz, 1987:308). She suggests that individuals might initially aim for a supernormal identity or a restored self then realise they could not achieve it and chose this level instead. To an older person who has had falls, this may mean that they realise that they could not continue to do the things they used to do prior to having falls because of the potential risk of falling again.

At the 'salvaged self level, individuals, despite their reduced functional abilities, try to perceive themselves as 'positive and worthwhile' (Charmaz, 1987:287), for example:

Such individuals attempt either to continue some favoured personal attribute or activity from the past, or they may simply attempt to present themselves to others in a favourable way. These people feel severely debilitated or disabled from their illnesses. (Charmaz, 1987:310)

In other words, they try to define themselves 'in the best possible light' (Kingston, 2000:219). This could mean that an older person who has had falls makes positive comparisons of self with other fallers and maintains that he or she could still live independently despite being restricted in his/her movements.

Charmaz (1987:288) identifies some conditions under which preferred identities are defined, and these include: 'type and degree of illness; meanings of experiences of
illness; the timing and sequencing of illness; and expectations of and for self. She also
states that personal and social meanings of illness and the experienced illness 'shape
identity construction and definitions of stigma' (Charmaz, 1987:289). An older person
may curtail some of their activities or hobbies that they had without realising that it was
the falls or the impact of the falls that influenced the range of activities they decided to
forego. This could happen because they were unaware that they were gradually changing
their routines due to their growing frailty, attributing it to the ageing process. It may also
be possible that the type of falls and the injuries resulting from these falls influence their
'personal and social' meanings of falling. For example, an older person's personal
meaning of falling may be attached to his or her loss of balance because of osteoarthritis.

Charmaz's (1987:290) suggests that prior experience with illness affects people’s ‘choice’
of preferred identities; this raises the debate about whether people actually have choices
in relation to their preferred identities. It could be argued that it is not so much the
choice, but rather negotiations or 'trade-offs' (see Wynne-Harley, 1991). Secondly, where
falls are concerned, it has been argued that the experience of each falling event may not
be similar, making it difficult for older people to know what to do to minimise the impact

Charmaz (1987:292) maintains that ‘some people move down the identity hierarchy in a
linear pattern, while others move up and down it’. She explained that some circumstances
such as changes in physical status and the availability of social and psychological support
can lead people to shift their identity levels, for example from a ‘salvaged’ self to a
wholly restored self. For older people who have had falls, changes such as becoming
more reliant on their family, or having to rely on a zimmer frame to walk more steadily
may become a great concern for older people themselves as they may perceive
themselves to be more dependent.

Although Charmaz’s (1987) preferred identities have been identified by Kingston (1998)
as a sociological perspective assisting in the understanding of the phenomena of falls,
there are limitations in its application to the focus of the proposed study. For example,
Charmaz (1987:287) suggests that at the contingent personal identity level, the person 'defines risk and possible failure'. It assumes that older people could define their risk of falling, and have similar risk perception across gender and class. This problem has been highlighted by Martin (1999) who reports that perceptions of 'risk' are not clear-cut and may be difficult for older people to articulate. Charmaz's preferred identities might only offer a limited perspective to aid understanding of the phenomena of falls, and might not assist in the understanding of the subsequent behaviour taken by the older person who has had falls.

2.3.2 Falls as a Stigma

This section will discuss ways in which stigma may develop, and how stigma relates to falls among older people and their self identity. The literature on stigma is prolific and a detailed review of this literature is beyond the scope of the chapter.

The concept of stigma has been applied to a variety of conditions, including various forms of illness such as mental illness, epilepsy, cancer, and AIDS (MacRae, 1999). Goffman (1963:3) utilises the term 'stigma' to refer to 'an attribute that is deeply discrediting', hence a person with this attribute is seen as different from others, in such a way that is undesirable and shameful. The stigmatised person is devalued and seen as 'less than a whole person' (MacRae, 1999:54). The person's identity is said to be at risk of 'being spoiled'.

Work on stigma and the management of self by Goffman has been influential in the study of chronic illness (Nettleton, 1995). Goffman (1968:12) distinguishes two types of identity: the 'virtual social identity' which is 'the character we impute to the individual' and the 'actual social identity' meaning those attributes which the individual has.

Parallels can be drawn between problems of urinary incontinence and of falls since both affect older people. Estimates of the prevalence of urinary incontinence vary widely depending on the definition used (McGrother and Clarke, 1996). In Great Britain it is
estimated that up to 4% or one million adults over 40 are affected with socially disabling urinary incontinence and around 10% of older adults may have a significant problem (McGrother and Clarke, 1996). In relation to older people with urinary incontinence, failure to maintain normal function reflects badly on the character of the sufferer (Norton, 1999). Problems with incontinence can be a cause for shame, embarrassment and guilt (Kelley and Shepherd, 1998). Feelings of isolation and loneliness are commonly reported by people with urinary incontinence (Incontact, 1996), threatening self-image, and preventing some people from feeling like responsible adults, thus suggesting to some 'a loss of control or regression to a childlike state' (Wilkinson, 2001:35). Lay people consider incontinence to reflect a lack of self-control (Norton, 1999). Shame bears directly on self-identity because it depends on feelings of personal insufficiency (Giddens, 1991:65). Simons (1985) reported that most older women thought urinary incontinence was a normal and unavoidable occurrence with advancing age; as many relate it to having children and 'something to be borne without complaint' (Kelley and Shepherd, 1998:391). Whereas Mitteness (1992) contends that incontinence can be seen as a violation causing the person to feel an outcast of society. However, Wong's (1995) study indicates that older people did not necessarily accept incontinence as a normal occurrence with advancing age and utilised various strategies to cope with it. In Dowd's (1991) study of older women's experience of urinary incontinence, problems related to urinary incontinence were perceived as threats to their self-esteem.

Goffman (1968:15) suggests that the attitudes and actions people have towards a person with a stigma are based on the assumption that 'the person with a stigma is not quite human'. Goffman further explains:

Persons who have a particular stigma tend to have similar learning experiences regarding their plight, and similar changes in conception of self ... one phase of this socialisation process is that through which the stigmatised person learns and incorporates the stand-point of the normal, acquiring thereby the identity beliefs of the wider society and a general idea of what it would be like to possess a particular stigma (Goffman, 1968:45).

The likelihood of stigmatisation will depend on several factors such as its visibility, its obtrusiveness and how much others are aware of it (Goffman, 1968). The visibility of a
fall by an older person may depend on where the fall occurs, whether the faller has visible signs of injury resulting from the fall, or whether the faller lets someone know about it. In some cases, the latter may not be within the control of the faller as the fall may occur in a public place necessitating a hospital admission which, may lead to close relatives being informed of the incident. Williams and Barlow’s study (1998:138) of people with arthritis found that avoidance strategies were utilised to preserve self and ‘to minimise self-consciousness’. The authors also note that ‘concealment’, likened to ‘covering’ [a term coined by Goffman (1968)], is a self-defence strategy. For example, ‘clothing was chosen and worn to mask bodily change to reduce feelings of self-consciousness and to maintain an appearance similar to that of same-aged peers’ (Williams and Barlow, 1998:138). The visibility of the impact of falls, such as bruises, or having to use a walking aid, can provoke anxiety, and feelings of self-consciousness, threatening the private and public self.

Scambler and Hopkins (1988) highlight the distinction between ‘enacted’ and ‘felt’ stigma. In their study of people with epilepsy, the authors refer to enacted stigma as instances of discrimination against people with epilepsy based on the perception of them as somehow unacceptably different or inferior, the exceptions being instances of ‘legitimate’ discrimination such as banning them from driving (Scambler and Hopkins, 1988). Felt stigma refers to ‘the fear of meeting with enacted stigma, although it also embraces a sense of shame that frequently attends “being epileptic”’ (Scambler and Hopkins, 1988:157).

The above discussion may be applied to older people who have had recurrent falls. The felt stigma may be perceived when older people feel shameful about their falling events, which in turn, impacts upon their self identity and self worth. Falling events draw the attention of others to oneself, especially if the fall happens outdoors in public places. This can be embarrassing for the older person. Secondly, if the fall results in severe injury, it means that the faller may have to rely on others such as health professionals, and family members and/or friends. This draws attention to their reliance on others for help. Thirdly, the feeling of not being in control of one’s bodily functions, as experienced by an
incontinent person, may be the same for someone who has had recurrent falls; falling being seen as ‘an intrinsically physical event - a bodily occurrence, over which the individual had no control’ (Martin, 1999:53).

The notion that falls and those who fall might be perceived as being stigmatised is an under-studied area. Although Martin (1999:69) indicated that ‘falls are negatively construed as medical events occurring to old frail people, and possibly, to those with a drink problem’, it is not known how perceptions of stigma influence the construction of the meaning of falls and the subsequent actions taken by older people. This is one of the areas that the present study seeks to examine.

2.4 Falls as a ‘Status Passage’ and a ‘Biographical Disruption’

This section examines the usefulness and relevance of ‘status passage’ (Glaser and Strauss, 1971) and ‘biographical disruption’ (Bury, 1982) as a means of understanding falls and their impact on the older person who has had recurrent falls.

2.4.1. Falls as a ‘Status Passage’

According to Kingston (1998, 2000), the social theory of status passage offers a means in understanding a fall and its impact. He asserts that:

For the individual who falls there are implications that need to be given meaning in a lifecourse and existential context, alongside issues about the individual’s future health and welfare status. Status passage and preferred identities offer a theoretical context in which to explore such concerns (Kingston, 1998:116).

Glaser and Strauss’ (1971) concept of status passage is about individuals moving from one situation or period in their life to a succession of different phases. In relation to falls among older people, falls may be viewed as a passage that is inevitable in old age, resulting in changes in health and lifestyles.
Several characteristics of the concept of status passage are relevant for understanding falling experiences. For example, Glaser and Strauss (1971:3) state that 'no one is assigned, nor may s(he) assume, a position or status forever'; this could be applied to falls since such events are transient often resulting in a temporary stay in a hospital, or a visit to the GP surgery. Falls and their consequences could be seen as 'an unforeseen accident or disaster' or a 'crucial incident', a phrase coined by Glaser and Strauss (1971:23). Another feature of status passage is its temporality, which Glaser and Strauss (1971:33) view as 'the rate, pace, or speed' of the passage, and how it 'fluctuates in distance and direction'. Kingston (2000:222) relates this to the length of time an older person may restrict his/her activities of daily living following a fall, or how his/her health status is affected.

The shaping of a passage, as Glaser and Strauss (1971:57) see it, is 'the course or line of the passage' using direction and timing as the two axes. Glaser and Strauss also state that some passages 'just occur' (Glaser and Strauss, 1971:62). To people who fall, the fall may 'just occur' because it is accidental. In this instance the passage may be 'unscheduled' thus producing 'an identity crisis for a passagee who does not wish to move' (Glaser and Strauss, 1971:29).

The desirability of a passage, according to Glaser and Strauss (1971:113), relates to particular illness passages in which the person involved may feel that 'the less said about the passage to all concerned the better, until it is all over'. This can be seen in falls that are generally perceived as undesirable. In such circumstances the older person may desire to keep quiet about his/her falling event, and chose not to inform close relatives. For example, Kingston (1998) found that eighty-seven (80%) of the 109 participants in his study chose not to discuss the fall with friends or relatives. Of the twenty-two who did discuss their fall, this represented twelve (11%) with their husbands, nine (8.3%) with their son/daughter, and one (0.9%) with another person. The feeling of being controlled, or thought of as a 'non-competent' person by their family members, may be stigmatising for an older person. Being told what to do or not to do in case a fall recurs, may mean a loss of independence and a loss of self (Charmaz, 1983).
Whilst the above discussion illuminates the usefulness and relevance of status passage in understanding falls as a phenomenon, it may also be that a fall represents a ‘crisis’ or ‘critical incident’ that was described as:

Sometimes a condition has been developing for a long time, but neither passagee nor agent has been aware of this, so when it manifests itself it is seen as a crucial incident (Glaser and Strauss, 1971:24).

In relation to an older person who has had recurrent falls, it is questionable if falls can be seen as a ‘passage’. It is unlikely that the person is unaware of their falls, since repeated falls may result in psychological distress (Murphy and Isaacs, 1982; Kingston, 1998).

2.4.2 Falls as a Biographical Disruption

Within a lifecourse perspective, it is possible that older people might make sense of their falling events as a ‘biographical disruption’ (Bury, 1982). In his study of people with rheumatoid arthritis, Bury (1982) introduced the notion of chronic illness as a kind of biographical disruption; an experience in which ‘everyday life structures, its taken-for-granted features, and the tacit knowledge upon which they rest’ are disrupted (Simon Williams, 2000:4). According to Bury (1982, 1991) chronic illness becomes interwoven into the person’s life and identity. It is possible that falls may be conceptualised in this way in terms of the consequences for individuals and their families.

According to Bury (1982), any illness constitutes a disruption; an obstruction to the current of daily life (Hyden, 1997). The person with chronic illness may be forced to examine the future from a different angle (Hyden, 1997). This disruption is likened to Gidden’s (1979:123) ‘critical situation’:

We can learn a lot about day-to-day situations in routine settings from analysing circumstances in which those settings are radically disturbed.

Three aspects of disruption experienced by people with chronic illness have been identified (Bury, 1982). The first relates to ‘the disruption of taken-for-granted assumptions and behaviours: the breaching of common-sense boundaries’ (Bury,
1982:169). Bury identifies this as the ‘what is going on here’ stage which ‘involves attention to bodily states not usually brought into consciousness and decisions about seeking help’ (ibid.). It could be argued that older people, having experienced recurrent falls, might become more aware of their functional limitations. The embarrassment due to the disabilities resulting from the falls, such as not being able to get about confidently can become an issue for older people. This ‘disruption’ may result in the older person having to seek help to maintain their activities of daily living.

The second aspect of disruption is explained by Bury (1982:169) as:

more profound disruption in explanatory systems normally used by people, such as a fundamental rethinking of the person’s biography and self-concept is involved.

Bury further suggests that a person may realise that medical knowledge is incomplete, and that because the treatment is based on practical trial and error judgement, this may compel the person to search for a more comprehensive level of explanation. The person may question the cause of the illness. In relation to older people who experience recurrent falls, this aspect of disruption can be applied to how an older person may start seeking explanations of why they fell. The disruption caused by the falling events may intrude into an older person’s sense of self-confidence.

Bury (1988:170) describes the third aspect of disruption as ‘a response to disruption involving the mobilisation of resources in facing an altered situation’. He considers the resources to include cognitive and material ones that are tapped to deal with biographical disruption. The disruption caused by falls may be reflected in the older person’s need to seek formal and informal help in order to cope with the consequences of their falls, whilst maintaining some levels of independence.

These aspects of disruption described by Bury (1982) could be relevant to the experience of older people who have had recurrent falls. Falls can involve a disruption of normal taken-for-granted activities of daily living, such as becoming more aware of their functional limitations and the embarrassment due to the disabilities resulting from the
falls. Not being able to get about confidently due to a fear of falling can become an issue for older people. This experience affecting the identities and the sense of self in older people who have had falls can be likened to the ‘biographical disruption’ described by Bury (1982) who draws attention to the impact that disability has at a particular time within an individual’s life course. As for people with chronic illness, maintaining normal activities for older people who have had falls can also become a ‘burden of conscious and deliberate’ action in that ‘the simplest outing becomes a major occasion of planning and expedition’ (Bury, 1982:176).

Some studies have illustrated the range of types of ‘biographical disruption’; for example, Morgan (1988) highlights the rapid or prolonged onset of renal failure. Scambler (1989) illustrates in his study of epilepsy that sudden symptoms can cause the person not only to have to face a changed situation, but also the stigmatising reactions of others. MacDonald (1988) and Kelly (1986) show the need to recognise the element of ‘grief’ associated with cancer diagnosis and radical surgery. Robinson (1988) demonstrates how people with multiple sclerosis required early recognition of the condition in order to avoid being misunderstood as malingering or even drunk. Like some of these conditions it could be argued that older people who have had recurrent falls may not only have to face a changed situation, but also the potential stigmatising reactions of others, particularly if they have fallen in public places where strangers may not know the reason for their fall(s).

2.5 Conclusions

This chapter has examined some of the key issues relating to falls among older people, from both biomedical and sociological perspectives. The lack of consistency in the literature concerning the definition of falls highlights one of the problems in the way falls are perceived both from lay and professional perspectives, and underlines the need to examine how the meaning of falls may be socially constructed by older people who have experienced falls. Within sociological perspectives, the constructs of ‘stigma’ (Goffman, 1968), ‘preferred identities’ (Charmaz, 1983), ‘status passage’ (Glaser and Strauss, 1971),
and ‘biographical disruption’ (Bury, 1982) have been examined. Whilst Glaser and Strauss’s status passage and Charmaz’s preferred identities have been suggested by Kingston (1998, 2000) as aiding an understanding of the ways in which older people who have had falls conceptualise their episodes of falls, it has been argued that they offer a limited explanation since the perceptions of the risks of falling, and how these might influence the actions of older people and their key family members have not been explored. None of these sociological perspectives specifically offer an understanding of how gender might differentiate the meaning of falling, and the subsequent actions taken by older people and their key family members.

While Goffman’s notion of stigma is seemingly relevant in helping to understand how risks and consequences are constructed by older people and their family members, there are some limitations in its application to the proposed study. Most of the studies which have used Goffman’s work as a theoretical framework have examined more obviously stigmatised conditions or diseases such as epilepsy and incontinence, while no one, as yet, has demonstrated its potential in illuminating falls. It is proposed that felt stigma may be more pertinent for older people who have recurrent falls since it embraces a sense of shame, which older people might associate with their falling events.

Finally, the chapter has examined how falls might be perceived as a biographical disruption (Bury, 1982) since this involves a disruption of normal taken-for-granted activities of daily living, and the embarrassment associated with the disabilities resulting from falling. In the light of the above discussion, a key focus of the proposed research will be to explore how the meaning of falls is constructed by older people and their key family members, and how these meanings impact upon older people’s identity and notion of stigma related to falling. Another focus will be the extent to which gender impacts upon the meaning of falls, the identity of older people, and their notion of stigma.
Chapter 3

Management of Risk among Older People

The chapter draws on the perspectives of symbolic interactionism, that is based on three fundamental premises: 'that human being acts upon things on the basis of the meanings that the things have for them; that the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows, and that these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters' (Blumer, 1969:2). It is argued that older people who have had falls will define the situation or experience differently depending on how they perceive or interpret their falling episodes. Their perceptions could also be influenced by their perceptions of risk and risk taking in relation to preventing future falls.

The chapter will focus on key aspects relating to risk and risk taking which are important to older people who have had recurrent falls. The term 'risk' appears in much of the medical literature with reference to falls among older people, particularly on how to prevent falls. However, it is argued that the social construction of risk from the older person's perspective has a bearing on the ways in which they manage their falls, and seek to prevent future falls. Hence, the key concepts of risk and risk taking are relevant, and these will be discussed and clarified. The chapter will also explore the meanings of safety and hazards, particularly in relation to falls among older people. Some of the discussion will draw on the work of Alaszewski et al. (1998), Denscombe (1993), and Morgan et al. (1997).

3.1 The social construction of risk

This section will initially examine the concept of risk and its related terms and how these are socially constructed. The theoretical approaches to risk will be explored, together with the health and risk behaviours of older people. Since notions of risk are intricately related
to conceptualisation of hazards and safety, these terms will be critically examined, from the perspectives of health professionals, family carers, and older people. Firstly, the key concepts of risk, hazards, and safety will be examined as these influence how meanings of risk may be constructed by older people.

3.1.1 Defining ‘Risk’

The term ‘risk’ has been widely used in a range of disciplines including philosophy, mathematics, statistics, epidemiology, economics, psychology, and sociology (Heyman, 1998; Lupton, 1999). Risk is a key concern and preoccupation for both older people and health care professionals (Kemshall and Pritchard, 1996), and in relation to falls among older people, this issue raises fundamental implications concerning the extent to which older people take or do not take risks in relation to falls and falls prevention.

There is a clear indication in the literature that risk denotes a threat or a danger to an individual or a group of individuals, although risk and uncertainty tend to be regarded as conceptually the same thing (Lupton, 1999). In Alaszewski’s (1998:10) description of ‘the risk ice-berg’, other related words include ‘hazard’, ‘harm’, and ‘safety’. These related words will be explored further in the section.

The dominant ideas about risk within health care are associated with hazard, threat and loss (Adams, 2001). This is particularly applicable where caring for older people who have had falls are concerned. For example, falls can be caused by environmental hazards, and are a threat to the physical well-being of older people such as through physical injuries (Fleming and Pendergast, 1993). Falls can result in a loss of confidence, which in turn, can lead to an increased dependency due to self-imposed restrictions on daily activities of living. The view that risk is associated with hazard, threat and loss tends to see risk in probabilistic terms relating to the estimation of different types of outcomes or loss (Alaszewski and Manthorpe, 2000). It also excludes the possibility that there may be positive benefits associated with risk taking (Adams, 2001). This view of risk is problematic since it does not consider the social and cultural factors associated with risk,
and 'neglects the contribution of language to the perception that particular situations are a risk' (Adams, 2001:308).

Carson (1995) advocates a broader conception of risk that balances positive and negative outcomes with certainty and uncertainty, suggesting the need to shift the focus from identification of risk to the process of decision making. By extending the definition of risk it is then possible for health care professionals to use their knowledge and professional judgement to weigh up positive and negative outcomes in order to make the best decision (Alaszewski, 1998). The usefulness of this extended approach can be seen in how older people who have had recurrent falls, make decisions about what or what not to do in trying to prevent falls. It is possible that older people weigh up the outcomes of the risk(s) in relation to falling, and make judgements about their perceived risk of falling, which in turn influence their future actions.

3.1.2 The Concept of Hazards

Following Warner (1992), Alaszewski (1998:10) suggests that a hazard or a danger can be defined as 'a potential threat which can result in harm, loss, or negative consequences for an individual or group'. Hazards are 'threats to people and the things they value' (Kates and Kasperson, 1983:7027). However, the British Medical Association's (1987:13) guide Living with Risk describes hazard as 'a set of circumstances which may cause harmful consequences', while risk is 'the likelihood of its doing so'. Douglas (1992) notes that this hazard/risk differentiation produces a moral dimension as those who take risk may be held accountable in some way or other. However, in the face of natural hazards that originate from natural environmental systems such as earthquakes or hurricanes (Hood et al., 1992), those who live under this set of circumstances cannot be held accountable. It is also recognised that there are many hazards in the environment that are either produced or exacerbated by human activity (for instance, floods) (Hood et al., 1992). However, the majorities of studies on falls among older people have not found that the presence of environmental home hazards is a major risk factor for falls (Lord et al., 2001).
Pidgeon et al. (1992:89) noted that risk perception involves people's beliefs, attitudes, judgements and feelings as well as the wider social or cultural values and dispositions that people adopt, towards hazards. Here, it can be seen that the concept of 'hazards' is linked to perceived risk.

3.1.3 The Concept of Safety

'Safety' has been highlighted as one of the terms in the risk 'ice-berg' (Alaszewski, 1998:11). It refers to 'the absence of harm' and 'the processes by which harm is prevented and avoided' (Alaszewski, 1998:12). Warner (1992:6), in his report to the Royal Society Study Group, defines safety as 'the freedom from unacceptable risks of personal harm'. He provides a cautionary note that safety is defined in the context of risk of personal harm and that it can be traced quantitatively in decision making on acceptable risks. As a concept it relates to the freedom from risks that are harmful to a person, or group of persons.

In his discussion on the concept of safety, Adams (1995) draws examples from the early days of motoring up to the present time, and observes that behavioural modification resulted from perceived changes to risks to personal safety. Adams (1995:31) also suggests that 'the relentless pursuit of risk reduction has made safety an enormous industry'. By this, he implies that it is not easy to be exact about its size, as safety 'merges with everything else - manufacturers of safety glass, for example, produce both glass and a safety product' (ibid.). To illustrate the enormity of the scope of the risk reduction industry, one only needs to think of "safety in the home", "safety at play", and "safety on the road" to realise its significance (Adams, 1995:31).

One study that examined the concept of safety is that of Roberts et al. (1992), who explored the relevance of regarding safety as a social value in relation to children's accidents in a community in Glasgow. The ways in which a need for safety influenced behaviours within the family were examined. Their working definition of safety as a
social value was ‘a quality of life which is defined, sought after, developed and maintained, by the whole communities or societies’ (Roberts et al., 1992:188). I had expected to find the concepts of risk, hazards and safety clarified since the study also explored the impact that the risk of accidents had on personal and social life, and how people saw accidents as ‘an inevitable hazard or as something they had to take steps to control’ (Roberts et al., 1992:192). Instead, the terms such as ‘accident risk’, ‘health risks’, ‘healthy hazards’ (ibid.) were used interchangeably. Nonetheless it is helpful to know from this study that safety behaviours are learned through individual and shared experiences since these will have a bearing on effective accident prevention.

3.1.4 Risk Taking

In his discussion of falls at any stage throughout the lifecourse, Kingston (2000) suggests that there are conflicting views regarding risk taking. Citing an example of a child at a stage when he learns to walk, Kingston (2000:224) pointed out that during this stage the ‘child will fall reasonably consistently’, a behaviour considered to be risk taking by the parents. Because the risks were considered to outweigh the dangers (little injuries), this behaviour was deemed acceptable and inevitable. The acceptability of risk alters at a later stage, as Kingston (2000:225) adds:

Conversely, when an elderly person takes risks and falls, this risk taking may be considered foolhardy, with some apportioning of culpability, if not blame. This view might be taken that the risk is outweighed by the danger.

Risk taking involves complex decision making (Carson, 1995:27). Lupton and Tulloch (2002:323), in an exploratory study of 74 Australians, identify that risk involves ‘a weighing up of whether or not to take up an action’. Their participants comprising mainly of young and middle-aged adults, had a dominant tendency to categorise risk as negative. Their participants’ emotion of fear and dread were associated with interpretations of risk as danger and the unknown, as Lupton and Tulloch (2002:323) add:
Uncertainty, insecurity and loss of control over the future was associated with risk, as was the need to try and contain this loss of control through careful consideration of the results of risk-taking.

It is therefore inevitable that professional and family members involved with caring for older people sometimes believe that risks should not be taken because of the dangers attached. Both professional and family carers can become 'over-protective' towards the older person, particularly if s/he is considered to be 'vulnerable' (Carson, 1995). In this instance, risk taking may be actively discouraged because it is felt the older person needs to be protected from danger(s).

This section has examined the key concepts of ‘risk’, ‘hazards’ and ‘safety’. There is a general consensus that risk represents a threat to an individual or a group of individuals, and has a broader dimension that encompasses positive and negative outcomes. The concept of hazard is considered as a set of circumstances that can cause harm to an individual or a group of individuals, while risk is then referred to as the likelihood of a set of circumstances or hazards causing harmful consequences. By contrast, safety is a social value, in which an individual is considered free from risk or harm.

3.2 Theoretical Approaches to Risk

This section examines the theoretical approaches to risk, drawing upon the work of Douglas (1966), Beck (1992) and Giddens (1991). Lupton (1999) identified three socio-cultural approaches to risk. The first approach stems from the work of Douglas (1966) who maintained that the body is used symbolically and metaphorically in discourses and practices that surround risk. This approach also contends that risk is used in society to determine and maintain conceptual boundaries between the self and ‘the Other’ (Lupton, 1999), and from Douglas’ (1966) viewpoint, the society’s conceptualisation of the body reflects anxieties about policing the body’s boundaries. Such anxieties include danger, purity and pollution associated with body fluids (for example, vomit and faeces). Lupton (1999) suggests that this approach considers risk as an objective hazard, threat or danger constructed through social and cultural processes.
The second approach identified by Lupton (1999) concerns the macro-social processes that are characteristic of Western society. Examples of this approach can be seen in the work of Ulrick Beck (1992) and Giddens (1990, 1991). Giddens (1991:43) contends that all societies believe that there are threats to order and security, and seek to counteract the negative consequences: threats to individual and collective well-being and security. He refers to such threats as 'risk', and contrasts it to 'trust' which he perceives as a way of giving individuals and groups security. Trust, as a 'protective cocoon' helps individuals by filtering out the 'potential dangers impinging from the external world' (Giddens, 1991:244). Beck (1992:21) defines risk as:

a systematic way of dealing with hazards and insecurities induced by modernisation itself. Risks, as opposed to older dangers, are consequences which relate to the threatening force of modernisation and to its globalisation of doubt. They are politically reflexive.

Beck's reference to 'older dangers' included plagues, floods and famines, which are now rarely perceived as divine acts or the result of 'nature goes wrong' (Lupton, 1999:68). Adams (1995) argues that by defining risk as a way of dealing with hazards, Beck (1992) has created an unhelpful misunderstanding in the usage of the words 'risk' and 'hazard'. The lack of congruence can be found in the synonymous use of the words 'risk' and 'hazard' in one chapter of the work (see Adams, 1995, Chapter 5). Whereas the above definition suggests different characteristics of risk (for instance, that it is reflexive, it is an outcome/an effect. Adams (1995) suggests that a distinction between the cause and effect might have clarified the confusion.

The third socio-cultural approach to risk identified by Lupton (1999) is represented by Foucault's (1979) notion of governmentality, which is understood as the strategies, techniques, programmes and aspirations, the calculations and tactics, of all those authorities that shape the beliefs, attitudes and behaviour of the population (Nettleton, 1992). This approach understands the identification of 'risky' social situations as 'a strategy of social control and regulation' (Adams, 2001:308). Whilst this approach has
been used to provide theoretical insights into care provision for people with dementia (Harding and Palfrey, 1997) and mental health nursing (Crowe, 1997), little is known of its usefulness in the study of older people who have had recurrent falls.

Social, cultural and political processes influence ‘the formation of individual attitudes towards risks and their acceptance’ (Pidgeon et al., 1992:9). However, there may be generational differences in how risk is perceived, with those in the younger generation being more attuned to the debate on risk, which pervades all areas of human interest such as health, sports, and motoring (Adams, 1995). Indeed, Green and Hart’s (1996:6) exploration of children’s perceptions of how accidents happen and accident prevention found the children in their study were ‘knowledgeable about accident risks and competent at managing those risks’. This suggests that there may be generational differences in risk perception, which may in turn impact upon risk taking actions. In relation to falls among older people, this may have implications for the way key family members perceive the risk of falls by the older person they are caring for, and undertake actions to reduce the older person’s risk of future falls.

The above discussion has examined three socio-cultural approaches, and highlighted that social, cultural and political processes influence an individual’s construction of the meaning of risk. Each of the approaches has its relevance and importance, for example, Foucault’s (1979) notion of governmentality has provided helpful insights into policy decisions on dementia care (Adams, 2001).

3.3 Current research on risk and risk taking

This section discusses key issues raised in current research on risk and risk taking that may provide helpful insight into the way older people who have had falls perceive risk, and take risks.
3.3.1 Research Relating to Health and Illness: Older People’s Perspectives

This section examines the literature that considers health and illness in old age from the older person’s perspective. It is not the intention to provide an in-depth discussion of all the issues pertaining to this area, but rather, to offer key insight into how risks and falls may be seen in context. It is suggested that how older people perceive health and illness may influence their behaviour, for example, minimising risk, and preventing accidents and falls.

Researchers like Stainton-Rogers (1991), Blaxter (1990), Calnan (1987) and Cornwell (1984), who focus on lay health beliefs, indicate that gender, class and ethnicity influence how individuals define health but there is a lack of consistency in their explanations of health and illness. For example, Calnan’s (1987) study of class differences in health perceptions involved a sample of sixty women in southeast England. He identified four concepts of health: health as ‘never ill’; health as being able to ‘get through the day’, to carry out routines; health as ‘being fit and active’, and taking exercise; and health as ‘being able to cope with stresses and crises in life’ (Calnan, 1987:73). No clear distinctions between the classes were found. Both working- and middle-class women tended to consider themselves as ‘healthy’ if they were not ill and were able to ‘get through the day’, and rejected the notion that poverty caused ill-health. Calnan (1987:12) maintains that irrespective of their social class, ‘women had clear recipes about how to maintain health’ but ‘they did necessarily feel they were applicable to disease prevention’. This view of health can be detrimental to older people, ‘who may be healthy in some respects but not others’ (Cowley, 1999:197).

Blaxter (1990) found that the absence of disease was the most common definition used in her quantitative study based on a large and representative sample of over 9000 people. Where age differences were concerned, she found that older people were more likely to consider health in a more ‘holistic’ way by including the social dimension such as being able to socialise (Blaxter, 1990:31). She also found gender differences, for example, expansive answers were more likely to be offered by women than men when defining
health. In sum, it is suggested that lay perceptions of health tend to include the functional dimension, that is, what the individual considers his or her state of health permits them to do; and the subjective feelings of ‘wellness’ and ‘illness’ (Fee et al., 1999:9).

Fee et al. (1999) studied the social factors influencing older people’s health beliefs and health-promoting behaviours utilising focus groups and in-depth interviews. Three age-groups were studied: 55-64, 65-74, and 75 and over, using a diverse group of participants, for example, those who lived alone, some with or without disability, and people in different types of living accommodation. In their conceptualisation of health, the participants reported the impact of the ageing process on their ‘mental and physical’ capabilities, culminating in them having minor ailments, accidents and memory lapses (Fee et al., 1999:9). They considered health and mobility problems as inevitable in later life, and reported having ‘had little ultimate control over their health in older age’ (Fee et al., 1999:51). This has important implications for my study. If falls are perceived by older people as related to their health, it could be deduced that older people may feel they have little control over their falls, and that mobility problems causing falls were seen as an integral part of the ageing process. This perception may influence their subsequent actions in relation to the risk of falling, and the prevention of future falls.

Several causes of diseases and disorders associated with ageing have been identified by the Medical Research Council (1994) which include problems with sight, hearing, dentition, cardiovascular and cerebrovascular diseases, osteoporosis and osteoarthritis, dementia, depression and incontinence. However, it is argued that the biomedical perspective tends to view the individual as responsible for ‘changing unhealthy habits and adopting more healthy lifestyles’ (Sidell, 1995:14). This approach also implies that the individual is in control of their health despite evidence that suggests that much ill-health is beyond the control of the individual (Acheson, 1998).

A study by Morgan et al. (1997) on the perceptions of older people about the significance of symptoms and the action they would take in response to particular symptoms, found
that many symptoms classically associated with common diseases were often seen as normal by older people. The researchers highlight the dilemmas faced by older people:

If they [older people] can cope with the activities of daily living, they may regard themselves as healthy, despite having what we regard as medical disease ... If to have ill health is to be old and to be in good health is not to be old, then ageism (internal and external) will make older people reluctant to describe themselves as anything but healthy ... If some older people also regard normal ageing as a process that inevitably means disease, they may feel that there is no point in disturbing their GP (Morgan et al., 1997:428).

This may provide an explanation as to why many accidents, such as falls, are not reported by older people who would rather not seek medical attention. This is supported by a recent study by Kingston (1998) indicating that 87 of his sample of 109 older persons who had had a fall had not discussed the fall either with their family members or with a friend. Kingston (1998) argues that individuals often choose to keep a closed 'awareness context' at least as far as family members are concerned. An important implication for my study is that some older people may choose not to reveal to me or to their relatives all the falls they have experienced.

From a sociological perspective, it could be said that the health status of an older person is the result of many factors including 'life-long health habits (such as diet, exercise, and the use of health care), heredity, exposure to occupational and environmental hazards, and access to the health care system' (Morgan and Kunkel, 1998:339). Individual health behaviours are affected by societal values and shaped by the experiences of the individual within their family (Morgan and Kunkel, 1998). Whether falls are perceived by older people and their family members as preventable will be explored in the proposed study, because this will impact upon their perception of having control, and on their subsequent behaviour in relation to the prevention of future falls.

Since lay perceptions of health tend to include the functional dimension, such as their functional ability in getting out and about, it is possible that the impact of the ageing process upon lay perceptions may lead to feelings of having little control over their health, which in turn may influence older people with recurrent falls to think that falls
may be part of their ‘normal’ ageing process. Given that some acute illnesses may present as falls, it is likely that older people may construe the meaning of falls according to the perceived cause(s) of falls.

3.3.2 Research on Risk Taking

Grinyer (1995:42) contends that to assume that risk to health could be separated from social risks would be to minimise the complexity of the response to information about risk. Individuals may weigh the social risks against perceived health risk to decide which is deemed the lesser of two evils. This section will discuss briefly health behaviours by older people and examine how these might relate to the risk taking behaviours adopted by them.

Cook and Procter (1998:278) maintain that ‘risk-taking is part of daily living at all stages of life’, and Josephs (1993) advocates a recognition of risk taking in health behaviour. A study commissioned by the Department of Trade and Industry Consumer Safety Unit (Wynne-Harley, 1991) to determine the extent to which older people consciously accepted or incorporated risks in their daily lives found that most people interviewed saw risks to older people mainly in terms of falls and consequent fractures (of the femur), burns (or fires) from domestic appliances, and hypothermia - sometimes a direct result of a fall and lack of immediate attention. Thus it was found that older people define personal risks in their own way, and manage them by balancing multiple costs and benefits. Older people may accept certain risks in order to avoid being patronised by professionals or younger relatives (Reed, 1998). Wynne-Harley’s (1991) study also found that older people ‘trade-off’ certain risks. She cites an example of a woman who was more concerned about the risk of dying of hypothermia if she fell in an unheated bathroom than being electrocuted and falling over the wires. In another example, a woman continued to use her bicycle to alleviate her arthritis, which was a greater threat to her quality of life than the possibility of being involved in a road traffic accident (Wynne-Harley, 1991). Most older people choose to continue to live on their own rather than moving to a nursing
or residential home, despite knowing they have a greater risk of having falls if they remain in their own home.

The notion of ‘trade-off’ has also been raised by Ryan (1997) who discusses the risk taken by people working with residents with mental health needs. He argued that these people took risks for two reasons: the first being to cut corners in their work, and the second was to do with enabling the person to become more independent. The underlying principle behind these actions is similar to that taken by a mother with a young toddler in that a number of cuts and bruises are an acceptable ‘trade-off for the development of the child as they learn from experience’ (Ryan, 1997:169). Ryan also recognises that some injuries are not acceptable to the mother who will intervene to prevent those occurring. This could be applied to family caring situations where an older person and/or a key family member might accept a few bruises and cuts resulting from the older person’s fall as an acceptable ‘trade-off for the maintenance of the older person’s independence. However, if the fall experienced by the older relative has undesirable consequences such as bone fractures, the older person themselves and/or their key family member might intervene to minimise the effects of the undesired event or to try to prevent future ones from happening.

The Risk of Falling

The risk of falling amongst older people is well documented. Injuries from falling result in significant costs to health and social care services, and a loss of independence for the older person (Easterbrook et al., 2001). The risk of experiencing a fall increases during the retirement decades, with those in the oldest age group, 85 and over, at greatest risk of falling (Dowswell et al., 1999; Lord et al., 2001). For example, Parker and Pryor (1993) noted that the average age for hip fractures occurs at 80 years.

Where older people living alone are concerned, the World Health Organisation (WHO) (1977) identified them as an ‘at risk’ group, and they were seen as a target for specific attention by the Royal College of General Practitioners (1990) in their report on assessment of older people. Medical sociologists, Taylor and Ford (1983:705) identified
older people living alone as an 'intermediate' risk group, alongside 'the recently widowed and those from social class V'. This is not supported by other studies, for example Iliffe et al. (1992), who originally hypothesise that older people living alone are an 'at risk' group, with a high level of morbidity which leads to greater demands on health and social services found that there were no significant differences among those living alone and those living with others in measures such as cognitive impairment, impaired mobility, or use of general practitioner or hospital services. In both of these studies (Taylor and Ford, 1983; Iliffe et al., 1992), the definition of risk is not provided, and it is an imposed definition deriving from a defensive biomedical perspective, rather than reflecting the older person's subjective perspective.

The medical perspective in caring for older people tends to focus on pathological aspects of ageing, particularly the way that some older people with health problems face accentuated risks. Bennet and Ebrahim (1995) suggest that changes in eyesight such as a reduction in acuity, or in mobility status, may place an older person at greater risk because of their inability to manage hazards related to the environment. This may consequently lead to falls since environment hazards are found to be one of the risk factors for falls. But this biomedical perspective provides a narrow understanding of the risk perceptions of falls by older people.

From a sociological perspective, Martin (1999:21) found an 'absence of material relating to ‘risk’ in older age’, and had to draw on other work which relates to young people and sexual health in order to extend her understanding of the construction of risks. She argues for ‘a sociological understanding not of ‘risk-taking’ behaviour, but of how people think about risk in different contexts, and how this impinges on both their sense of identity and on their everyday practices’ (Martin, 1999:22). The benefits of being perceived as an active, less dependent older person may outweigh the risk of falls and the restrictions imposed by self and/or others from activities such as shopping.

Denscombe (1993:507) indicates that perceptions of the extent of risk are crucially affected by the ‘dread factor’, the vividness of the risk, the frequency with which the risk
is encountered, the ‘sense of invulnerability’, and the ‘tendency to dismiss low risks are negligible and not worth worrying about’. Denscombe (1993) maintains that the dread factor influences perceptions in relation to the level of risk posed by a particular threat. How vivid a risk is can be influenced by two salient factors: personal experience and exposure to information. In other words, the more frequently an individual is confronted with information concerning a specific risk the lesser the individual regards the risk. Dencombe (1993:507) explains:

Where people are exposed to a risk frequently the evidence is that they tend to perceive the risk as less likely to happen than they would if they were exposed to the risk only occasionally. The more regular and routine is the exposure of the risk, the lower is the expectation that the risk “could happen to me”.

Douglas (1986:29) refers to the evidence that ‘people tend to underestimate the level of risk where it is objectively a “low probability” risk: they underestimate risks of events that are rarely expected to happen’. The above has implications for older people who have had recurrent falls. It could be that those who experienced more frequent falls might perceive themselves to be more likely to fall again, which in turn, could influence their subsequent actions in preventing future falls. Those who seldom experience falls might be dismissive of their risk of falling, which may result in them not being pro-active in taking measures to prevent future falls.

The proposed study will provide a broader scope through an exploration of the risk perceptions of falls by older people and how these impact on their subsequent behaviour. Another strand of the study is to determine how the meaning of risk by older people is influenced by gender.

3.3.3 Home Environmental Risk and falling

Earlier discussion has indicated that the environment poses a risk of falls among older people. The type of environmental challenges that an older person chooses to expose themselves to, or, in other words, the extent of a person’s risk taking behaviour, would be expected to be an important part of the interaction between the older person and their
environment (Lord et al., 2001). This section examines the literature relating to how environmental risks are perceived by older people, drawing upon the work of Clemson et al. (1996; 1999) and Carter et al. (1997) who have examined the home environments among older people who have had falls.

Clemson et al. (1996) conducted a case-control study to assess older people’s homes for environmental hazards as risk factors for falls. Their study involved 252 subjects aged 65 and over: 52 hip fractures cases, 43 who had two or more falls in the past year but no hip fracture (they were classified as ‘fallers’) and 157 ‘non-fallers’, that is, those without hip fractures and with fewer than two falls in the past year. All were aged 65 and over, and were referred to an occupational therapy department for home assessment. They found that the homes of ‘fallers’ were no more hazardous than the homes of non-fallers. It was also found that those fallers who had cognitive impairment had significantly more hazards in their homes than non-fallers with cognitive impairment. One explanation for the lack of association between falls and home hazards in this study is that hazards that were involved in falls had been removed or modified by the time of the home assessment. Another explanation is that their sample were ‘fairly frail’ (Clemson et al., 1996:100), as there is some evidence to suggest that intrinsic factors such as physiological changes, not the environment, cause most falls among frail older people (Morfitt, 1993). However, an examination of the perceptions of older people in relation to hazards in their home environment would have provided greater understanding about risk perceptions.

A subsequent study by Clemson et al. (1999:531) used in-depth interviews to explore the perspectives of nine older women who had not ‘followed through’ with environmental modification recommendations to reduce their risk of falls in the home, focusing on what influences women not to follow these recommendations. The core concept of ‘exerting control’ was found to provide an explanation for such behaviour. Clemson et al. (1999:537) observed that:

Exerting control was a behavioural, cognitive and affective process whereby the women made decisions about whether or not to follow through with environmental modification recommendations based on their knowledge of
environmental risks, perceptions of degree of risk, perceived ability to mediate these risks through behaviour and the degree of freedom she had in decision making.

Exerting control also meant that some of the women achieved control over their environment by using behavioural strategies such as ‘taking care’ and ‘slowing down’ to prevent future falls (Clemson et al., 1999:537). It is, however, not known if older men with recurrent falls might exert control in the same way as these older women. The proposed study will extend the work of Clemson et al. (1999) by examining the extent to which gender influences the subsequent actions of older men and women with recurrent falls, and that of their key family members.

Carter et al. (1997) investigated the prevalence of environmental safety hazards in the Australian homes of people aged 70 years and over, and their knowledge of causes of injuries to older people and the safety measures that were implemented to prevent such injuries. A cross-sectional interview survey of 425 people was completed, followed by a home safety inspection that used a predetermined format. The study found that 80% of homes had at least one hazard and 39% had more than 5 hazards. Eighty-eight percent of participants were able to identify falls as the most common cause of injury and 87% accurately named at least one safety measure. Although many of the older people knew what could be done to prevent falls in general terms, they had not made changes to make their homes safer. Carter et al. (1997:200) also noted that many of them did not think their homes were unsafe (97% of the sample rated their home as fairly safe or very safe), ‘although they were potentially very hazardous’. However, those who were never seen by service providers were ‘twice as likely to have more than 5 hazards as those who were visited weekly or more often’ (Carter et al., 1997:200). Thirty percent of older people who considered their homes as very safe had more than 5 hazards, while among those who rated their home as very unsafe, not very safe or fairly safe, 57% had more than 5 hazards. Their study offers insight into how older people perceive the safety of their home environment, and that recognition of home hazards does not necessarily lead to actions to make their home safer. However, it is recognised that some older people, have health problems that put them at risk, for example, reductions in visual acuity, hearing and
mobility may lead to a reduction in an older person’s ability to manage environmental hazards (Reed, 1998).

Manthorpe and Alaszewski (2000:59) explored ways in which users and informal carers view risk, and found that older people were ‘aware of the hazards presented by their homes and the harm that could result from an accident’. For example, older people felt they were more likely to have an accident, such as a fall, inside their home than outside, and identified other hazardous activities including cooking. Older people also perceive risk as applicable to all areas of life, and ‘as something they had to learn to live with’ (Manthorpe and Alaszewski, 2000:59). This attitude has implications for the actions older people who have had recurrent falls undertake to minimise their risk of future falls.

The above illustrates that environmental risks leading to falls among older people need to be identified by older people themselves so that they can make personal choices about the types and levels of risks which are appropriate in certain situations. Older people’s attitude towards risk such as perceiving risk as something they had to learn. But older people may sometimes not be considered to have the ‘intellectual’ capacity to weigh up such risks and make choices for themselves, therefore, to have a better understanding of the meaning attached to falls, it is worthwhile exploring health professionals’ and family carers’ perceptions of risk.

3.3.4 Health Professionals’ and Family Carers’ Perceptions of Risk

Risk has been a central theme in the care of older people within the community (Alaszewski and Alaszewski, 2000). The literature on risk concerning older people acknowledges both the need for them to have rights and choice, and at the same time that they may be vulnerable to and need protection from harm (Alaszewski and Alaszewski, 2000). From a professional perspective, seeking to identify the factors that put an older person ‘at risk’ of harm from accidents and other hazards is an aspect of risk assessment (Brooker et al, 1997:182). Professionals are also engaged in risk management, which is
considered to be empowerment-oriented, ‘seeking to counteract “ageism” by stressing the positive aspect of risk taking’ (Alaszewski and Alaszewski, 2000:31).

Reed (1998) noted how often older people are stereotyped as intrinsically cautious and risk averse, and suggested that health professionals’ approach to risk underpins most of the discussions of how older people view and respond to risk:

Much of the material concerned with risks for older people is produced by professionals, researchers and policy-makers, and reflects their perspectives. Images of frailty and vulnerability predominate. Responses to these images express either paternalistic concern with protection, or an equally paternalistic promotion of risk-taking. Both positions fail to take into account the ability of older people to make their own decisions (Reed, 1998:251).

Wright with Whyley (1994) employ a risk assessment approach in their study which involved interviews with frail older people, relatives of people with dementia, local authority and private agency home care organisers and assistants, and district nurses. Participants were asked about their personal experience of ‘domestic accidents and the safety hazards they perceived for older people at home’ (Wright with Whyley, 1994:26). The researchers found that gas and electric appliances, and in particular, falls were major hazards:

Inevitably falls were the most common type of accident described. Three common underlying reasons appeared to be ill health, excessive alcohol consumption, and environmental factors. In addition, a significant number of falls appeared to be spontaneous, with no obvious underlying cause (Wright with Whyley, 1994:27).

Accidents such as falls highlight the debate concerning the vulnerability of older people. This raises the issues of risk assessment and of managing risk (Manthorpe and Alaszewski, 2000). It also highlights the need to sustain older people’s autonomy and independence that would require an approach that involves balancing ‘the risk of accidents against the autonomy provided by reasonable risk taking’ (Alaszewski and Alaszewski, 2000:34).
Concerned that nurses and other health professionals might focus more on hazards and the harmful outcomes of failures to identify them, Alaszewski and Alaszewski (1998) examined their responses to decision making situations. The authors interviewed health professionals and examined the diaries they kept of their own observations of 'real' clinical decisions. Participants were asked to identify at least two decisions made during each shift. The study found that some of the health professionals 'had to balance the client’s rights to take risks against the professional’s obligation to ensure safety and to minimise harm' (Alaszewski and Alaszewski, 1998:109). The study also found that safety was 'more closely linked to risk than vulnerability and abuse' (Alaszewski and Alaszewski, 1998:110). Risk was also felt to be a key element in decision making and underpinned the health professionals’ decisions, an example being the maintenance of a safe environment. The study concluded that health professionals defined risk primarily in negative terms as hazard, danger and negative outcomes of action, and that their definitions of risk were related to their perceptions of the influence of risk on their professional practice. It also highlights the potential discord involved when health professionals perceived that their clients’ best interests conflicted with the expressed wishes of one of the participants in the decision-making process. In relation to falls among older people, a potential dilemma may arise in situations where older people's safety issues are seen as a priority, and risk taking discouraged.

The dilemma of safety issues has also been discussed by Watkin (1993:606) in relation to situations where nurses needed to assess the extent of risk when planning interventions with older people. An example involves an older woman who suffered a stroke:

At the night hospital Mrs Jones slept in a Parker-Knoll recliner chair, with no cot sides, despite the fact she became restless in the night, as she was less frightened and more comfortable in a chair than in a bed ... Naturally there were risks involved with using the chair, and Mrs Jones did fall from it on one occasion, but the risks were considered less important than the rights she gained in terms of comfort and freedom ... Surely most elderly people would prefer to be cared for by a nurse who allows them independence even if they consequently have a fall, than one who denies them any independence? (Watkin, 1993:606)
This highlights the potential problem of being too protective as it denies older people any rights and choice.

Little empirical work has examined older people and their families’ perceptions of risk of falling, although the issue of risk has been addressed in relationship to other areas of health and social care (Alaszewski et al, 1998), and the provision of care to older people (Brearley, 1982; Chater, 1999; Manthorpe and Alaszewski, 2000). Clarke and Heyman (1999) distinguish the family’s perspective on risk and that of professionals in relation to risk associated with people with dementia and their families. Their study suggests that the family’s perspective on risk is influenced by their experience of the person with dementia, and the family’s understanding of the needs of both themselves and the person with dementia. This contrasts with the professional’s view which was invariably influenced by their pathological approach to dementia, and the association of physical and mental decline with dementia. Clark and Heyman (1999) also indicate that risk is a construct used by family and health care professionals.

It is suggested that the risk perceptions of family carers can impact upon the subsequent actions of older people who have had recurrent falls. Family carers may become protective of their older relative, and may be reluctant to take the risk of allowing the older person to live an independent life. Wynne-Harley (1991:11) noted that ‘families tend to worry very prematurely even about healthy active parents even those in their late 50s’. Concern may be channelled towards encouraging a move to smaller, newer or otherwise more appropriate accommodation for the coming years. This view may be deemed as a constructive action and one ‘which may possibly avert a need for what many believe to be inevitable residential care in the future’ (Wynne-Harley, 1991:11). Given this stereotype of frail old people by some family carers, it may be that older people, when confronted with recurrent falls, might choose not to inform their family carers for fear of being channelled into alternative accommodation. Indeed, one study found that after controlling for other factors, the odds of entry into care were three times higher for those who had suffered an injurious fall than those who had not (Wilkins, 1999).
In their examination of informal carers’ view of risk, Manthorpe and Alaszewski (2000) interviewed groups of carers providing support for a variety of different vulnerable people. It was found that carers tended to view risk in terms of negative consequences, as hazard and harm; many carers identified the external environment as dangerous and found that they took measures to ensure that the vulnerable person stayed at home, and others were concerned about hazards in the home. The study indicated that that there is ‘a degree of convergence between how family and nurses view risk, with most agreeing that it was both inevitable and to be encouraged if any predictable dangers could be eliminated’ (Manthorpe and Alaszewski, 2000:70).

This section has examined current research on risk and risk taking, from both the older person’s perspective, as well as the professionals’ and family carers’ perspectives. Evidence from research relating to health and illness suggests that the majority of lay people tend to perceive health in terms of functional ability. Factors found to have an influence on their health beliefs include mental and physical capabilities, as well as their notions of control. However, in relation to risk taking, it has been suggested that older people sometimes ‘trade-off’ in order to maintain their independence. Other factors such as personal experience and exposure to information have also been shown to have an impact on the way risk is perceived, and actions taken.

It was highlighted that a dilemma exists for both professionals and carers in relation to the maintenance of safety in the interests of older people. Professionals may engage in empowerment-oriented risk management by stressing the positive outcomes of risk taking. The dilemma faced by professionals and carers also centres on the need to balance ‘the risk of accidents’ with the maintenance of autonomy by older people (Alaszewski and Alaszewski, 2000:34). This issue could influence the way family carers respond to older people’s risk of falling, and their subsequent actions to prevent falls.
3.4 Autonomy and Control in relation to Risk

In relation to the meaning of falls and the risk of falling, the notions of autonomy and control are relevant since these may influence older people’s perceptions of whether they think they have some control over events such as accidents and falling and therefore could prevent them from happening. Citing the work of Giddens (1976), Cowley (1999:200) points out that ‘ascribed meanings, norms and power relate to the particular context of a person’s life and the experiences they have had in the past and expect to have in future’. In other words, having greater control over one’s life is an important aspect.

3.4.1 Autonomy

Cook and Procter (1998:281) state that the concept of autonomy refers to ‘an individual’s ability to make rational decisions, and put them into practice’. To be autonomous, the personal attributes required include comprehension of the situation, and social power to obtain relevant information and implement decisions (Cook and Procter, 1998). To the extent that older people ‘continue to be stereotyped as dependent, senile and institutionalised, and as a burden on their families and the welfare state’ (Fee et al., 1999:15) they are likely to be perceived as not autonomous or not in control of their lives. Diminished autonomy may result from changes in social status, such as the stigmatisation of disability or old age, or from withholding of information, and from symptoms such as cognitive impairment, depression or severe pain (Cook and Procter, 1998). In health care provision, often there is debate regarding the patient’s capacity to act autonomously (Beauchamp and Childress, 1994). The following discussion will examine the meaning of autonomy because of its relationship to independence and also because it is one of the main ‘tensions’ in relation to decision-making in family caregiving (Cicirelli, 1992). Some of the discussion is drawn from a literature review by Davies et al. (1997) on autonomy and independence for older people.

Davies et al. (1997:409) highlight that ‘definitional precision is rarely encountered within the literature and autonomy remains a widely used but loosely defined concept’.
Referring to work by Atkinson (1991), Macmillan (1986) and Hertz (1993), Davies et al. (1997:409) suggest that autonomy, as a concept, is ‘both multidimensional and context-dependent’. This is supported by Arber and Ginn (1993:19) who see autonomy as ‘a separate dimension from independence, since an individual may be dependent on another person for personal care, but still have autonomy’.

There is a lack of congruence in the usage of the term autonomy in the literature, Cicirelli (1992) suggests that autonomy may be treated as synonymous with independence while Collopy (1988) considers them as separate concepts. Davies et al.’s (1997) review identifies two types of autonomy, namely decisional autonomy or decision making, and executional autonomy (implementing decisions). Their review explains that the former type requires an individual to be capable of ‘rational thought and self-governance’ (ibid.:409); although it is unclear what self-governance is meant to be, for example whether self governance is synonymous with independence.

The dilemma of autonomy versus beneficence, highlighted by Cook and Procter (1998) and discussed above, may arise in the negotiation between family carers or health professionals and older people, where one party believes that they can take decisions on behalf of the older person. The authors also highlight the dilemmas faced by nurses who attempt to balance the maintenance of safety and the promotion of patient autonomy, a view echoed by Brooker et al. (1997).

Autonomy, as a moral entitlement of persons, has been considered as ‘a powerful therapeutic agent in its own right’ (Cook and Procter, 1998:282); enhancing a person’s sense of autonomy is found to benefit the person’s health (Rodin and Langer, 1977). In their study of nursing home residents, Rodin and Langer (1977) experimented with residents’ perceived levels of control over their environment by exposing two groups to different ‘pep talks’ about control and personal responsibility, whilst receiving similar care. The experimental group was encouraged to take more responsibility and was found to be in significantly better clinical condition than the control group after three weeks, and after 18 months. Although the mechanism for this change cannot be explained
clearly, the study suggested that the benefit of giving residents more autonomy might have resulted in changes to the way residents interacted with staff, relatives and others, which in turn benefited their health.

Percival's (1996) research into life in sheltered housing found that autonomy was important to the tenants. Using interviews and observations of tenants living in a local authority sheltered housing scheme in London, Percival (1996) reported that having the freedom to be independent and the ability to make their own choices were highly regarded by tenants. It was highlighted that these may be at odds with what the warden perceived to be a priority, that is, the need to maintain a safe, secure and protected environment.

In the light of the above discussion it is suggested that to an older person who has had falls being autonomous may mean being able to take responsibility and make decisions about the level and type of risks he or she takes in relation to the possibility of them falling again. It also implies that older individuals have the necessary resources to implement their own decisions to prevent future falls.

3.4.2 Control

Ponto (1999) maintains that having perceived control over events can boost a person's self-esteem and promote better adjustment in later life. In contrast, it is suggested that loss of perceived control can result in low self-esteem, low morale and ill health (Langer, 1983). The locus of control theory (Rotter, 1966) maintains that 'people tend to believe either that they have, or they do not have, some control over their lives' (Nettleton, 1995:40). Calnan (1994:70) adds:

This construct consists of three different dimensions about the source of control of health: the internal, powerful other, and chance. People who score high on the internal scale are more likely to believe that health is the result of their behaviour, while high scores on the other two suggest either that health depends on the power of doctors or on chance, fate, or luck.
It needs to be recognised that the construct of control is multi-faceted (Skinner, 1996). Where falls are concerned, McKee et al. (1999:560) highlight the ‘lack of an explanatory framework that could explain why certain control cognitions work and why others do not’. Their discussion is based on a study relating to the psychological perspective on falls among older people, and suggests that efficacy beliefs about how one recovers following a fall are not associated with the outcome of recovery, whereas a person’s perception of the preventability of falls do influence their recovery from falls.

In essence older people could perceive the causes of falls as being the result of their behaviour, such as being always in a hurry and not looking where they are going, or something which happens by chance, or fate. There has been very limited research in this area, and my study will enlarge on this body of knowledge by examining the construction of the meaning and causes of falls by older people who have had falls.

3.5 Conclusions

This chapter has examined the literature pertaining to risk, and the theoretical approaches in which risk is located. Risk and the other related terms of ‘hazards’, ‘safety’ and ‘risk taking’ have been examined. It has been shown that risk taking is part of daily living at all stages of the life course, but how older people incorporate risk involves balancing costs and benefits. Some factors influence the perceptions of risk and these include the perceived level of risk posed by a particular threat, personal experience, exposure to information, the sense of invulnerability, and the frequency with which the risk is encountered. Some older people ‘trade-off’ certain risks, and this could influence their social meaning of falls, and their actions in preventing future falls.

It has also explored how notions of health and illness could influence the social construction of the meaning and risk of falls by older people. The biomedical model of health associates ageing with a reduced ability to maintain homeostasis, whilst the social model places more significance on physical and socio-environmental interactions. Notions of health and illness from older people’s viewpoint can influence their behaviour
in terms of minimising risk and preventing falls. Older people’s explanations of their falls, particularly what causes them, might be influenced by their perceived state of health and well-being.

The concepts of control and autonomy have been explored in terms of the ways in which they impact on the meaning of falls. Little is known of how older people exert control over decisions in relation to preventing falls, although Clemson et al. (1999) have indicated that awareness of home environmental hazards can influence older women’s ‘follow through’ with professional recommendations for environmental adaptation.
Chapter 4

Gender and Generation: Family relationships

This chapter will focus on gender as a social construct and how it might influence the identities of older men and women who have had falls, and the inter-generational relationships between these older people and their key family members. Particular aspects of gendered identities such as that of gendered responsibility and dependence, control and power will be explored. Since gender and ageing are intimately linked in social life, these will be examined in relation to negotiations within the family, and the nature of caring within various types of relationships within the family.

The approach taken in this thesis will be based on a constructionist perspective. Courtenay (2000:138) further explains:

Women and men think and act in the ways that they do not because of their role identities or psychological traits, but because of concepts about femininity and masculinity that they adopt from their culture.

In other words, gender is ‘something that one does, and does recurrently, in interaction with others’ (West and Zimmerman, 1987:140).

This chapter will begin with a critical examination of the ways in which gender is socially constructed. With particular focus on older people, it will explore the influence of gender on risk and responsibility, dependence, and power and how these impact upon inter-generational relationships, and the nature of caring within the family.

4.1 Gender as a Social Construct

An examination of the conceptualisation of gender within sociological literature indicates how diverse it is. Whilst there is a general acceptance that gender relates to ‘something to do with the social behaviours and characteristics associated with biological sex’ (Howard
and Hollander, 1997:11), there is little consensus on what this statement actually means. Its synonymous use with related terms such as sex, gender role, gender stereotype, gender identity, sexuality, and sexual orientation, may be an explanation for the lack of consistency in its meaning (Howard and Hollander, 1997). Moreover, Goffman’s (1976) discussion of ‘gender display’ and West and Zimmerman’s (1987) ‘doing gender’ extend its meaning. Nonetheless, the clear distinction between sex and gender by many writers including West and Zimmerman (1987:127) is particularly helpful:

Sex is determined against socially agreed upon biological criteria for classifying persons as female or males, and gender is the activity of managing situated conduct in light of normative conceptions of attitudes and activities appropriate for one’s sex category.

That gender is a prominent source of identity is acknowledged, although research on gender tends to centre on differences between women and men (Howard and Hollander, 1997; Thompson, 1994; Gonyea, 1994; Connell, 1995). The World Health Organisation (1998:10) indicates that:

Gender relates to how we are perceived and expected to act as women and men because of the way society is organised, not because of ... biological differences.

However, it is suggested that the approach used by Goffman (1976) and by West and Zimmerman (1987) on ‘gender display’ and ‘doing gender’ respectively will help our understanding not only of how older people perceive falls but also how gender may impact upon the subsequent actions of both older people who have had falls, and that of their key family members.

4.1.1 Masculinity and Femininity

From a social constructionist approach, different meanings of masculinity and femininity exist within any one society at any one time (Kimmel, 2000). Hence, it is argued that not all individuals are the same since their experiences are ‘structured by class, race, ethnicity, age, sexuality, region’ (Kimmel, 2000:10). Cameron and Bernardes (1998:686)
contend that masculinities depict the varied ways ‘men’s maleness’ could be expressed, and Thompson (1994:xii) maintains that men ‘could have their own age-specific standards of masculinity’. These views highlight the complex ways in which masculinity is conceptualised.

Connell’s (1995:44) suggestion that masculinity and femininity are ‘inherently relational concepts’ reflects ‘the processes and relationships through which men and women conduct gendered lives’ (p71). Historical definitions reinforce ‘power relations of men over men’; traits of ‘authority and mastery’ are often associated with masculinity, and traits of ‘passivity and subordination’ with femininity (Gonyea, 1994:237). This appears to be congruent with what Connell (1987:183) calls ‘emphasised femininity’, which is arranged around compliance with gender inequality. Charmaz’s (1995:267) exploration of the identity dilemmas of chronically ill men found that ‘the dilemmas revolve around these oppositions: active versus passive, independent versus dependent, autonomy versus loss of control’. It could be argued that these identity dilemmas may be similarly experienced by older people who have had recurrent falls, who may feel a loss of control when they fell.

4.1.2 Gender Display

Goffman’s (1976:75) account of ‘gender display’ is based on the premise that when people interact with each other, displays provide evidence of each person’s ‘alignment in a gathering’ - the position he or she seems prepared to engage in a social situation. These displays are ‘highly conventionalized behaviours’, scheduled at junctures in activities (for example, doing something or engaging in discourse) (Goffman, 1976:69). The schedule of junctures can be at the beginning or end of activities so that interference with the activities themselves may be avoided.

Goffman (1976:75) further explained masculinity and femininity as:
Prototypes of essential expression—something that can be conveyed fleetingly in any social situation and yet something that strikes at the most basic characterisation of the individual.

Its usefulness as a concept has been examined by Connell (1995) and others. For example, West and Zimmerman (1987) explored how gender might be ‘constituted through interaction’ by turning to Goffman’s (1976) ‘gender display’ for the development of their argument. Since the focus of my study is on older people who have had falls, it is suggested that coping with their falls may be regarded as a testimony to their ‘essential expressions’ of masculinity and femininity. The social meaning of falls by older people may be influenced by the social situation in which falls are experienced; whether the fall experienced by the older person was in a public place, and how others responded to them.

4.1.3: ‘Doing Gender’

West and Zimmerman (1987:130) saw the need to move beyond the notion of gender display to examine what is involved in ‘doing gender’, that is, ‘an ongoing activity embedded in everyday interaction’. Within their interactionist approach, it is argued that the distinction between sex and gender will further describe what doing gender involves (West and Zimmerman, 1987).

The way people are categorised into ‘girl’ or ‘boy’ or ‘woman’ or ‘man’ functions in a social way, thus if people can be seen as ‘members of the relevant categories, then they are categorised that way’ except ‘in the presence of discrepant information or obvious features that would rule out its use’ (West and Zimmerman, 1987:133). Thus, in managing social situations, a person may be ‘doing gender’ so that whatever the particulars, ‘the outcome is seen and seeable in context as gender-appropriate, or gender-inappropriate’ (West and Zimmerman, 1987:135). That is, gender is not ‘what we are but something that we do’ (Risman, 1998:23). An example of ‘doing gender’ can be seen in a situation where a man ‘does’ being masculine by taking a woman’s arm to guide her across a street. The woman ‘does’ being feminine by consenting to be guided and not initiating such behaviour with a man (West and Zimmerman, 1987:135). This gender
display is managed in such a way that its outcome is viewed in context as gender-appropriate or gender-inappropriate if the woman initiates the behaviour or resists the assistance. In relation to falls among older people, it could be suggested that a man 'does' being masculine by assisting an older woman when she falls, and not to help her would be viewed as 'gender-inappropriate'. Likewise, for an older woman who has fallen, to resist assistance would be interpreted as 'gender-inappropriate'.

Although the tradition of 'doing gender' has been widely accepted in feminist sociology, it also has its weakness since it implicates legitimate inequality, suggesting 'what is female in a patriarchal society is devalued' (Risman, 1998:23). Its weakness also lies in its neglect of 'inadequacy felt among gendered selves' (Risman, 1998:24). Nonetheless, following this tradition of 'doing gender' could potentially explain the actions and attitudes of older men and women who have had falls.

4.1.4 Gender as a Structure

Building on the work of other gender theorists such as Connell (1987), Lorber (1984), and West and Zimmerman (1997), Risman (1998) believes that the opportunities and constraints that are negotiated during social interactions help to explain the privileges that men have in families. Although her thesis relates to the continuing gender inequality in American family life, it has much to offer to our understanding of gender, and its impact on the individual and the family. The premise of Risman's (1998:6) argument is that we are 'unequivocally taught to be feminine women and masculine men', because we adhere to the rules expected of us in our behaviours. Any deviation from this principle can result in individuals being judged immoral and incompetent as men and women.

Fundamentally, Risman's (1998) perspective on gender as a social structure suggests that: a) gender is a social structure which is the basis of sexual stratification, b) the existence of such a structure 'both enables and constrains action' in a way that some people have more privileges than others, which 'nearly always subordinating women to men' (Risman,
the gender structures operate on the individual, interactional, and institutional level, and d) these structures can change (see Risman, 1998:29).

Risman's (1998:17) analysis of gender theories from a historical perspective highlights, for example, that the limitations of the sex-role theories have serious conceptual weaknesses because they 'presume behavioural continuity throughout the life course'. Other conceptual weaknesses include the preference to view gender at individual levels, such as the differences between 'biological males and biological females', and not acknowledging the role of 'interactional expectations and the social structures', (Risman, 1998:17). This contrasts with Kimmel's (2000:16) contention that:

We learn the appropriate behaviours and traits that are associated with hegemonic masculinity and exaggerated femininity, and then we each, individually, negotiate our own path in a way that feels right to us.

Whilst Risman's argument reflects a resistance to gender stereotypes, it ignores the dominance of men over women, such as that seen in the workplace, and in the traditional family when men were regarded as head of the family. Kimmel (2000:16) explains:

The social institution of our world-workplace, family, school, politics-are also gendered institutions, sites where the dominant definitions are reinforced and reproduced, and where "deviants" are disciplined. We become gendered selves in a gendered society.

In other words, the organisations of our gendered society have evolved in ways that reproduce both the differences between men and women and the dominance of men over women (Kimmel, 2000). The dominance of men over women has been highlighted by Whitehead (2002) who examines the dominant notions of femininity and masculinity. Whitehead (2002:117) further asserts that whilst the public and private spheres are not solid entities, there are distinctions where 'males are particularly visible in their display of masculinity'; that is, in the public world of work, management, and professions. He pointed out that although women might occupy much of the space that is within the public spheres, they do not preside over spaces where power is exercised (ibid.) The above perspective is helpful because it may provide an understanding of a) why older
people may behave in a certain way following their falls, with regards to their perceptions of the cause and consequences of falls, especially whether they thought they were judged to be incompetent by virtue of their deviant behaviour; b) how their subsequent actions following their falls may be gendered; and c) the way in which their expectations of themselves and their identities, and their family’s expectations of them may be gendered, particularly if they adhere to the rules expected of them in their behaviours.

The above discussion has examined the meanings of gender and sex, masculinity and femininity. It has been suggested that gender is a social construct, which provides a prominent source of identity for individuals. It could be said that ‘gender display’ and ‘doing gender’ are related in that the latter has gone beyond the notion of gender display to argue that it is ‘not what we are but something that we do’ (Risman, 1998:23), so that its outcome is viewed in context as gender-appropriate or gender-inappropriate. This perspective may provide an understanding as to why older people may behave in certain ways following their falls, and how their subsequent actions may be gendered. As Risman (1998:26) suggests, to understand human action, ‘we must understand not only how the social structure acts as constraint but also how and why actors choose one alternative over another’.

4.2 Gendered Identities: Responsibility, Dependency and Power

The different life experiences of males and females, according to Chodorow (1991:279), result in girls being more socialised into having a self-identity of ‘connectedness’ which engenders interdependence whereas boys are more likely to develop a self-identity of ‘separateness’ which fosters independence. In other words, ‘the basic feminine sense of self is connected to the world, the basic masculine sense of self is separate’ (ibid.). This relates to Chodorow’s (1978) assertion that girls learn to attune to and accept the needs of others. It contrasts with boys who become more individualised and status conscious. It is therefore helpful to examine the extent to which these concepts are altered among older people. The following discussion will focus initially on how, from the life-course
perspective, notions of masculinity and femininity might change, which in turn will impact upon an older person's identity. For example, Charmaz (1995) indicates that men's identities can be threatened by illness, and as a consequence men face greater identity dilemmas than women. This section will also examine particular aspects of gendered identities that are considered to impact upon older people who have had falls, and their key family members. The aspects include the gendered nature of responsibility, dependency and power.

4.2.1 Transitions from Adolescence to Adulthood and Old Age

Some of the discussion will be drawn from Williams' (1998) work which explores the ways in which gendered identities impact upon the meanings and management of chronic illness during adolescence, and that of Hockey and James (1993) who examine the conceptual system framing the life course, with particular focus on the life experiences of children and older people.

Although youth and adolescence is described by Jones and Wallace (1992:4) as a process of 'definition and redefinition, a negotiation between young people and their families, their peers and the institutions of wider society', the same could be said of old age since people in old age may have to redefine their role. Adolescence is viewed as a masculine construct (Lees, 1993), with boys and men regarded as the standard in youth research (Williams, 1998). Because of the belief that girls' behaviours are not 'typically' adolescent (for example, being reckless or rebellious) (Lees, 1993), there is complication during their transition to adulthood, which led Daykin (1993:98) to suggest that:

The discourse of femininity itself creates expectation of passivity and submissiveness which continually undermine attempts to obtain the independence and autonomy associated with adulthood.

Williams (1998) notes that although in young children, both masculine and feminine traits are found to be associated with self-esteem; among adolescents, masculinity plays a bigger part in predicting self-esteem. Her study of teenage children with chronic illness
indicates that training for independence was related to the gender of the younger person. The mothers of sons were more involved in providing and supervising the management of their son’s chronic illness, and were ‘actively encouraging their sons to take on more responsibility for self-management as they [sons] got older’ (Williams, 1998:119). In contrast, mothers of daughters were less involved in the management of their daughters’ chronic illness, since their mothers saw the majority of girls as being more responsible, mature and independent. Many of the boys in her study were seen by their mothers as in need of help and support in relation to their chronic illness even though boys were thought to be healthier than girls. In relation to the focus of my study, Williams’ study raises some pertinent questions. How do adult children perceive their older parent in relation to their need for help and support? To what extent and under what circumstances does gender impact upon this?

Within marriage, there is recognition that a degree of interdependence and role reversal may be inevitable especially with increasing age, depending on the balance of capabilities among married couples (Askham, 1995). However, in relation to the way household and domestic responsibilities are divided, it appears that the division of tasks among older couples adheres to traditional gender roles, with women continuing with the feminine tasks and men undertaking a few more tasks, predominantly masculine ones, after their retirement. A dominant feature that stems from their marriage contract among older cohorts is that husbands were expected to be ‘honoured and obeyed’ and their wishes came first (Davidson, 2001).

The extent to which masculine and feminine traits continue from adulthood into old age can be gleaned from the impact paid work has on men. Within marriage, the husband’s retirement has been found to be associated with an increase rather than a reduction in demands upon his wife’s time since he is seen as needing companionship and entertainment (Ward, 1993). Gradman (1994) and Whitehead (2002) note that in adulthood, particularly for men, work brings a sense of masculinity both overtly and covertly. Work maintains perceptions of status, ability and worthiness in men (Knights
and Wilmott, 1999). In other words, it empowers men to meet ‘the social norms for masculine attitudes and behaviour’ (Gradman, 1994:105). Hence, retirement may be seen negatively by men and considered as entry to the ‘feminine aspect of household and family’ (Willing, 1989:61). After retirement, men’s expectations of themselves continue with regards to strength, decision-making and power (Gradman, 1994). This may not be the case for all men since some may retire because of ill-health or disability, impacting upon their perceived self-identity and their expectation of continued power and strength. Older men may regret being less able to continue traditional male tasks within the home than they had undertook when younger (Wilson, 1995). Older women continue to take most responsibility for domestic work for as long as they are able, though some reported doing less domestic work, either through choice or because of disability (Wilson, 1995).

Widowhood in later life may result in less continuity since widows and widowers have to adapt and cope with major change ‘both in gendered roles and relationships and in their images of self’ (Wilson, 1995:109). For example, for most women widowhood meant being in control of their finances, and to do as they wished (Davidson, 2001). Whereas, for widowers, Mason (1996b) found that the loss of a wife deprived them of the sentient activities undertaken for them by their wives. The cessation of this activity is considered a loss by the men.

4.2.2 Gendered Responsibility

It could be expected that older men raised in an era when men were expected to be family breadwinners might have strong expectations about gendered responsibility. The following discussion will explore how the gendered meaning of responsibility can impact upon older people’s perceptions of their falling experiences, their risk perception, and upon their subsequent actions to prevent future falls.

Studies of children indicate that notions of responsibility may be gendered. For example, Green and Hart’s (1996) study of children’s accident narratives, found that boys were
more inclined to tell stories about risks that were deliberately sought, while girls were more inclined to tell stories about their own safety. That girls were more likely than boys to articulate notions of responsibility and learning from their experience led Green and Hart (1996:28) to assert that ‘girls were more likely to present both themselves and other girls as responsible risk managers, and to create gender appropriate identities and gendered notions of responsibility in their narratives about risk taking’. This may have implications for the way older men and women perceive their own responsibility to take actions to prevent future falls. Older men and women may have stereotypical expectations of femininities and masculinities, which influence what they do to prevent future falls.

Gendered notions of dependency and responsibility were explored by Williams (1998:30) who found that the parents of the teenagers in her study, on the one hand, were expected to motivate their children to be independent and manage their own self-care, and on the other, were expected to be responsible for their children when problems occurred. Mothers, in particular, experienced conflict as they were the parent most likely to be seen as responsible for care. In their efforts to be responsible for their children, mothers especially of boys also risk being labelled as overprotective (Williams, 1998). Her study raises some important questions in respect of gendered responsibilities. It begs the question of whether daughters of older people who have had recurrent falls might themselves feel more responsible compared to sons for preventing future falls. In other words, how would gender impact upon adult sons’ and daughters’ notions of being responsible for their older parents in relation to the prevention of future falls?

In relation to risk-taking Lupton and Tulloch (2002) found some gender differences in their participants’ accounts of voluntary risk-taking experiences. Whilst men tend to describe risk-taking involving sporting activities, travelling abroad, or daring deeds, women were more likely to be concerned about sexual risk, risks of violence and crime. However, the authors found that with increasing age, people were not as conservative in their risk-taking, and less cautious because ‘they felt a lessening of responsibility for their family’ (Lupton and Tulloch, 2002:328). This suggests that older people may be willing
to take more risks than when they were younger. In relation to older people who have had falls, it could be that there may be generational differences in the way risk-taking is perceived, which in turn, could impact upon their actions in preventing the older person’s future falls.

4.2.3 Gendered Dependency

Hockey and James (1993) assert that dependency is primarily a social relationship resting upon the exercise of power. In their discussion of gendered dependency, Arber and Ginn (1991:67) note that:

The dependence of men and women for domestic/caring services are rarely acknowledged as dependency and entail little if any loss of autonomy, status or power. If all people are dependent, some are more so than others, in terms of the subordinate status they acquire as a result of their dependency.

They further assert that factors such as class and gender may impact considerably on older people’s access to and exercise of power.

In terms of boys and men, Lees (1993:306) maintains that: ‘Masculine identity is constituted in opposition to everything feminine. It involves a denial of dependence’. For older men, Soloman and Szwabo (1994:56) found that older men who internalise traditional notions of masculinity experience difficulty in acknowledging their dependency on others since this reflects diminished ‘mastery’. This is supported in Gordon’s (1995) study of men with testicular cancer, which found the men attempted to deny or hide their feelings associated with having cancer. In relation to chronic illness Charmaz (1995:268) states that illness can ‘reduce a man’s status in masculine hierarchy ... raise his self-doubts about masculinity’. However, these men not only received positive social identity validations but also private self-definitions which ‘affirmed their gender identities as men in the household’ (Charmaz, 1995:272). These validations came when the men were most physically dependent but retained their central position as husbands.
and fathers. The impact on their wife can best be summarised in Charmaz’s (1995:282) observation:

...partners often find themselves in an elaborate dance around dependency. ... these women provide identity supports for their partners that mute the identifying effects of dependency and loss.

Charmaz (1995) also suggests that in public, some men devote vast energy trying to contain their illness and hide or cloak their disability, on the assumption of preserving their masculinity. At the same time they may maximise the significance of illness and disability in their private lives by changing themselves into ‘dependent patients at home’ (Charmaz, 1995:284). This stance resulted in their wives ‘undertaking roles such as maintaining their husbands’ special diets, and drug compliance’ (ibid.), illustrating how notions of dependency are gendered, that the men did not ‘lose’ their status through their increased dependencies within the private sphere.

4.2.4 Gendered Power

Masculinity and femininity in later life may be hard to express because of the power relationships involved. Gonyea (1994) suggests that masculinity and femininity reflect the processes and relationships through which gendered lives are conducted. Emphasis on the imbalance of power whereby traits of passivity and subordination are associated with femininity has been noted (Gonyea, 1994; Howard and Hollander, 1997). However, West and Zimmerman’s (1987) assertion that ‘women can be seen as unfeminine, but that does not make them “unfemale”’ remains unchallenged.

The notion of power is considered a key one in relation to the proposed research. Issues of power relate to the ways in which older men and women construct their meaning of falls and the extent to which family inter-generational relationships impact upon the actions taken by themselves and by their key family members. Hockey and James (1993:104) state that the family is ‘a model for the structuring of power relationships within society as a whole’, and the metaphoric use of the child/parent relationship as one
strategy through which the care of older people is managed. By ‘parenting’ a dependent older person, the balance of power ultimately lies within the hands of the parent [the adult carer], not with the adult ‘child’ [the older person] (Hockey and James, 1993:114). However, in relation to older people who have had falls and their key family members, it is possible that an unequal relationship has been created between two individuals, both of whom are adults, although this may differ according to the gender of the two parties. This section will discuss the relationship between gender and power, and how this might influence the actions of men and women within and across generations.

Following Matthews’ (1984) concept of ‘gender order’, Connell (1987:99) sees gender order as ‘a historically constructed pattern of power relations between men and women and definitions of femininity and masculinity’. Whitehead (2002:113) draws attention to O’Brien (1983) who posits ‘the fate of the private (reproduction, family relationships-women) in the hands of men’. In other words, the public domain is a place where men’s sense of identity is nurtured. This highlights the gendered power relations that exist in society.

However, in relation to serious illness, Charmaz (1999:220) suggests that it can ‘reduce a man’s status in masculine hierarchies, shift his power relations with women, and raise his self-doubts about masculinity’. She asserts that wives provide their husbands with a ‘continuing link to both past and future identity through the intensity of their involvement in the present’ (Charmaz, 1995:272). In this way, men receive validation of their identity that confirms their positive social standing, and their self-identity. However, little is known about this is affected among non-married men. By contrast, women with chronic illness exhibited greater resilience to illness, and made fewer attempts to cling on to their past selves after permanent changes have been defined (Charmaz, 1995). Charmaz (1995:5) further adds:

Having a chronic illness means more than learning to live with it. It means struggling to maintain control over the defining images of self and over one’s life.
How chronically ill men view their conditions in the light of uncertainty and how their definitions affect their self identity have also been examined by Charmaz (1995). She found that chronically ill men define their conditions in four ways: as an enemy, an ally, an intrusive presence, or as an opportunity (see Charmaz, 1995:275). It appears that a man may hold each of these definitions at different points in time, for instance, a man who may view his condition as ‘an ally’ may redefine it as ‘an intrusive presence’ when his condition limits his activities. She also suggests that ill people relinquish some identities but retain others as some men ‘intensify control over their lives when they develop strategies to minimise the visibility and intrusiveness of illness’ (Charmaz, 1995:276).

Power is more likely to be retained by older men than older women despite their disability and old age. Rose and Bruce (1995) found that even physically disabled men frequently retain power over their wives who are their carers. This contrasts with older women, whose disability reinforces and validates women’s powerlessness (Morris, 1991), although disabled men may experience feelings of conflict between their ‘masculine’ and ‘disabled’ roles. Morris (1991) suggests that this may result in men using their former identity to resist their disabled roles. This is analogous to chronically ill men’s problem of ‘an uneasy tension exists between valued identities and disparaged, that is, denigrated or shameful ones’ (Charmaz, 1995:286), which may explain why many of the men Charmaz interviewed tried not to reveal their illness, especially in public places.

For some older people, their falling events may result in diminished ability to undertake certain activities. It may be possible that some older men who have had recurrent falls find it more important than women to ‘pass’ and not be labelled as a ‘faller’. Older men who have had recurrent falls may feel they were being ‘relegated’ into a lower place in male hierarchies, compared to their female counterparts. My study will explore how the meaning of falls constructed by older people who had had falls impacts upon their identity and their notions of power and dependency, and how this differs by gender.
4.3 Gender and Family Relations

This section of the chapter provides a brief overview of the literature pertaining to inter-generational relationships, with specific attention paid to the negotiations within the family, gender and the nature of caring within the family. Hockey and James (1993:117) highlight the role of the family not only as the social context within which children are raised, but also as ‘a site which is seen to be associated with particular sets of social values’. This is thought to work in two different ways. Firstly, the family continues to be seen as a haven within a hostile environment, the locus of personal, informal social relations, and a refuge from the formal, hierarchical relations of power which characterise the public world (ibid.). Secondly, not only power, but also the notions of equality and closeness are brought into being through the use of family terms. They suggest that parental power, in relation to dependent people of all ages is, however, ‘double-edged, encapsulating the twin possibilities of both care and control’ (Hockey and James, 1993:118).

4.3.1 Negotiations Within the Family

In parent-child relationships, the principle of ‘amity’ operates in the family and within generations (Mogey, 1991). By amity, Mogey (1991:184) meant that:

Goods and services, money and loving, flow from those who control these resources to those who have need of them ... This self-regulating behaviour is continuous between members of different generations.

However, the tendency of sons to distance themselves from the family during the early years of career and marriage is widely reported (Matthews, 1994).

In their exploration of how kin relationships operate in practice, Finch and Mason (1993) suggested that anticipating the need for future help is characteristic of ordinary family life, and that negotiations can happen even if such help is not needed. They highlighted that negotiations may be about giving the other person some opportunities to have a say,
thus protecting their self esteem. What is not known is the extent to which the gender of each member of the dyad within family caring relationships impacts upon the type of negotiations that take place.

Caring within the family involves family members not only in providing direct assistance to the older person but also frequently also ‘managing’ the care he or she receives through formal service providers (James, 1992); this also involves negotiating for or making arrangements on the older person’s behalf, checking on the uptake of formal services, and supplementing any care needed by the older person (Martin Matthews and Campbell, 1995). It is likely that family members caring for an older person who has had recurrent falls may monitor the older person’s needs in relation to preventing future falls, and may decide to make arrangements on the older person’s behalf, without negotiating with the older person in the first place.

4.3.2 Gender and the Nature of Caring

Research studies on informal care by family members tend to focus on an individual as the unit of analysis rather than on dyads or the larger family network, with such studies often describing relationships only through the eyes of one of the participants (Morgan and Kunkel, 1998), and with most research taking the adult child’s perspective (Troll, 1988). Young and Kahana (1989:660) maintain that ‘simultaneous investigations of gender and relationship are infrequent, so few studies can document trends’. They also noted that spouses and children are sometimes contrasted, and when female-male comparisons are made, differentiation is rarely made between adult child and spousal carers. Harper and Lund (1990:243) observed that ‘while there has been considerable research on women as caregivers, male caregivers, generally, have been neglected’.

Despite the above criticisms, these studies provide some understanding on the caring aspects of family life, although they often pivot around the practical everyday living of people in families (Gregory, 2000), for example, housework (Oakley, 1974), and caring
for frail or older people (Finch, 1989). This study provides a broader perspective by focusing on individuals as part of a dyad, in particular, the older mother and son relationship, older mother and daughter relationship, and older father and daughter relationship.

It is argued that the private experience of one’s own family is constantly held up against alternative notions of what should and does not take place. In their analyses of obligation, Qureshi and Walker (1989) and Finch and Mason (1993) have demonstrated the ways in which kinship rules are negotiated in situations and provide an understanding of how family obligations function (Twigg and Atkin, 1994). Qureshi and Walker’s (1989:92) study of the caring relationship among Sheffield families found:

Relatives were ... the principal source of care and tending for the elderly ... it was primarily daughters who were bearing the physical and mental burdens ... the caring relationship was first and foremost one between elderly mothers and younger daughters.

The authors argued that irrespective of the quality of relationships, family members, in particular children, are seen as the first line of assistance for older people. This is consistent with the findings of most studies that people tend to rely on one close family member for all their support needs. Jarvis (1993) noted that this person is usually the spouse, but if a spouse is not available, older people may initiate substitutions in the choice of support provider in the following order: a daughter, followed by siblings, other relatives, friends and neighbours, down to formal service support.

Studies of the nature of intergenerational caregiving have largely focused on female carers. For example, Bowers’ (1987) study of intergenerational caregiving involved semi-structured interviews with 31 female and 2 male adult children caring for their older parent suffering from dementia. Bowers indicated that much of the work of caring is ‘invisible’ because it does not include overt behaviour and may not be easily identified by the person being cared for. Her study identified five categories of caring: anticipatory, preventive, supervisory, instrumental, and protective care. Anticipatory caregiving
consisted of ‘behaviours or decisions that are based on anticipated, possible needs of a parent’ while preventive caregiving ‘includes activities carried out by offspring for the purpose of preventing illness, injury, complications, and physical and mental deterioration’ (Bowers, 1987:25-26). More direct intervention may be needed by the older relative that the carer may give assistance with, and Bowers calls this ‘supervisory care’. Instrumental care includes the ‘hands-on care’, protective care aims to maintain the self-image of the person being cared for. According to Bowers (1987:26), family carers perceive this last type, protective care, as ‘the most difficult and important type of care provided’ since it is often in conflict with other aspects of care, in particular, instrumental care. Bowers found that carers often cited the reversal of role, describing how salient it is to ‘protect both the parent’s identity and the parent-child relationship’ (ibid.). Whilst Bowers’ study provides an understanding of the processes of intergenerational caregiving, an examination of the extent to which gender influences these processes would have been useful.

However, Nolan et al. (1996:43) argue that protective care may be ‘counter-productive and covering up dependency is neither possible or desirable’. The authors maintain that protective care does exist, often motivated by ‘high ideals’ and cited an example of ‘protecting’ the cancer patient from their diagnosis (Nolan et al., 1996:43). They further add that ‘it is essentially paternalistic and often not in the best interests of either the carer or cared-for person’ (Nolan et al., 1996:43). Furthermore, they claim that there were occasions ‘where an older person had been admitted to care in the belief that this was a temporary measure when in reality the carer and the professional involved saw it as a permanent move’ (ibid.). It could be interpreted that older people were inadvertently coerced to accept decisions made by their carer.

Mason (1996b) draws on her work with Finch (Finch and Mason, 1993), and suggests that care is an activity that is multi-dimensional and, relational, involving morality, feeling and thought. Utilising the work of Stanley and Wise (1993), Mason (1996b) advocates the rejection of binary notions of the self and its relationship with the body,
mind and emotions, and introduces two new inter-related concepts, ‘sentient activity’ and ‘active sensibility’, to encapsulate the thinking and feeling around care. ‘Sentient activity’, according to Mason (1996b), refers to thinking and feeling as skilled activities relating to family caring, for example, attending to or interpreting the needs of specific others, and organising or thinking through relationships between self and others. This concept is illustrated through her discussion of Brannen et al.’s (1994) work, who found that mothers (very seldom fathers) engaged in ‘worrying’ about their teenage children’s well-being and activities. This work may be invisible in that the person doing it is not fully aware of all that is involved, and operates mainly on a less conscious plane. Whereas ‘active sensibility’ operates largely on a conscious plane in relation to physical caring activities and decision making in terms of performing tasks, and relates to the activity of feeling a responsibility or a commitment to someone, as Mason (1996b:31) writes:

I am referring to a relationally and socially constructed ‘predisposition’ to draw a connection between self and specific others, and to take on a responsibility to care.

These commitments are considered by Mason (1996b) as being actively constructed through negotiations with others, allowing the person being cared for to play a more active role in the negotiation of care.

4.3.3 Types of Relationships

In order to examine the negotiation between older people who have had falls and their key family members in relation to the actions taken to prevent future falls, it is valuable to focus on some of the types of relationships, namely parent-child and spousal dyads.

Intergenerational relationships between older people and adult children

Research has consistently suggested that gender of parent and child influences the relationship between them. Mother/daughter dyads are typically closer than any other combination, with more daughters acting as confidantes and fewer likely to disappoint their mothers. The relationship most likely to experience conflict is that between a father and son, with cross-gender dyads (mother/son, father/daughter) falling somewhere in between.

Adult children frequently provide informal care to their ageing parents. Where an adult child’s relationship with their mothers is concerned, research tends to examine the impact of caregiving by adult children (McCarty, 1996; Matthews, 1979; Talbott, 1990), and the relationship between mothers and daughters (Chodorow, 1978; Walter, 1991). This focus on women caregivers makes comparison of the relationships between mother/son dyads and mother/daughter dyads difficult.

Research on the relationship between older parents and adult children has been criticised by Mancini and Bliezner (1989) as largely quantitative. Nonetheless this provides an understanding of the role of older mothers in their relationships with their adult children. For example, Matthews (1979) examined the relationship between older mothers and their adult children. Utilising exchange theory (Dowd, 1975), Matthews’ (1979) analysis found that the older mother is less powerful than her adult children in the family. This was not only due to the older mother’s deficiency in resources (both social and material) to exchange with her children but also her lack of access to other relationships from which she could obtain what she needed. Consequently the older mother resorted to using compliance and respect to acquire resources from her adult child or tried to reciprocate in order to obtain the help and resources given by the adult child. Talbott’s (1990:601) study, which also examined the mother-adult child relationship, found that feelings of being ‘unwelcome intruders’ in their children’s lives, and ‘being dependent on their children for emotional support’ had led some of the older mothers to make themselves subservient to their children.

Citing Chodorow (1978), Abel (1990:150) argues that where mother/daughter relationships are concerned, the dominant patterns of parenting have resulted in the development of ‘greater relational capabilities in women who also remain preoccupied
with issues of separation and individuation, especially in relation to their mothers’. The mother/daughter relationship has been reported as one of deep ambivalence (Chodorow, 1978). However, this is challenged by other studies which examine the dynamics of the adult daughter/mother relationship (see Abel, 1990).

Walter (1991:39) suggests that the more ‘peerlike the mother/daughter relationship at the time of the caregiving experience, the less stress the adult daughter experiences as a caregiver’. This study involved individual face-to-face interviews with forty-eight daughter/mother dyads who were not co-residents. A modification of Zarit’s Burden Interview (Zarit et al., 1980) was used to measure the degree of stress experienced by the daughter. Using Fischer’s typology (1986), interviews were coded to determine the type of mother/daughter relationship. Walter (1991:45) explained that ‘a hierarchy of responsibility - the extent to which one member of the pair is responsible for the other’ differentiates four types of mother/daughter dyads. The first type, ‘responsible mother/dependent daughter’ features the mother giving and supervising the daughter’s life; the second type, ‘responsible daughter/dependent mother’ sees the daughter developing a ‘highly protective relationship with her mother in which she is more likely to give than to receive help from her mother’ (Walter, 1991:46). In this type, the role of the daughter is reversed, she is more likely to supervise her mother’s life and is unlikely to seek advice from her mother. The third type of relationship ‘mutual mothering’ is depicted by a ‘balance of responsibility and dependence, with a tendency to supervise each other’s lives, particularly around decision making’ (Walter, 1991:46). The last type of relationship, ‘peerlike’ friendships is characterised where both mother and daughter ‘endeavour to support each other’s autonomy but demonstrates reciprocated concern for one another’ (ibid.).

Walter’s study (1991) provides another dimension as to how the relationship between adult daughter and mother may be perceived, and identifies the nature of the dependence of each member of the dyad within the decision making process. For example, within a ‘responsible daughter/dependent mother’ dyad, the daughter may develop a protective
relationship towards her mother who has had falls, and is therefore more likely to supervise her mother’s life. This will have a bearing on the actions undertaken by the daughter in preventing her mother’s future falls.

Walter (1991) also found that emotional support was one activity most often provided by all the daughters in her study, which is a finding consistent with other studies (Brody, 1985; Lewis and Meredith, 1988). However, daughters are also found to provide not only emotional care but also physical care (Finch and Mason, 1990; Wenger, 1984; Dwyer and Coward, 1991; Horowitz, 1985).

Spousal Relationships
Within family caring research, it has been recognised that spousal care continues to be the dominant type of caring relationship in retirement (Wenger, 1990). It has also been stressed that spousal relationships differ in kind and extent from those featuring child-parent relationships (Young and Kahana, 1989). For example, spouses are more likely than adult children to provide intimate personal care (Stone et al., 1987; Morgan and Kunkel, 1998). However, the gender of the carers can impose a significant influence on the caregiving experience.

Miller’s (1990) study, one of the few studies which used in-depth interviews to examine the spousal caring relationship, reported that wives caring for husbands with dementia find it especially hard to assert control, because they were accustomed to defer to their husbands’ authority. Similar finding has been made by Rose and Bruce (1995) who explored in detail the kind of caring tasks and household chores undertaken by carers and the care-recipients. Rose and Bruce (1995:122) found that ‘men carers were more likely to do as they are pleased, and deal pragmatically with any ensuing negative reactions from their wives’. In relation to this study, it is suggested that this difficulty in asserting control by older wives may impact upon the subsequent actions by older wives to prevent their husband’s future falls.
4.4 Conclusions

This chapter has examined the ways in which gender, and masculinity and femininity, are socially constructed. The inter-relatedness of gender and ageing has been illustrated through the ways ageing affects men and women differently. Gender, as a source of identity, can impact upon men’s and women’s actions and behaviours. ‘Doing gender’ re-creates the expectations that older men and women ought to behave differently. This leads to dilemmas around independence and dependence, active and passive, and autonomy versus loss of control, which may be more acute for older men whose identity is validated by their social standing, and self-identity. Research shows that older men continue to retain their power within the family and are less likely to ‘lose’ their status despite their increased dependencies. This contrasts with the lack of power experienced by older women who become dependent on others. My research will explore gender differences in the extent to which older men and women feel able to negotiate ways of preventing future falls, and differences in power and dependence among them.

The literature indicates that the notion of responsibility is gendered. Gender is implicated in the conflict experienced by mothers who feel that they are the parent most likely to be seen as responsible for the care of their children. Research indicates that girls were more likely than boys to accept responsibility for the safety of others, resulting in girls responding to stereotypical expectations of femininities. The implication could be that older women who had had falls might feel more responsible to respond to stereotypical expectations of how they should behave as women.

Finally, the chapter has examined some aspects of the dynamics within family relationships, and considered the nature of caring within the family, and in different types of relationships. The concepts of ‘active sensibility’ and ‘sentient activity’ have been explored, giving an insight about the negotiations that take place within informal caring in the family.
Chapter 5

Research Design and Methodological Considerations

The preceding chapters have provided an account of the background and the theoretical perspectives underpinning the research. This chapter outlines the research design and choice of methodologies. It describes how the research was carried out, addressing issues relating to access and to conducting the interviews with older people and their key family members.

5.1 Research Aims and Overview of the Research Design

The aim of this study was to explore the ways in which the meaning and experiences of falls are constructed by both older people who have had falls and by their family members. By examining these meanings, I hope to be able to explore how these influence older people’s identity, their notions of control, autonomy, dependency, power and stigma, and the subsequent actions taken by older people and their family members in order to prevent future experience of falling. Gender is the key theme throughout the study, namely to examine how gender impacts upon the social construction of the meaning of falls, and on the subsequent actions taken by both older people and their key family members.

The study aims to answer three broad research questions:

1. How is the meaning of falls constructed by older people who have had falls? To what extent does gender impact upon the meaning of falls? How does the experience of falling impact upon an older person’s identity, their notions of control, dependence and independence, and stigma?
2. How is the meaning of the risk of falling constructed by older people who have had falls and their key family members? How does the meaning of the risk of falling impact upon the subsequent actions taken by older people and their key family members? To what extent is the meaning of the risk of falling gendered?

3. How does gender impact upon the types of actions taken by older people and their key family members in relation to trying to prevent future falls? How do the types of actions taken by older people and their key family members differ according to the gender of each partner in the caring dyad? How does gender of each partner influence the nature of the dyad relationship in terms of control, autonomy and dependence?

This section outlines the rationale for the choice of design for the study. A discussion of the sample criteria and of the respondents in the study is also included.

Since the research aims to explore the meaning and experience of falls among older people, qualitative research is the appropriate choice to yield meaning and understanding (Colbourne, 1998), providing a multidimensional account of the human experience (Field and Morse, 1994; Bluff, 1997; Fitzpatrick and Boulton, 1994). Because the study is exploratory, I have not developed hypotheses, only research questions.

Referring to qualitative research, Domarad and Buschmann (1995:15) maintain that it is:

A way of studying the empirical world from the perspective of the subject, rather than from the perspective of the researcher.

In doing so, they argue that ‘all subjects have their own reality, their own truth and it is the researcher’s job to allow individuals to express that truth’ (ibid.). For my study, I hoped that older people who have had falls would be able to tell me their experience and meaning of their falls from their own perspective. Accordingly, I chose interviews as my method of data collection. Silverman (2000:90) claims that ‘there is a broader, societal context’ which may explain why many qualitative researchers use interviews. From a symbolic interactionist perspective, I would argue that people’s knowledge, perceptions,
and understanding of their experiences are ‘meaningful properties of the social reality’ (Mason, 1996a:33), and that interviews with older people who have had falls and with their key family member would enable me to obtain a detailed understanding of this reality. However, it is acknowledged that talking to older people and their family members will not enable me ‘to get inside their heads’, and that I will only ‘be able to gain access to those interpretations and understandings which are revealed in some way in an interview’ (Mason, 1996a:40). I am also conscious of the importance of understanding the ways in which respondents give both ‘public’ (what they think is publicly acceptable) and ‘private’ (individualised and personal) narratives in a research context (Cornwell, 1984), and that lay constructions of the meanings of their experiences and behaviours are constantly re-assessed over the life course (Milburn, 1996; Backett and Davison, 1992).

5.2 The Sampling Strategy and Sample Criteria

Exploring the experiences of falls among older people can be a sensitive topic because some older people may not wish to tell other people about their falls, as discussed in Chapter 2, because of the stigma attached to ‘falling’. Ashton (1998:px) highlights that ‘a significant proportion of falls among older people is thought to be under-reported’. Falls can be embarrassing; they may have a negative connotation of ageing and reflect a loss of control of one’s balance, as discussed in chapter two. For example, Martin (1999:50) found that ‘those who have had falls were perceived in negative terms to be old, frail and dependent and, possibly, to have a drink problem’. It is also a sensitive issue because falls could result, for example, in an older person being placed in a nursing home. Wilkins (1999) found that after controlling for other factors, the odds of entry into residential care were three times higher for those who had suffered an injurious falls than those who had not.

The aim of sampling is to ‘select elements for study in a way which adequately represents a population of interest, both in relation to the purpose of the research, and at reasonable cost’ (Lee, 1993:60). This aim may not be easy to achieve since the topic being explored
is a sensitive one. However, there are strategies for sampling 'rare or deviant' population, and of the strategies identified by Lee (1993) two were thought to be appropriate: networking or snowballing, and outcropping. 'Networking' involves the researcher 'starting from an initial set of contacts and is then passed on by them to others, who in turn refer others and so on' (Lee, 1993:65). Whereas 'outcropping' involves the researcher seeking out specific settings that bring together members of the group to be studied.

Lee (1993) outlines the potential problems of sample bias, with networking and outcropping, suggesting that one can never be sure that the sample selected is representative of the wider population; however, for my study the aim is not to produce data which could be generalisable to the wider population.

Miles and Huberman (1994) and Strauss and Corbin (1990) contend that in qualitative research, events, incidents, and experiences, not people per se, are typically the reason for using purposeful sampling. Indeed, Denzin and Lincoln (1994:202) write:

Many qualitative researchers employ purposive, and not random, sampling methods. They seek out groups, settings and individuals where ... the processes being studied are most likely to occur.

In the light of this, an opportunistic sampling strategy appears to be an appropriate choice.

5.2.1 Sampling Criteria: Older People Who Are Recurrent Fallers

Since the focus of my study is on older people, I need to define what I mean by an older person. The definition of an older person included within the literature on falls is based on people exceeding a certain age (Cryer et al., 1993). As mentioned in Chapter 2, one of the factors which makes comparison across studies difficult is the range of ages included. The age range of 65 years and over is chosen for this study, as this has been used by most studies on falls (for example, O’Loughlin et al., 1993; Cwikel, 1992). Others like
Campbell et al. (1990) used 70 years as its lower age-limit, and Tinetti et al. (1988) and Downton and Andrews (1991) opted for those 75 years old and over.

In Chapter 2, I highlighted the problem of defining who is a faller. Overstall (1992:32) has defined a ‘nonfaller’ as people who have fallen only once during the previous year and ‘true’ fallers as those who have fallen twice or more during the previous year. Clemson et al. (1996) used the term ‘recurrent’ fallers to describe those who have had two falls or more in the past year. For the purpose of this study I have chosen to focus the study on ‘recurrent fallers’, that is, those who have had two or more falls during the past 12 month period.

To better understand the processes by which the meaning and experience of falls are structured, I have decided to target a population of older people living in the community, that is, in the ‘natural’ setting (Denzin and Lincoln, 1994). This is because approximately 90 per cent of older people in Great Britain live in accommodation either owned by themselves or rented; only 5 per cent live in their own home in sheltered housing with a warden and the remaining 5 per cent live in some form of institutional settings, such as nursing homes or hospitals (Tinker, 1997).

The General Household Survey (GHS) in 1998 indicated that in Great Britain among those aged 65 and over, thirty-seven percent (24% for men and 47% for women) lived alone, see Table 5.1 (Bridgwood, 2000:27).

For my research, I have decided to include only those who live alone. An older person living alone would have some elements of independence, and this is likely to impact upon their meanings and consequences of falls. These people who live alone may live in their own house, bungalow or flat, in an annexe, or in sheltered housing.
Table 5.1  Living arrangement of people aged 65 and over

<table>
<thead>
<tr>
<th></th>
<th>Men (%)</th>
<th>Women (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lived with spouse</td>
<td>64</td>
<td>41</td>
</tr>
<tr>
<td>Lived alone</td>
<td>24</td>
<td>47</td>
</tr>
<tr>
<td>Lived with spouse &amp; others</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Lived with sibling(s)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Lived with a son or daughter</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Lived in other household</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100%</strong>*</td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td><strong>Number</strong></td>
<td>1337</td>
<td>1745</td>
</tr>
</tbody>
</table>

Source: OPCS (1998:27, Table 3).

*Percentages do not sum to 100% because of rounding

In relation to the marital status of older people, the 1998 GHS reported that 46% of women aged 65 and over were widowed, while 72% of men were still married or cohabited (Bridgwood, 2000). This gender difference could be explained by greater life expectancy of women and their tendency to marry men older than themselves. Although the likelihood of falls among older people is not found to be associated with marital status, the meaning of falls in relation to perceptions of risk, may be influenced by marital status. The marital status of an older person may also have implications for service use, for instance, following a fall, an older person living alone may be more likely to experience a longer ‘lie’, that is, lying on the ground for longer before being found.

A key focus of the research is to examine how gender impacts upon the meaning of falls, the identity of the older person, their perceptions of risk and of stigma, I aim to recruit an equal number of older men and older women in order to maximise my ability to compare gender differences. According to Bridgwood (2000:7), in 1998 a higher proportion of women than of men were aged 85 and over, and women outnumbered men by two to one in this age group. The likelihood of living alone increases with age, from 19% of men and 31% of women in the 65-69 age group to 43% of men and 72% of women aged 85 and
over (Bridgwood, 2000:7). Therefore, given the demographic picture of living arrangement and marital status of older people, it became apparent that I may have potential problems in recruiting equal numbers of men as well as women.

In summary, the inclusion criteria for older people in my study were: aged 65 and over; have had two or more falls in the past 12 months, and living alone either in their own home, in an annexe to a house, or in sheltered housing. In addition, the older person needed to be able to name a key family member who provides care in any of these aspects: physical care, organisational/managerial care, or emotional care. I chose not to include in my sample of older people, those who were blind, terminally ill, confused, or suffering from dementia, or those who could not speak English, because these conditions could influence the meanings of falls.

5.2.2 Sampling Criteria: Key Family Members

Earlier I have discussed the type of sampling strategy to be used for my sample of older people and that an integral part of the research is to interview a key family member. The following discussion will outline my rationale for sampling family members, and the inclusion and exclusion criteria for these.

Accidents, such as falls among older people, can impact on personal living arrangements, affecting both the older person and others who may be members of their family or friends that may have to take on a caring role once an older person has had an accident such as a fall (Ashton, 1998). Family members may play a part in influencing older people’s perception of self and their subsequent actions relating to the impact of falls. The research aims to compare the older person’s and the family member’s perceptions of the risk of falling, as well as the subsequent actions taken.

In this study the older person who has had falls was asked to name a key family member. For the purpose of this study, a key family member is defined as someone related to the
older person by blood, marriage or adoption, and who assumes the major responsibility for providing care in any of these aspects: physical labour, emotional labour, or organisational/managerial labour (James, 1992). Given that I am focusing on older people who live on their own, it is likely that relatives would be primarily adult children, but may also be siblings, or sibling’s children if the older person is single.

5.2.3 Gaining Access to Older People

In relation to research on sensitive topics, Lee (1993:121) states that field research ‘by its very nature, requires people to carry out tasks which run against the grain of earlier socialisation and social experience’. He highlights the fear of rejection when obtaining personal details about people’s lives. He also suggests that gaining access is unpredictable and stresses the need to view the researcher’s access or presence as ‘continually renegotiated’ (Lee, 1993:122), since there are always some who would still question the researcher’s role. Perhaps more importantly, what the researcher does has always to be monitored for reaction by those with whom access has already been negotiated and accepted.

Gaining access to older people who had experienced falls required negotiation with several ‘gatekeepers’. Lee (1993) warns that gatekeepers can pose problems to the research, for example, by imposing implicit conditions or having preconceptions about how the research should be conducted. It is acknowledged that gatekeepers can also act as sponsors and key respondents. This section discusses the process undertaken to negotiate access.

It was decided that day centres and sheltered housing would provide a useful source for my sample. Day centres provide older people with a means of social contact and recreation, and in some, services such as meals, laundry facilities and chiropody are available (Tinker, 1997). Users attend these day centres on a voluntary basis, thus reflecting their autonomy and choice. People living in sheltered housing generally have
their own flat or a bungalow with communal facilities and a warden available to assist in the case of emergencies. Five percent of people aged 65 and over in private households lived in sheltered housing in 1994 rising to 10% if those with a non-resident warden (OPCS, 1996:157).

My initial plan was to use five borough-run day centres and three sheltered housing units for recruitment. I estimated that they would potentially provide me contacts with about 430 older people attending day centres, and 170 in sheltered housing. Two of the day centres are located in the town centre in a South East England market town, which meant that they are easily accessible for those using public transport. Each of these two day centres are ‘attached’ to a sheltered housing unit. Two other day centres are located in large villages 5 miles away, and cater for those living in more rural areas. The fifth day centre, with a sheltered housing unit next door to it, was situated in another large town 10 miles away. These sample sites provided a diversity in that older people living in both rural and urban areas were accessed.

Day Centres
Information on all the day centres was obtained via a local borough office. Personal contacts were made with managers of five of the day centres, which were all council-run. Those that were not chosen for the study included a day centre run by a private nursing home, and another that catered specifically for mentally ill users. For practical and financial reasons, three of the five day centres chosen were ‘attached’ to sheltered housing units. I attended the centres over a period of time (a week at each centre), during November/December 1999, in order to obtain a clearer picture of how the setting operated for their users. This enabled me to decide when was the best time to approach the users, to become more familiar with the settings, and be accepted by other voluntary helpers. I soon learnt to avoid bingo sessions, because users and volunteers did not like interruptions.
Sheltered Housing

My gatekeeper was the manager of all the sheltered housing units that were council-run, responsible for the wardens/managers in each of these three units in the borough. Following my meeting with him in October 1999, which detailed the process by which I wished to recruit my respondents, permission was granted with regard to me conducting door-to-door visits to tenants at the sheltered housing units on the condition that the manager/warden of the respective unit was aware of my visit. An alternative way to access older people who have had falls would have been by asking the wardens to identify those residents who had fallen, since any incidents, such as a fall inside the unit/flat, would have been recorded. However, the drawback of using this strategy would have been that there might be older residents who had chosen not to report to their warden about their falls, and that incidents like falling outside the flat might be unrecorded.

5.2.4 Recruiting Older People as Respondents

Bowsher et al. (1993:875) contend that 'the most effective recruitment tactic is personal contact by the researcher in the elderly person's place of residence or frequently visited centre'. Likewise, Greenwell and Spillman (1996) found direct recruitment was a more effective strategy compared to newsletters or flyers. This strategy was chosen to recruit older people in this study. Greenwell and Spillman (1996:558) also recommend that 'the researcher is introduced to the potential subject by a familiar and trusted person'. In my study, the managers of the five day centres introduced me to some of the users whom the managers knew had fallen. I approached 311 older users who attended the day centres and 127 sheltered housing tenants in order to recruit my sample.

Sheltered Housing

Making door-to-door contact with tenants in sheltered housing had its advantage as it enabled me to get to know the potential respondents and to ascertain if the older person met my inclusion criteria. However, I was aware that making door-to-door contact has its
problems: it can be intrusive and time-consuming. For some older people walking to the door could be a great task, as it could take them a long time. To assure them of my identity I wore my University campus card at all times.

The vulnerability of older people to intruders in their own flat was a reason why I felt the need to wear my campus card and to explain at the outset, when a tenant opened the door, that I was from the University of Surrey, and the purpose of my visit was explained. My first question tended to be: ‘My research concerns ... I am interested to know if you have had any trips, slips or falls in the past twelve months?’ This then allowed me to ascertain if the tenant fulfilled my first criteria of a ‘faller’. If the tenant affirmed, other questions were posed to determine if the other criteria were met. If the tenant reported no falls, my follow-up question would be: ‘Have you ever tripped or lost your balance while walking?’ If s/he replied negatively again, this confirmed that s/he has not fulfilled the inclusion criteria. An Information Sheet (Appendix A) was given to any tenant who fulfilled the criteria. I also asked if the older person has someone in their family whom they would call upon for assistance. It was important to inform the prospective participant that I would like to speak with their key family member. If the person agreed to participate, arrangement was made for the interview to take place at a convenient time. A contact number was obtained which enabled me to phone the older person the day before the interview to remind them of my impending visit and to answer any questions they may have had. Bergsten et al. (1984) found that telephone contact before an interview was reassuring and improved participation. At the initial meeting, information about the key family member was obtained, which included their name, relationship and address and telephone number.

Day Centres

Where users of day centres were concerned, recruiting for my sample entailed me drinking tea or coffee with them and introducing myself. The same procedure as described above for finding out if potential respondents met the inclusion criteria and, for obtaining details of the person and their key family member were followed.
5.2.5 Recruiting Key Family Members

As indicated earlier, key family members were recruited via older people themselves. Once the name and contact address were obtained from the older person, a letter together with an information sheet was sent to the family member inviting them to participate (Appendix B). Within a week, a telephone call was made to speak with them, to ascertain if they had my letter, and if they were willing to be involved. If they agreed, then an interview date and venue was arranged. I also reiterated that the interview would be tape-recorded, and assured them of confidentiality.

Since I planned to interview forty older people in my study, there were potentially forty relatives to be recruited.

5.3 The Sample

There are some key issues questions which one needs to address when considering a qualitative sampling plan (see Miles and Huberman, 1994). Although Mason (1996a:96) maintains that there is no reason why a qualitative sample must be small, she also acknowledges that these types of samples ‘are usually small for practical reasons to do with the costs, especially in terms of time and money’. Since each interview with an older respondent was planned to take up to one and a half hours I had to be realistic about the number of interviews conducted, as Mason (1996a:97) says, ‘your sample should help you to understand the process, rather to represent (statistically) a population’. This led me to a decision to interview twenty older men and twenty older women.

The potential problem of recruiting enough older men who live alone became clear when the main study started in March 2000. There were fewer men living in sheltered housing. There were also more older women than men who used day centre facilities. Because of the lack of older men who fulfilled my sample criteria, I considered how I might recruit more older men, and contacted other organisations such as the local Club for the
Disabled, the Royal British Legion, and the retired branch of the local Institution of Electronic Engineers. These organisations yielded one older female and five older male participants.

Table 5.2 provides a profile of the older people who had had falls and were interviewed.

**Table 5.2** Profile of older people interviewed: age range

<table>
<thead>
<tr>
<th>Age range</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-74</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>75-84</td>
<td>11</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>85 and over</td>
<td>7</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>20</td>
<td>20</td>
<td>40</td>
</tr>
</tbody>
</table>

Table 5.3 provides an overview of the relationship between older people and their key family members. Because of the difficulty of recruiting older men who met the sample criteria, I included in this study four older men, who were married and living with their wife, and one older man who was single and had no other kin. All the married men were self-caring although one was physically frail. One of the wives had severe arthritis and required her husband to help with shopping and some household chores like vacuuming. Four of the key family members identified by older women declined to participate (see Section 5.6), which meant a total of 35 key family members were interviewed.

**Table 5.3** Sample of Older People and their Key Family Members interviewed

<table>
<thead>
<tr>
<th>Male Key family members</th>
<th>Older women who have had falls (n=20)</th>
<th>Older men who have had falls (n=20)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>sons (n=10)</td>
<td>son (n=1)</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>brother (n=1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female key family members</td>
<td>daughters (n=5)</td>
<td>wife (n=4)</td>
<td>23</td>
</tr>
<tr>
<td>niece (n=1)</td>
<td>daughters (n=12)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of family members</td>
<td>16</td>
<td>19</td>
<td>35</td>
</tr>
</tbody>
</table>
5.4 Ethical Considerations

Silverman (2000:200) cites Max Weber (1946) as suggesting that ‘all research is contaminated to some extent by the values of the researcher’, but it is only through those values that particular problems are identified and studied. Mason (1996a:166-7) contends that because qualitative data tend to be rich and detailed it often means close engagement with the public and private lives of the respondents. Secondly, the modification of interests and access during a study can mean that new and unexpected dilemmas might arise as a consequence.

McCall and Simmons’ (1969:276) cautionary question: ‘To whom shall harm be done to in this study, and in what magnitude?’ made me aware that my study might stir up some memories, perhaps painful and embarrassing ones of the events of falling, and that ‘people may enjoy a conversation at the time but be unhappy about how much they revealed, or they may not enjoy it at the time but remember it gratefully’ (Robinson, 1996:43). The vulnerability of the respondent is always at the back of my mind as a researcher. My role as a trained nurse and my knowledge and experience in caring for older people equipped me with particular communication skills that helped in this aspect.

The research conformed to the British Sociological Association’s guidelines (1998) and the University of Surrey Committee on Ethics for professional conduct and ethical practice.

5.4.1 British Sociological Association guidelines

The British Sociological Association (BSA) (1998:1) Statement of Ethical Practice is meant to raise member’s awareness of the ethical issues arising in their work, and to ‘encourage them to educate themselves and their colleagues to behave ethically’. Members are reminded that they have a responsibility to ensure that the physical, social and psychological well-being of the participants is not adversely affected by the research.
I was also reminded that research participants should be made aware of their rights: they may choose not to participate whenever, and for whatever reason they wish.

5.4.2 University of Surrey Ethical Committee

Submission to the University of Surrey Committee on Ethics was made in October 1999 and approval was granted in early December 1999 on the understanding that their guidelines were observed. In fact, the guidelines had more to do with other types of research involving experiments including use of drugs, use of animal tissues, and the use of survey questionnaires. Nonetheless, it had some useful advice, such as what should be included in a consent form, and what to do in the case of obtaining untoward results during the study. Approval was not sought from Local Hospital Trust Ethical Committee on two counts. First, I was not an employee of the National Health Service (NHS) and the research governance code did not apply in my case. Second, my respondents were members of the public who were given written and verbal information about the study and had opportunity to withdraw from the study at any time.

5.4.3 Informed Consent

The University of Surrey Ethics Committee provided some useful guidance on how consent forms should be presented. They also suggested that the consent form should be the only document to contain the name of the research participant and that in all subsequent records, data and documents, the participant should be identified only by a code number or a pseudonym to preserve confidentiality.

Before the commencement of each interview, I reiterate the purpose of my study, and the rights of the participant to withdraw from the interview at any time. Because an older person with visual problems may not be able to see my printed information sheet and consent form clearly I typed them in a larger print (font size 14). The consent form (Appendix C) acknowledged that the respondent had received a full explanation about the
study (see Appendix A and B), and had agreed for the interview to be tape-recorded. At each interview, two consent forms were completed, one copy being retained by the respondent, who was reassured that they could withdraw from the study at any time.

5.5 The Research Tool: Interviews

As discussed earlier, qualitative interviews provide 'a way of generating data about the social world by asking people to talk about their lives' (Holstein and Gubrium, 1997:114) and its interactive process allows the interviewer to 'enter another person's world, and their perspective' (Measor, 1985:13). Charles et al. (1998:75) write:

Following Blumer (1986), we conceptualise meanings as 'social products' that are developed through a formative process of interpretation, and hold that individuals' definitions of a situation are important guides to their behaviour.

This is particularly relevant since I am trying to examine the meanings of older people in relation to both their subsequent actions and those taken by their key family members.

As the study was exploratory and did not seek to consider hypotheses, I had in mind some 'sensitising concepts' of interest (Blumer, 1986; Strauss and Corbin, 1994). These were the meanings and the experience of falls, risk of falling, notion of stigma, and self identity. Consequently the choice of interview type was unstructured so that its flexibility enabled me to explore aspects that were particularly important to my respondents. Lofland and Lofland (1984:12) describe the unstructured interviews as:

A guided conversation whose goal is to elicit from the interviewee rich, detailed materials that can be used in qualitative analysis... to discover the informant's experience of a particular topic or situation.

This provides a 'framework within which informants can express their own understandings in their own terms so that the data represent the subject's own truth' (Domarad and Buschmann, 1995:15). Montazeri et al. (1996) maintain that older people prefer a type of interview with a conversational feel. Martin (1999) found unstructured or semi-structured interviews to be a powerful tool for obtaining older people's views, while
Ramhoj and de Oliveira (1991) used this type of interview for exploring the meanings which respondents attach to events. This approach also relies on the spontaneity and confidence of the respondent. Hence interview guides were developed in such a way that they could be used either as a guide or in a more structured format, depending on the responses.

The interviews were audio-taped using a tape-recorder. Prior to the commencement of each interview it was necessary to check that the older person was comfortable, as some had medical conditions, such as arthritis, which made it uncomfortable to sit for a long period without a change of position. To ensure successful recording, the tape recorder was placed as close to the participant as possible whilst being out of direct vision of the participant. It was also important that I could see the tape recorder to be certain that it was working well, and to know when the batteries required replacing. Audiotapes with the capacity of forty-five minutes recording on each side were used for these interviews.

Some key issues relating to the interviews that are addressed in the following sections included how the interviews were managed, the pilot interviews, the main interviews and the researcher’s role in the interview process. Specific problems and challenges relating to interviews with older people and their family member are also examined.

5.5.1 Managing the Interviews

Punch (1998:180) suggests that a general checklist for managing the interview should include preparation for the interview, beginning the interview, communication and listening skills, asking questions, and closing the interview. Since the quality of the data will be influenced by the quality of the preparation (Punch, 1998), it is important that this is handled thoughtfully. The preparation for the interview involves preparing the interview guides for my interviews with older people who have had falls (Appendix D and F), and their key family members (Appendix E and G). Decisions on what should be
included in the guide were influenced by the chosen theoretical framework, what the literature suggested, and my research questions.

The type of interviews to be conducted were in-depth and unstructured. The advantages were that I would have a list of topics which I wanted to explore with my respondents but was ‘free to phrase the questions as I wished’, and ‘ask them in whatever order that was appropriate at that time’ (Fielding 1993:136). Because I was interviewing the older person and a family member separately, I needed to consider which questions might be asked of both parties, and which would be inappropriate to do so. The interview guides illustrate some of the similarities and differences in the questions asked (Appendix F and G).

Establishing rapport with research respondents is of paramount importance where in-depth interviews are concerned. According to Bray et al. (1995:351),

A mature person with good listening skills, who can empathise with older people’s interests or problems, is likely to achieve a satisfying and productive interview, particularly if the individual is familiar with the population group.

This view is echoed by Domarad and Buschman (1995:14) who maintain that such an interviewer ‘will have a better chance of obtaining data that accurately represents the views of elderly persons’. As an experienced nurse teacher in the care of older people, I felt I had the skill to make an older person feel at ease through my initial lines of communication. I was also aware that problems of impaired speech or hearing would need careful and sympathetic handling, so that feelings of frustrations could be minimised.

Fielding (1993) identifies two principles which inform research interviews; the first being that the questioning should be as open-ended as possible, so that information gained would be spontaneous. The second principle should be to encourage respondents to communicate ‘their underlying attitudes, beliefs and values, rather than a glib or easy answer’ (Fielding, 1993:138). However, there is also a need for the interviewer ‘not only
to listen beyond the informant’s words but also to understand beyond, recognising that both parties to the interview make their own social and cultural contribution to it’ (Bray et al., 1995:350).

One of the skills required in unstructured interviews is that of probing, to encourage the respondent to provide an answer and ‘as full a response as the format allows’ (Fielding, 1993:140). As the interview progressed, I used probes to clarify issues or to gain more detailed information on a specific matter that was raised by the respondent. I found myself either repeating the last phrase or word uttered by my respondent or asking ‘what else?’. This somehow encouraged the respondent to go on talking about the matter in hand. I was also mindful that ‘comfortable silences and time for reflection’ are allowed (Bray et al., 1995:351).

Domarad and Buschmann (1995:17) highlight that control is something to be guarded in the older person, ‘for ageing often diminishes control through functional and psychosocial losses’. As control is one of the factors which engenders self-esteem (Whall, 1987), it is helpful for the interview to take place in the older person’s home (Zola, 1986). However, there were a couple of times when the interview took place in a ‘quiet’ room located in another part of the day centre. This was because the older person attended the day centre every day during the week and felt it was best that I interviewed them there. This provided another way of allowing the older person to exert some control.

To close my interview, I indicated to my respondents that I had finished asking the questions I needed to ask, and wondered if they had any questions that they might like to ask me. Although the interview was formally over, I generally left my tape recorder running in case of unexpected additional insights. This happened sometimes when the respondent felt more relaxed towards the end of the interview.
5.5.2 The Pilot Study

The pilot study took place during December 1999-January 2000 and comprised a sample of four older persons who had had falls (three older women and one older man) and three key family members. The women in the sample ranged in age from 65 to 87. The older man was aged 87. The relatives consisted of two sons and one daughter, none of whom were co-resident. The older man was single and had no other relative.

Each interview lasted between forty-five minutes to an hour and a half (Appendix D and E). It was good practice to listen to the tape recording on the same day of the interview because it was ‘fresh’ and I made some brief notes if needed. Playing back the tape soon after the interview also enabled me to find out how clear my tape-recording was, and to make notes on key issues raised.

5.5.3 The Main Interviews

The pilot interviews proved useful in highlighting the need to explore in more detail age and gender differences regarding falls, and the interview guides were revised somewhat (see Appendix F and G). The main interviews were conducted during March to October 2000. I used the same method for access and recruitment for the pilot and the main sample, since no major problem had arisen during the pilot work (see Section 5.2).

5.5.4 The Researcher’s Role in the Interview Process

May (1993) raises some pertinent questions concerning the interviewer’s role. The first concerns the effect the interviewer may have on the interviewee and hence the type of material collected. Others, such as Fielding (1993:145), highlight ‘interviewer effects’, that is, the characteristics of the interviewer, such as their age, sex, race and social class, may influence the nature of the data obtained. I thought it could be my professional background which ‘eased’ the way. However, I was conscious that my Oriental origin and
accent might have potentially pose problems for me and my respondents. The cohort of older people was born in the early years of the last century and would likely to remember much of what happened in the Far East during the Second World War. Somehow I found myself volunteering information to my respondents that I originally came from Singapore, in case they thought I was Japanese and they may still have hostile feelings.

May (1993) identifies motivation as another interviewer’s role. Citing Moser and Kalton (1983), May (1993:97) maintains that it is imperative that ‘the interviewer must make the subjects feel that their participation and answers are valued, ... this means maintaining interest during the interview’.

Measor (1985) and Hammersley and Atkinson (1995) allude to the influence of the clothes worn by interviewers. For my study, I adopted ‘a professional and yet relaxed appearance’ (Bray et al., 1995:351) to help set the scene for the interview. As an experienced nurse teacher I also felt that I could achieve a satisfying and productive interview by empathising with older people’s interests or problems.

5.6 Interviewing Older People: Problems and Challenges

There are several problems as well as challenges when interviewing older people. This section of the chapter will briefly outline the problems and challenges encountered by the researcher.

Arranging interviews
One of the initial problems I experienced was arranging the interviews with older people. As well as making a note for my older respondents of the day and the time of the interview on the information sheet handed to them (Appendix A), I made it a practice to phone them the day before the interview to remind them. This was much appreciated since some of them had forgotten about the date of the interview.
Because of their ‘hectic’ social activities, two of the respondents chose to be interviewed at the day centres. Discussion with the manager enabled me to find a ‘lounge’ in the nearby sheltered housing unit, which was seldom occupied. To ensure that no interruptions occurred, a sign indicating ‘Please, do not disturb. Thank You’ seemed to work each time. The rest of the interviews were conducted in the respondent’s own home, which resulted in respondents feeling at ‘ease’ in their own familiar surroundings and having personal power and control in their own living environment.

Interviews declined

Another problem encountered was the experience of having interviews declined by older persons and key family members. Five older persons: three older females and two older men, changed their mind when I phoned the day before to confirm my visit. One man who had agreed to participate was told by his wife that he was too old to be involved and ‘not well enough’. Another man told me that he had second thoughts- he said he was not a ‘talkative sort of person’ and would not be able to be of assistance. One lady I visited to interview, told me that she doubted if she could be of any help because her son had told her that her falls happened more than two years ago. This supports Meacham’s (1995:40) argument that: ‘to the extent that family members and others believe that they have better access to the actual past events ... the reminiscences of the individual are seen as redundant’. One of the older women changed her mind as a result of her daughter telling her that it was pointless getting involved in the study because ‘nothing gets done’. The third lady, a 92 year old lady at a day centre, felt that she was too busy with her clubs and that she would not be able to find the time to help me. I accepted these five declines and did not attempt to persuade them to respond. The above demonstrated how some relatives could be influential and potentially powerful ‘gatekeepers’ because they were speaking on behalf of the older person, and treating them as dependent and unable to make their own decisions.

Four key family members of older women who had recurrent falls declined to participate (3 sons and 1 daughter). One son, in his fifties, felt that he could not be ‘any good’ since
he did not see his mother sufficiently often to know enough to help me. Another son, in his thirties, was unemployed and kept postponing the interview, giving reasons that he and his family were going away. After my interview with his mother, I learned that the relationship between mother and son had deteriorated over financial matters. Given this sensitive relationship, I was not surprised that participation was declined. The mother felt too stressed over the matter and had asked the son not to visit her again. Another son, because of his ill-health, did not wish to be involved. One daughter did not wish to participate in this study because she was ‘not interested’.

Accuracy of data

One of the commonest questions arising from interviewing older people is whether or not older people can be perceived as reliable, and can provide trustworthy information. Participant recall might be influenced by the perceived importance of the event or the possibility of the participant repressing threatening, unpleasant, or embarrassing events (Colbourne, 1998). Hence an older person might only remember those falls which had a greater impact on them, such as having to go into hospital, or those resulting in serious injuries.

Cummings et al. (1988) noted that falls resulting in no or minor injuries were less frequently recalled, and suggested that other methods are necessary instead of relying on older people’s memory. The use of a ‘fall diary’ has been recommended by Tideiksaar (1989). Kingston’s (1998) study of older people and falls had hoped to include information collated from diary entries to complement the quantitative data generated from the randomised control trial. However, the administration of diaries was discontinued after twenty diaries had been offered and met with refusal (Kingston, 1998).

Martin (1999:13) suggests that ‘the recall of a fall will be enhanced if the investigator links it temporally to a memorable event’. Using special occasions and events like Christmas, the New Year period, and Easter did help to jot my older respondents’ recall of falling events.
Since falling may be considered a stigma by older people, I was aware of the possibility that older people I approached might not wish to acknowledge that they had had falls. As a result, on my first meeting with an older person, I would explain that I was interested to know if they had had any trips, slips or falls.

Reassurance

‘The credibility of interview data is fostered when subjects demonstrate self-esteem’ (Domarad and Buschmann, 1995:16). Because older people might feel that what they said was unimportant and were concerned that they could provide me with only the most scant information, sometimes my respondents would say ‘I don’t see how I can help you’ or ‘you wouldn’t want to hear about my falls’. I had to reassure them that whatever they said was important and unique.

‘Dross Rate’

The amount of irrelevant information, known as the ‘dross rate’ may be high if ‘the respondent is elderly who is inclined to wander off the topic’ (Field and Morse, 1994:66). This happened more often in my interviews with older people than with their family members. There were times when I had difficulty in picking a convenient point of the respondent’s conversation to go back ‘... to our conversation earlier about your falls...’.

Slowness of response

Slowness of response among older people is often ‘mistaken for a lack of intellectual capacity’ (Domarad and Buschmann, 1995:18). I was conscious of this, and felt it was appropriate to provide thinking and recall time. I found myself saying ‘it’s alright, take your time’ and providing positive reinforcement like ‘you’re doing fine’.

Hearing problems

Interviewing older people was made more difficult by hearing problems. If the person wore a hearing aid, I would ensure that it was in place and functioning before the interview started. The older person with hearing loss may try to mask the deficit resulting
in data ‘that are inappropriate for the question, or data that are not accurate but sound appropriate’ (Domarad and Buschmann, 1995:18). I observed for any sign that might indicate to me that the person had not accurately perceived or encoded my question, for example, if the person tilts their head while listening. Background noises needed to be kept to a minimum. For example, an older lady I interviewed had a pet budgerigar. To stop the bird from making too many loud noises the lady showed me how to quieten it by placing a white cloth over its cage.

Researcher’s conflict

Some of the older people did wish to disclose personal information about themselves, some detailing very sad life histories and upsetting family situations. Invariably I went away from the interview feeling very touched and wished I could be of some help to improve their circumstances. There were times when I had to remind myself that ‘I am NOW a researcher, not a nurse’. On a couple of occasions the older person had desired to know why I wanted to speak with their family member. One individual voiced her concern about being put in a home by saying ‘I hope you are not going to agree with my son that I may be better off in a home’. I had to reassure her that this would not be the case.

Interviewing men

The shortest interviews I had were with two older men: aged eighty-eight and ninety-two respectively. These lasted only forty-five minutes, with many pauses and both did not speak much. The first man lived next door to his daughter, in an annexe. He had attended the day centre five days a week for the past five years and chose to have the interview there. After the interview he opted to sit on his own rather than with a group of older women who were drinking coffee. My interview with his daughter confirmed that he was a quiet gentleman. His daughter admitted to finding it difficult ‘to talk to my father’ and that ‘he has always been like that ... Mum was the one who steals the show’. The second gentleman lived in sheltered housing and, apart from having his lunch in the dining-room, he tended to spend most of his time in his flat. His daughter informed me
that her ‘dad has always been a private sort of person’. I was also relieved to find that other researchers, particularly women (for example, McKee and O’Brien, 1983) have found men to be more reticent when asked about their feelings.

5.7 Interviewing Family Members: Problems and Challenges

One of the potential problems of interviewing family members in their own home is that they may live a great distance from their older relative. Fortunately for me, all but three live within ten miles radius of their older relative. One key family member lives in Somerset but visits his father every other month, whilst the other lives in Bath and visits her father monthly. Mostly interviews were conducted in their living room. However, a couple of my interviews with key family members took place in a sitting room in a sheltered housing because they felt that it would be convenient for us to meet there during their visit to their older relative. Permission to use a quiet room like a sitting room which was infrequently used, was always sought from the manager in the first instance.

One of the problems I encountered was interviewing an adult son who lived with his wife. When I telephoned him to arrange the interview I told him that I would like to talk with him privately during the interview. However, when I arrived to conduct the interview I found that his wife was at home, and in their small bungalow, there was no other living room. A few minutes later she joined us with her cup of coffee and I felt awkward. Luckily I was ‘saved’ by two long phone calls answered by her. I have learnt that when interviewing others in the home that there will not necessarily be a separate room for the interviewee.

5.8 Data Analysis

Following each interview, a few brief notes were made relating to the interview such as how it went, was it successful and why, and any particularly striking themes that
emerged. I listened to the tape on the same day just to recall the essence of the conversation and to make further notes if necessary.

By transcribing the tapes myself, it enabled me to get a ‘feel’ for the data. I tried paying a typist to transcribe for me during the pilot study, and found it not cost-effective. The transcripts had several blank spaces indicating that the typist could not pick up what was recorded. Consequently I had to replay the tapes and fill in the gaps. On a number of occasions she had actually misheard what had been said. Given this experience, I made the decision to transcribe all remaining tapes myself, which assisted me in fully understanding and therefore subsequently analysing the data.

Initially I attempted to analyse the data using a grounded theory perspective (Strauss and Corbin, 1990), allowing various categories to emerge. For example, I was ‘sensitised’ to how the fallers were indicating to me the stigma of falling, and that where they fell might make a difference to how they perceived falling. For example, one older woman was angry with herself for falling because ‘She felt foolish for falling in the street’. This triggered in me the question regarding whether the location of their falls impacts on their perceptions.

5.8.1 Choosing A Qualitative Data Analysis Package

As I had potentially eighty interview transcripts to be analysed, it was appropriate to use a qualitative data analysis package since one of the advantage of using computer-assisted analysis of qualitative data (CAQDAS) is its speed in handling large volumes of data (Searle, 2000). There is improvement of rigour particularly in the ‘production of counts of phenomena and searching for deviant cases’ (see Searle, 2000:155). Williams’ (1998) experience of using the package, Non-Numerical Unstructured Data* Indexing Searching and Theorising (NUD*IST) appears to indicate its theory building ability. Martin (1999:26) had used NUD*IST to analyse the data on her study of falls amongst older people and was able to identify key concepts felt to be at the core of the research.
Other advantages of NUD*IST have been highlighted by various researchers. It allows codes to be attached to data, and retrieved and sorted in a variety of ways (Richards and Richards, 1991, Fielding and Lee, 1998, Silverman 2000). Interview transcripts are entered into the program and divided into text units or line units. It also allows paragraphs to be used as text units. In particular, NUD*IST 4 gives the researcher an easy-to-use interface for the handling of the project (Punch, 1998). Its features include the ability to view and edit the structure of the index system in a list form or a ‘navigable’ tree display, a ‘palette’ of analytic tools which are handy for working with text, the ability to reference external forms of data, and a useful system of text and index search tools (see Punch, 1998). He (1998:234) also states that it is ‘relatively easy for the beginning user to become familiar with’.

Reed and Roskell (1997) cautioned against retrieving all the things that relate to a particular topic which could produce a confusing picture because there is the potential danger of not paying attention to the sequence of the interview discussion.

5.8.2 Data Analysis: The Process

All interview transcripts were identified by a pseudonym. The sex of the older person who had falls was denoted by the suffix accompanying the pseudonym, for example, NicholsF and SmartM refer to Mrs Nichols and Mr Smart respectively. The key family member is identified by the prefix denoting the relationship to the older person, for example, SNicholsF refers to the son of an older woman, in this case, Mrs Nichols, and DSmartM refers to the daughter of Mr Smart. I have chosen N as a suffix to refer to a niece since no nephews took part in the study.

Analysis of study data
Life experience and intellectual ability influence the interpretation of data (Smith, 1992). My initial intention was to analyse the data using the grounded theory approach (Strauss and Corbin, 1990:42). However, this was cautioned by the authors themselves, who stated
that although the more professional experience one has, the richer will be the knowledge base and insight, there is the disadvantage that this kind of experience ‘can also block you from seeing things that have become routine or “obvious”’. Nevertheless I continued with the process although it evolved into a ‘modified’ grounded theory approach after the pilot study. Punch (1998:211) states that ‘open coding is a first level of conceptual analysis’ and this literally means ‘breaking open’ the data or labelling. During open coding I examined each line of the transcripts to ask ‘what is this piece of data an example of?’, ‘What does this piece of data stands for, or represent?’ and finally, ‘what category or property of a category does this piece of data indicate?’ (Punch, 1998:212).

Strauss and Corbin (1990) describe the two analytical processes, constant comparison and continued questioning; these contribute to ‘raising terms to concepts’ (Williams, 1998:104). For example, I compared the accounts of an older woman with that of an older man on how they felt about falling indoors and outdoors. This led me to consider the impact of falling in public places on the older person’s self identity and notion of stigma.

I followed the approach of Martin (1999) who used NUD*IST. First each document of the transcript was coded according to a number of base characteristics, including age and gender. Then key concepts were identified and these were posited as primary coding categories. New coding categories were then developed, either as sub-categories of the key concepts or as new dimensions arising from within the data as they emerged. Using the Index Search facility I was able to determine who used a particular term, for example ‘risk’ and in what contexts.

Williams (1998) discusses the usefulness of writing and rewriting drafts as part of the analytical process. Like Williams’ (1998) experience, writing for my supervisor, for conference papers, and journal articles, have proved beneficial in sharpening and refining my concepts and developing my theoretical framework.
5.8.3 Validation

Mason (1996a) highlights the crises of confidence experienced by many researchers concerning the validity of their own interpretations. In her view, one should be able to demonstrate how that interpretation was reached. This means ‘being able and prepared to, trace the route by which you came to your interpretation’ (Mason, 1996a:150). She identifies two techniques of demonstrating validity of interpretation. The first technique involves the researcher claiming a particular ‘standpoint’ and the second, ‘respondent validation’ entails checking the validity of the interpretation with my respondents. The latter approach may be treated as ‘yet another source of data and insight’, since feedback from respondents should not be taken as direct validation of the analysis (Fielding and Fielding, 1986:43). It also assumes that my respondents were in a position to judge and confirm (or otherwise) the validity of the interpretations I have made (Mason, 1996a:151). Because of the problems outlined by other authors (e.g. Dowell et al., 1995; Burgess, 1985) in that anger could be encountered when analysis is presented to respondents, I choose not to attempt to validate with my respondents, and none of the respondents asked to see the interview transcripts. Ribbens (1989:589) succinctly explains:

I increasingly come to believe that this is the greatest power sociologists may have - to define other people’s realities for them and others ... Perhaps we have to take responsibility for ourselves, recognising that in the end we are not data collecting instruments for anyone, but are data creating social beings, and acknowledge our own presence within the accounts we give of other people’s lives.

I would argue that the regular contacts I had with my supervisor every four to five weeks facilitated a reflection on the data as I had the time to discuss my work and the emerging themes arising from my analysis. These formal meetings provided me with the opportunity for the validity of the themes to be challenged.

In enhancing the validity of the data analysis, Silverman (2000:185) asserts that there is no reason why qualitative researchers should not, where appropriate, use quantitative
measures such as simple counting techniques which ‘offer a means to survey the whole corpus of data ordinarily lost in intensive, qualitative research’. For instance, I had asked older respondents about their perceptions regarding their risk of falling; similarly I asked their key family members what they thought made older people more likely to fall – see interview guides (Appendices D and E). Following the development of primary coding categories from the transcripts, in order to systematically examine the categories, I reanalysed the interview transcripts to construct a table, based on the comparison of how the term ‘risk’ and other associated words were articulated by both older people who had had recurrent falls, and their key family members. Using NUD*IST I was able to ‘trawl’ through my data sets to identify instances when such terms were used, and analysed them in context (Silverman, 2000:179).

5.9 Conclusions

This chapter has discussed the design and the methods chosen for the study. Because of the exploratory nature of this study, unstructured in-depth interviews were chosen as the appropriate method for data collection. Given the foci of the research, a key feature of the research was to hold separate interviews with older people who have had falls and with their key family members. The use of the NUD*IST programme was helpful in enabling me to retrace the analytic steps taken during the coding of data. It also assisted me in ordering and sorting my data into codes and concepts. Although Richards and Richards (1994) warn of the danger of taking the data out of context, I overcame this potential problem by referring back to the original transcripts and tapes frequently. The programme allowed me to experiment with building theories, and to gain confidence in retrieving all relevant coded material under particular headings, which could be seen as a validation check.

The ensuing chapters discuss the results of the study in relation to older men and women who have had falls, and their key family members. Quotes from the transcripts will be included, where appropriate, to illustrate the point being made. The way pseudonyms are
used was outlined in Section 5.8.2. My quotes are preceded by ‘Int’, short for interviewer. In line with transcript convention, the symbols [ ] indicate words inserted by the researcher, and the symbols ... indicate words omitted from the transcript by the researcher. At times lengthy extracts of the interview dialogue have been presented in order to preserve the context, within which issues were expressed.
Chapter 6

Social Meaning of Falls: Older People’s perspective

This is the first of two linked chapters which aim to examine the social meaning of falls and the meaning of risk from the perspectives of older people who have had recurrent falls. It will develop the work of Martin (1999), discussed in Chapter 3, which explored lay constructions of the risk of falling among older people.

This chapter discusses the construction of the meaning of falls by older people, including their gendered notions of stigma and that of biographical disruption. How these meanings impact upon older people’s notions of control and autonomy, and dependence and independence are examined. The perceptions of risk by older people who have had falls and by their key family members will be examined in the next chapter.

This chapter first examines the way in which a fall or falling was perceived by older people who have had falls, in particular, the terms used by them to talk about their falls in their social interaction with others, and the extent to which these meanings are gendered. The impact that gendered notions of control, dependence or independence, have upon the meaning of falls by older people are then examined.

6.1 Talking about falls: Older people’s Perspective

This section shows how the social meaning of falls by older people was constructed through the language used by older people when talking about their falls or falling events. One of the ways in which older people construct their meaning of falls is by their own definitions of falls they had experienced.
6.1.1 ‘Falls’ as ‘major’ versus ‘trips’ as ‘minor’

When asked to re-tell their falling events that had happened in the previous 12 months, and to consider what they thought caused them to fall, older people used particular terms to refer to specific ‘types’ of falls. The terms ‘slip’, ‘trip’ or ‘stumble’ tended to be used to refer to events such as tripping over an object, whereas the term ‘falls’ was more often used to refer to falling events that were not due to external causes. For example,

**CookM:** I couldn’t say I fell really, I just tripped over the kerb. It was uneven. I just landed on my knees, that’s all.

**HartM:** I wouldn’t say falls really, it’s more like slips and stumble, you know. I slipped over something. It might have been my mat over there, you know, and I just went down on the floor.

**LongF:** I got up one morning and somehow just fell ... sometimes I tripped over something because I was not looking where I was going.

Terms such as ‘trips’ or ‘slips’ or ‘stumble’ tended to be used to describe falling events that were caused by extrinsic factors associated with environmental factors such as loose objects on the floor, as reported by Mr Hart. In contrast, the term ‘falls’ were primarily restricted to those caused by intrinsic factors, that is, those associated with physiological problems such as dizziness, weakness, or poor balance:

**BickleF:** I think actually I fell because of my loss of balance ... because through lack of muscles now I’m weak on my legs ... I’ve got no strength in my legs, that’s why I fell.

**GiggsM:** I think my falls gotta do with my balance. You see, I do get dizzy spells sometimes, and I just lose my balance and fall down on the floor ... it’s my legs, they go jelly-like, and I can’t do much about it. They [legs] just go down and I go, on to the floor, bang.

Both Mrs Bickle and Mr Giggs associated their falls with a loss of balance due to some physiological changes. Also, they associated their falls with notions of ‘weakness’ and ‘loss of control’. Like some of the other older people who have had falls, Mr Giggs reported a loss of control in that he ‘can’t do much about it’, whereas
Mrs Bickle highlighted the weakness or lack of strength in her legs. It is suggested that older people construct their meaning of falls by indirect reference to the perceived cause of falls, such as physical (weakness in legs) and psychological (loss of control). This in turn has an influence on the social impact of falls as older people who have had falls may restrict their social activities with others.

In this study, older men and women also used descriptive words, such as ‘minor’ or ‘small’ to ‘big’, ‘major’, or ‘bad’ to make distinctions between the severity of falls, suggesting that the meaning of falls was value-laden:

**HudsonM:** I er only had one bad fall, and a couple of small ones ... the first one I think was a bad one ... I felt giddy and fell to the floor. I couldn’t do anything about it. The others were minor ones, you know, you sort of stumble over something ... if only I’d looked where I was going.

**SmartM:** I think I’ve only had one major fall and several minor ones. I am not too bothered with these minor ones, I sort of trip over really. It’s this other one that’s the problem.

**ChildF:** I’ve had about two falls so far, but had one major fall about two months ago.

**DenchF:** I’ve had one really bad fall, and a small one, you know, I didn’t hurt myself much ... That bad one, they [ambulance men] took me to the hospital, I needed stitches at the back, where I caught my head round here.

The above illustrates that the meaning of falls constructed by older people is influenced by the characteristic or nature of their falls. For instance, what caused the falls, whether they were trips or stumbles, or falls; and whether they were minor or small, and major or bad. The minor or small ones, were often perceived as ‘trips’ and were those that did not have serious consequences to the person. For example, Mr Smart’s account indicated that his major fall needed medical attention, and differed from his minor ones that did not result in him needing medical care. Similarly, Mrs Dench’s fall was considered ‘bad’ because she needed to go to hospital. Not only does this finding support the work of Martin (1999:29) in that ‘the term ‘trips’ is used to refer to falling occurrences with an ‘obvious external cause’ such as tripping over an
object, as reported by Mr Cook and Mrs Long, it also extends her work by suggesting that older people perceive ‘trips’ as ‘minor’, and ‘falls’ as ‘major’ or ‘bad’.

In this study, the nomenclature older people used to talk about their falls suggests that ‘falls’ were perceived as ‘bad’. In Mrs Dench’s situation, this was to do with the impact of the fall resulting in her needing medical attention. In Mr Hudson’s case, his fall was ‘bad’ because he felt giddy and, like Mr Giggs, he felt he could not do anything about it. With recurrent falls, the older person is more likely to perceive s(he) is no longer in control of events; this suggests that falls are not avoidable, which could undermine self-confidence. Because of a lack of personal control associated with falls, falls were perceived as a threat to an older person’s sense of identity since falls meant needing some help or medical attention, which challenged their independence. In contrast, older people perceive ‘trips’ to be avoidable, as reported by Mr Hudson. This sense of being in control of events is reflected in their accounts of ‘if they had looked where they were going’.

This section has discussed the ways in which older people re-tell their falling events, and suggests that older people tend to use the terms ‘trips’, ‘slips’ or ‘stumble’ which were perceived as ‘minor’, caused by external factors, and avoidable. Whereas ‘falls’ were more likely to be perceived as ‘major’ or ‘bad’, and unavoidable, representing the degree of severity of the falls and a perceived lack of control by the older person. These findings support Martin’s (1999) study which indicates that falls have a negative connotation. My study found that older men and women used terms such as ‘trips’, and ‘falls’ in a similar way to differentiate the circumstances and causes of their falling occurrences.

6.2. Gendered Stigma: Public and Private Falls

Goffman (1963:27) maintains that the stigmatised person ‘is likely to feel that to be present among normals nakedly exposes him to invasions of privacy’, and this can be
applied to older people who have had falls. For example, to fall in public spaces draws attention to the person’s ‘frailty’ or ‘lack of bodily control’ (Martin, 1999). This section examines the perceptions of older respondents who have had falls in relation to their notions of stigma, in particular the extent to which these are gendered. Some of the discussion focuses on the social impact of falling in public compared with private spaces.

6.2.1 Location of Falls

Falling at home in contrast to falling in public spaces may mean different things to older people. Twigg (1999:381) maintains that ‘home is itself structured in terms of privacy and intimacy, with certain areas remaining relatively hidden from strangers and associated more intensely with personal life’. She also draws attention to the notion of home as ‘the embodiment of identity ... it puts a limit on the degree to which the individual can be depersonalised’ (Twigg, 1999:387). Hence, falling at home may not only be ‘hidden from strangers’ but also protect one’s identity. In other words, an older person who falls at home may not be particularly worried about what others think of them. On the other hand, public spaces where people ‘come and go’ (Twigg, 1999) provide an arena in which events are open to scrutiny. Falling in public spaces may pose a threat to an older person’s sense of identity since falling may bring about shame and embarrassment. Shame bears directly on self-identity because it influences feelings of personal insufficiency (Giddens, 1991:65). The following discussion details older people’s reports of their experiences of falling in public compared with private spaces, and examines how these differ for older men and women, and the extent to which these influence the social meaning of falls.

Table 6.1 provides an overview of the falls experienced by older people in this study. In this table, the private domain includes falls which happened indoors at home, as well as outdoors at home, such as in the garden. The public spaces include falls
occurring in any other areas apart from the home, for example, falling in the street, in shops, at a local club, and in the dining room of a day centre.

**Table 6.1** Location where falls occurred reported by older men and women

<table>
<thead>
<tr>
<th>Location</th>
<th>Where Falls occurred</th>
<th>Number of Older Men (n=20)</th>
<th>Number of Older Women (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private domain only</td>
<td>At home (e.g. bathroom, bedroom, kitchen, garden, etc.)</td>
<td>4 [20%]</td>
<td>11 [55%]</td>
</tr>
<tr>
<td>Public spaces only</td>
<td>Falling in public places (e.g. street, shops, at social functions)</td>
<td>9 [45%]</td>
<td>6 [30%]</td>
</tr>
<tr>
<td>Falling in both public and private locations</td>
<td></td>
<td>7 [35%]</td>
<td>3 [15%]</td>
</tr>
</tbody>
</table>

Table 6.1 indicates that the majority of older men (80%, n=16), but under half of women (45%, n=9) had experienced falls in public places. More older men (n=7) than women (n=3) experienced falling in both public and private locations. More older women (n=11) than men (n=4) reported falling at home only. Nine older men reported falling only in public spaces compared to six older women.

**Table 6.2** Total number of falls and their location

<table>
<thead>
<tr>
<th>Location</th>
<th>Where Falls occurred in the past 12 months</th>
<th>Number of Falls by Older Men</th>
<th>Number of Falls by Older Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private domain</td>
<td>At home (e.g. bathroom, bedroom, kitchen, garden, etc.)</td>
<td>29 [42%]</td>
<td>49 [73%]</td>
</tr>
<tr>
<td>Public spaces</td>
<td>Falling in public places (e.g. street, shops, at social functions)</td>
<td>40 [58%]</td>
<td>18 [27%]</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>69 [100%]</td>
<td>67 [100%]</td>
</tr>
</tbody>
</table>

Table 6.2 shows the number of falls in the past 12 months reported to have happened in private and public spaces. These figures again show gender differences, with the majority of older men’s falls occurring in public spaces (58%) compared to only 27%
of older women’s falls. This supports other studies, for example, Bath and Morgan (1999) reported that 71% of men fell outdoors compared to 56% among the women.

6.2.2 Public Falls

The social impact of falls could be influenced by where the fall had taken place. For all older people, the experience of falling in public spaces was embarrassing, as one of the female respondents, Mrs Day succinctly put it: ‘If you fall outside it’s public, isn’t it and everybody looks’. Other respondents commented:

MalkinF: Oh when I fell outside the post-office, my shopping went everywhere ... people were coming to me, asking if I was alright ... I felt so embarrassed about it.

Int: How do you feel about falling in public places?
RushM: You feel a bit foolish obviously ... I’m the type of person who doesn’t like a lot of fuss and I think I get a little embarrassed.

Int: Did you hurt yourself when you fell in the town?
HullM: Only my bum and pride. I was embarrassed really to have to ask for help.

HullM: Well the last time I fell over, and I don’t think I could have stopped myself from falling over ... like recently, when Julie had her fortieth birthday, she held a party. I fell at that party, nothing serious, but I felt so foolish.

Int: How do you feel about falling in front of people at that party?
HullM: They know my problems, about my legs and all that ... but I do feel such a fool. An old chappie like me doing that at a party. If they didn’t know me they’d think I was drunk. But I do feel shaky afterwards.

Int: How did you feel when you fell by the roadside?
TuckM: Well I did feel embarrassed actually come to think of it. It’s when people rushed to help me [in the street] that it makes it all the more worse, I mean, don’t get me wrong. I appreciate their help but it sort of draws attention to the situation, and I imagine other drivers must have slowed down their cars to see what was going on. It is frightfully embarrassing when I recovered my senses. I was a bit dazed but a few days later I thought it over, it did come home to me that it must have been quite a scene. And I don’t like this sort of attention.

Int: What you, or men in general?
TuckM: I think actually men too. We don’t like that sort of attention. It’s alright if you fall at home and your wife pays the attention and showed concern. It’s not too public, is it? I think it makes a difference to our dignity, it’s about what others see us, isn’t it?
It is evident that feelings of embarrassment and inadequacy may be generated, in particular, when others like strangers proceed to give assistance. Mr Hull reported that apart from the physical impact of the fall, his pride was hurt, suggesting that falling in public posed a threat to his self and social identities. Both older men believed that their embarrassment was much to do with what others thought of them, posing a threat to their social identity. For Mr Hull, this consequently affected his feeling of inadequacy and self confidence. For Mr Tuck, this resulted in him feeling that his dignity as an older man was affected. He also underlined his belief that older men in general did not like the sort of attention that occurs when they fall in public, unlike the attention that men might get from their spouses in the privacy of their own home.

The responses from the public towards older men who fall were deemed less sympathetic than those towards older women:

WallM: Frankly speaking, people won’t help you when you fall if they think you’ve had a bit too much to drink ... they think we’re drunks. Now you don’t often think of women as drunks do you, when you see them fall ... If I see one fall, I would rush to help her ... no man should leave a woman to fall and not help.

and

ThornM: When you see older women fall, they get help. You’ll find people would not hesitate to help. I mean I’ve seen it happen. An old lady fell, and people walking in the street who saw it happened went up to get her up. A few of them helped her up. That’s the difference. If you’re a man, you’re drunk. If you’re a woman, you need help.

These gender differences highlight the gender-differentiated ‘ongoing activity embedded in everyday interaction’ (West and Zimmerman, 1987:130). The ‘doing gender’ is seen through the outcome of a fall; when a woman falls, she is seen as needing help and gets it, which is considered gender-appropriate. Whereas, when a man falls, he is seen as drunk:

ThornM: It’s only natural. You see a woman falling you stop to help. You can’t just walk away. They may be carrying too much shopping, they may, I mean, they could have easily tripped over something, and people would rush to help her.
Mr Thorn’s viewpoint that women are treated differently if they fall in public is also supported by older women in this study:

*PayneF*: I did fall on the road once. I tripped over a turf of grass [laughs]. I was crossing the road, and there was a little ramp and it took my balance off and I just went flat. A lady in the car stopped, and came back and said ‘are you alright?’ and helped me up and carried on.

*Int*: How did you feel at that time, when she came to help you?

*PayneF*: Glad I suppose. There are some kind people about.

*Int*: How different would it be if you were an older man and you fell then?

*PayneF*: Probably not the same because this er drunkenness seem to apply more to men than women, I should think. I think they’d [public] think I was a drunk, if I was a man.

Mrs Payne’s experience of falling in public spaces suggests that the public reacts differently to older women than to older men. Older men who fall in public are more likely to be thought to be drunks, while older women who fall in public are not; instead, help is given. It could be that these perceptions about the public’s response towards older men who fall were influenced by older people’s own social attitudes that in their generation being drunk affects men much more often than women (Kenneth and Jones, 1975), although little is known about the relationship between alcohol consumption and falls, particularly among older people (Downton, 1993). Nonetheless, the finding suggests that the social impact of falling in public spaces is reflected in the social responses of the public towards older men and women who fall.

By falling in public the person becomes a ‘public’ display, for older men particularly, it seems to be more discrediting. The reported experiences of falling in public spaces by older men in this study indicate that the stigma associated with falling is gendered. Most of the men in this study perceived the ‘falling’ events as ‘a nuisance and I can do without it’ [ThornM]. This reflects the negative connotations which older men have of falling, thus supporting Martin’s (1999:50) study which found that those who fall were ‘perceived in negative terms to be old, frail and dependent’. In this study, falling in public influenced the ‘virtual social identity’ and the ‘actual social identity’ of the individuals (Goffman, 1968). For instance,
HartM: It must have been in A.- about a year ago. Plenty of people about, you know, plenty of people walk by me, thought I was drunk or something, you know. Yeh, there were plenty of them who walked past me. Then it took a sixteen year old boy he gave me a hand up ... I was surprised to find a teenager to come and help. I would have expected some grown-ups you know.

Int: I see. Why do you think other people did not want to help you?

HartM: Well, they think you are drunk or on drugs somehow ... I was up there one day, was a bit unsteady on my legs, you know, a little shaky and the policeman said ‘excuse me sir, are you drunk?’ I said, ‘what, at nine o’clock in the morning?’ ... I was a bit doddery, you know, a bit staggery ... must have been a month after that one when that youngster came to my help. So I said to him [policeman] ‘I’d like to be but I’m not’

Int: Why’s that?

HartM: You see, it would have been better to have an excuse for being a bit doddery, but I can’t explain why I was like that, you know.

Mr Hart’s experience of falling shows the approach by others including a policeman. It underlines that stigma is gendered, for the following reasons. Firstly, it could be argued that it is unlikely that an older woman would have been assumed to be drunk by a policeman. Secondly, it illustrates the attitudes the public has towards men who fall in general, regardless of their age, and that falling in public places for older men is more stigmatising than it is for older women. Through the process of social interaction with others they believe that falling in public was affecting their social identity. Third, the consequence is that older men are more likely to restrict public activities than women. Five of the sixteen older men, compared to two older women who had fallen in public spaces reported restricting their social activities, avoiding public spaces such as shops and post offices because of a fear of falling, and what others might think of them. For example, as a result of that experience, Mr Hart had not been to the town centre on his own for nearly a year, for fear that he might fall again, and be mistaken as a drunk.

Only one woman mentioned that falling in public for her was primarily seen as embarrassing, although she perceived that the public might have thought she was drunk:

NicholsF: They [the public] must have thought I was drunk or something when I fell over the pavement.
However, unlike Mr Hart’s experience, Mrs Nichols did not return to that street for about two months because of her lack of confidence in walking past the same spot where she had previously fallen, rather than because of the potential stigma of falling in public.

Falling in public spaces also raises the issue of the legitimacy of falling. Mr Hart would not have minded being labelled as a drunk who fell, if it had been true. On the contrary, his fall was beyond his control and thus discredited his masculine identity. This underlines the importance of older men’s identity in the public sphere, supporting Whitehead’s (2002:114) observation that ‘the public sphere is a place where males are supposed to inhabit naturally, a place they must colonize, occupy, conquer, overcome, control. It is a place where men come to be (men)’. Falling in public spaces therefore, undermines an older man’s masculine identity.

The stigmatising impact of falls upon older men was also supported by their key family members:

**DTuckM:** When my father fell in the pavement, he was devastated, I mean, he was very shocked and embarrassed really. He sort of mentioned to me after it’d happened, when I saw him that evening. I felt sorry for him, I know I would be embarrassed if I fall in the open. People are bound to want to know what’s going on. So I can sympathise with him. I think it affected him more.

**Int:** Why do you think so?

**DTuckM:** I don’t know, may be, it’s because it’d happened to a man. I’m only guessing. I think it hurt his pride you know, I’m sure it did because after that fall, he was er very reluctant to go out again.

**Int:** What, in case he falls?

**DTuckM:** Yes, and er because he was embarrassed about it. I think he didn’t want other people to think there was something wrong, I don’t know, may be they’ll think he’s not OK. May be they look at him and thought there’s something not quite right with him.

Mr Tuck’s daughter’s account illustrates how some of the key family members recognised the negative impact public falls had on older people, particularly older men. Older men were perceived by their key family members as being embarrassed
about their falls, and concerned about their social identity, as well as their masculinity. This was supported by Mr Smart’s daughter who reported:

**DSmartM:** He[her father] fell outside the club and naturally I helped him up. But he was uncomfortable about that. Yes, he was definitely embarrassed about tripping up and landing on all fours ... I’m sure he didn’t like it one bit, falling out there. It was too open and there were people about, you know. It’s only natural that people stopped to look what happened.

**Int:** What difference does it make whether he fell in the open or at home?

**DSmartM:** Oh a lot of difference I should think. I mean, when he fell in the living room, it wasn’t in front of anyone. It just happened that when the Dial-A-Ride people came to collect him to go to the Day Centre that they found him cut and bruised. But they knew him, he’s been going there for a couple of years now. It did make a difference, they knew him and he knew them.

**Int:** But when he fell in the open, I mean outside in the public ...

**DSmartM:** Well, that’s different. He was out in the open and then he fell. He didn’t like the attention he received. I knew he thought all eyes were on him, and he didn’t like it at all. He was definitely embarrassed, oh yes, he was ashamed of it. It sort of make him think, well, he doesn’t like to be seen frail and old. He hates it.[laughs]

**Int:** Hates what?

**DSmartM:** Hates being seen out there, falling, and of course, people are bound to think of him as a ‘poor old chap’. He just dreads to think what others thought of him when he fell that time. He’s too proud, it’s this image thing, isn’t it?

Mr Smart’s daughter differentiated the impact between public and private falls, supporting the views of older people themselves. The ‘openness’ of a public fall meant that when older people fell, they were unable to hide from the view of strangers, whereas falling in private spaces meant that the events were not witnessed by strangers. However, falling in public spaces meant that for older men, in particular, their image became stereotypical of a ‘poor old chap’ who was weak and frail. This image was much resisted by older men. In contrast, the stigma associated with falling in public places was not highlighted by key family members of older women who have had recurrent falls:

**SLongF:** I think if you fall outside it’s surely more embarrassing. I know she [mother] was embarrassed when she fell outside. She said so herself. Don’t get me wrong, she appreciated the help she got. Someone happened to walk past and helped her up. But I know I would feel awful, I mean in front of strangers ... Can’t be very nice, is it?
DPayneF: When she fell at the bus-stop, she was cross with herself. She said she should have looked where she was going. Luckily for her, someone was there, who happened to be waiting for a bus, he helped her up, and she was grateful of that help. Funny thing, we were just talking about it recently, and I asked her how she felt. She just said, ‘Oh, what do you expect’. I mean ur she’s talking about being embarrassed about falling in front of other people. I know I would feel the same, but then when you get to a certain age like she is now- she’s turned 79 last month- you have to accept that this sort of thing is more likely to happen. I think basically she felt embarrassed about it but then it didn’t stop her from going out on the bus again.

Int: How different would it be if an older man had a fall in public?

DPayneF: An older man, er I think he would definitely feel embarrassed. There’s no doubt about it. I also think if you’re a man, it is worse for them. I don’t know, I’m only guessing. It’s just that when you see an old chappie fall, you tend to think ‘gosh, poor man’ or ‘what’s wrong with him?’ ... I might be wrong but that’s my view anyway.

These accounts illustrate that key family members viewed falling in public places was more stigmatising for their older male than for their female relatives. It supports the commonly held view by older people in this study that when an older woman fell in public places she received help from the public, whilst an older man would be assumed to have something wrong. This implies that falling in public raises questions about an older man’s ‘virtual social identity’, that Goffman (1968) suggests is the character imputed to an individual. This supports MacRae’s (1999:54) argument that the person who is stigmatised is ‘seen as less than a whole person’.

6.2.3 Private Falls

To fall in a private space means that one’s falls may be unknown to strangers. Falling at home was preferred by all the older people who have had falls. Such preference was stated because falling at home safeguarded the older person’s identity. Even those who have only fallen in private spaces were able to imagine what it would have been like if they had fallen in public spaces:

Int: I know you’ve only fallen at home. How would you feel if you were to fall outside, say in the street?
ScarrF: God forbid. They [public] are likely to think I am disabled, incapable of holding my legs, and just a frail old woman who needs lots of help. They will probably be willing to come over and see if I’m alright. I expect they will call an ambulance and then I am whisked off to the local hospital.
Mrs Scarr had only experienced falling at home, and for her the thought of falling in public spaces brought with it the notion of disability, frailty and in need of help. It also illustrates how she perceives the advantage of falling at home, ‘no one would know’. The social identity of an older person who falls in private spaces has not been threatened compared to falling in public spaces. The person who falls in private spaces is able to safeguard his or her identity, even if the falls were due to their diminished physical well-being. A similar viewpoint is expressed by Mrs Bickle who identifies some of the differences between falling in public and private spaces:

**BickleF**: At the back of your mind, you think to yourself, I might have a fall while I’m out, I’d rather fall indoors.

**Int**: Why?

**BickleF**: Well, because it causes more confusion, ambulances being called, and all that sort of thing. Even if I fall indoors, they [ambulance] will come and help if necessary, but indoors you can sometimes save yourself, holding to things. It’s private, behind these four walls [laughs]. If you’re outside you can’t sometimes get away with it.

**Int**: Get away with what?

**BickleF**: Being seen by other people, they think you’re too old [laughs].

Like Mrs Scarr, for Mrs Bickle, falling in public spaces not only draws attention from other people unknown to her, but there is a greater likelihood that someone from the public will get medical assistance, whereas when falls occur in private spaces, calling for medical assistance relies on the person who falls, or someone close to him/her. Also, when a person falls in a private space, they are more likely to hang on to some furniture to stop themselves from falling or injuring themselves badly, giving them a sense of personal control and independence.

Older men’s views about falling in private spaces were in accord with older women’s:

**HudsonM**: I’ve only fallen in here [his flat], and it’s alright. I press the alarm to ask the warden for help if I think I needed to. Otherwise, it’s business as usual.

**Int**: How would you feel if you fell outdoor. I mean, out in the open.
**HudsonM:** It would be terrible, it can't be nice, I mean, having outside and everyone gazing at you. I should hate that.

**Int:** Why's that?

**HudsonM:** I don't know. I guess it must be their pride. I know if I fall out there [outdoor] I would feel embarrassed, shameful, and worried.

**Int:** Worried?

**HudsonM:** Yes, worried. Worried about what people think. They might think I've been drinking [laughs].

**Int:** Is that so? Won't they think the same if you'd been a woman?

**HudsonM:** Not likely. You don't see older ladies here drunk.

Mr Hudson's comments underline the general feelings among older men in particular, that falling in public spaces is discrediting, and that the social impact led them to worry about what others thought of them. However, he was not worried about getting help from the sheltered housing warden when he fell indoors. He could make his own decision about whether to seek her help, unlike falling in public spaces, where he would have had no choice about receiving help.

### 6.2.4 Falling in Public and Private Spaces

Falling in both public and private spaces imposes a difficulty common to all who have had falls. The difficulty is in 'covering' the visible signs of falls, or injury from a fall, as the following illustrates:

**SmartM:** You get a feeling that when you walk in there [dining room at a day centre], all eyes must be looking at you thinking what you’ve done to get these bruises. I mean, this black eye was worse last week when I hit it on the low table.

**Int:** You think all eyes were looking at you. How does it feel to be the centre of attention?

**SmartM:** Not much, not something I would wish for. But I can’t hide it, it’s here, right here in this eye, and wearing sun glasses would be too obvious that something has happened. They might think I’ve been in a fight [laughs] not that I’m of that build. Look at me, I’m all skin and bones, can’t get into a fight now at my age.

For Mr Smart, the fall he experienced in his home resulted in the visible signs of his bruises, which led him to a consciousness of the 'virtual social identity' ascribed to him as someone who falls. Even though he was not among strangers at the day centre
since he was a regular user, he was still conscious about the meanings other people may ascribe to him. In other words, falling in the private space of an individual’s own home, can pose a problem concerning the visible signs of the impact of the fall. The awareness of Mr Smart’s ‘skin and bones’ draws our attention to his body image, and how ageing impacts upon his self-definition as someone who ‘can’t get into a fight now’ representing a challenge to the ‘traditional assumptions of male identity’ (Charmaz, 1995:286). It may be interpreted as ‘an uneasy tension’ that Charmaz (1995:286) believes to exist ‘between valued identities and disparaged, that is, denigrated or shameful, ones’.

This section has discussed the experiences of falling in private and public spaces, and how this may influence an older person’s meaning of falls. It is suggested that these meanings are gendered in the sense that older men are more likely than older women to perceive it to be more discrediting to fall in public spaces. This view was also supported by their key family members. More older men than women fell in public spaces, and found this experience more stigmatising; it brings with it the notion of disability, frailty and being in need of help. The older person became a public display. Falling in public spaces not only draws attention from other people unknown to the older person, but there is a greater likelihood that someone from the public will call for medical assistance on their behalf, whereas when falls occur in private spaces, seeking medical assistance relies on the older person who falls, or someone close to him/her. The research suggests that it is more stigmatising for older men who fall because of the perceived stereotypical images of drunkenness and falls, and the threat to their ‘public’ masculinity identity. Falling in public is perceived to affect their virtual social identity, that is, the attributes that others impute upon them. Falls also led older men to be concerned about the legitimacy of falling. It has been shown that falling in public and private spaces potentially imposes a difficulty common to all who have had falls, which is in ‘covering’ the visible signs of falls, or injury from a fall that may exist.
6.3 Falls as Gendered Disruptions

The meaning of falls may be perceived as a ‘biographical disruption’ (Bury, 1982). This section examines the construction of the meaning of falls by older people through personal biography, and in the context of a ‘biographical disruption’.

6.3.1 Falls in Personal Biographies

Williams (1994:178) maintains that people make sense of events in their lives through ‘narrative reconstruction’, that is, through personal biography. The personal biographies indicated by the older men in this study included their previous participation in the second world war, and their previous occupation. Charmaz (1995:279) suggested that older men with chronic illness ‘aim to reclaim the same identities, the same lives they had before illness ... For these men, their “real” selves are and must be only the past self’. It is, therefore, possible that older people who have had falls make sense of falling events within the context of their past, and one of the ways is through their past experience of taking part in the second world war.

**CookM**: ‘When I was in the war, it was alright to *fall*. What with explosions coming out from nowhere, you are expected to *fall* down onto the ground...’

Mr Cook’s reference to his previous experience of falling indicates that it was ‘alright’ then to fall. His implicit meaning of ‘to fall’ here stems from the legitimacy and expectation of falling, and its relevance to old age. It could be interpreted that he did not expect to fall now but it was ‘alright’ when he was younger fighting in the war when falling was a norm. Some of the older men’s reference to their participation in the war compares what it was like to fall then, compared to falling now:

**HudsonM**: It’s our experience I guess. When you’ve been in the army and fighting the enemy there’s no hope if you panic, is there? So when you *fall*, you shouldn’t panic really. You’ve been trained not to panic, I think.

**CantM**: Never thought I could be tripped up you know, I mean, you don’t expect to fall. In the navy you might have *fallen* a few times on the deck, you know, when the going is tough, but you picked yourself up again. Everyone
HullM: I was telling my son only the other day; during the war I was in the army, all over the place you see, and you think nothing of falling. You fall to save your own life. When we were bombed, you quickly dive down, fall down quickly onto the ground, trenches, and cover your face and wait. Things exploded here and there, and in them days, I was young enough to get up quickly. Now, if you were to ask me to do that, I shan't be able to do anything like it ... I should think that was the last time I fell as an adult until now when these stupid things happen ... these stumbles and trips.

The experiences of falls during their previous service in the army or navy had made a strong impression upon this generation of older men. Whilst Mr Hudson had learned not to panic, Mr Cant considered it as a ‘darn thing to do’. Mr Hull makes reference to how quickly he recovered himself from falling during bombing. These analogies suggest that falls were not a negative experience in that they were fighting a war and here, falling was seen as gender-appropriate. The expectation to fall is also voiced by another older man:

TidyM: Well you don’t think nothing about falling. I was in the building trade, was always up and down. So it was no problem to me at all. You expect to have the odd fall and get yourself up.

Mr Tidy recognised falling as an occupational ‘hazard’ and this was not seen as a problem, which is in contrast to falling now. This illustrates the difficult situation that older people have in coming to terms with falling later in old age. For older men, it would appear that by making reference to their previous ‘work’ during adulthood, perceptions of status, ability, and worthiness can be maintained (Kosloski et al., 1984). That is, it empowers older men to meet ‘the social norms for masculine attitudes and behaviour’ (Gradman, 1994:105). Indeed, Whitehead (2002:125) underlines how ‘men’s sense of masculine self may be constantly reaffirmed at work’. This study supports Solomon and Szwabo’s (1994:43) observation that ‘external experiences may alter the outward behaviours of many men but that their self-concept is consistent with the role they integrated early in life’. Masculinity, in these older men’s views may be
seen to be associated with strength and bodily control, such as having the strength to fight in a war, and to fall, and ‘not panic’, and be able to ‘get up quickly’.

An issue arising from older men’s reference to their past experience of ‘falls’ either during the war as in Mr Cook’s, Mr Hudson’s and Mr Cant’s case, or their past occupation, like Mr Tidy’s, is the legitimacy of falls. To fall then was a permissible thing, an acceptable ‘norm’ or expectation. However, with increased age, to fall adds another dimension: it becomes ‘unacceptable’ to them because of the meaning it sends out to others around them. Such signals include being in greater need of help, and increasing frailty and dependence. This supports the negative connotations associated with falling as asserted by Martin (1999).

6.3.2 Falls as a Biographical Disruption

Within a lifecourse perspective, falling events may be conceptualised as a biographical disruption, which has far reaching consequences for older people and their families. In his study of people with rheumatoid arthritis, Bury (1982) conceptualised chronic illness as a kind of biographical disruption. The disruption of ‘taken-for-granted assumptions and behaviours’ as highlighted by Bury (1982:176) was identified by older people, especially older men who have had recurrent falls:

**VokesM:** You do take what you do normally for granted. At one time, I would have no qualms about getting up and go up to the town. But now, I have to think about how I’m going to get from A to B, and it’s not easy. What used to take a minute seems to take me hours.

**TuckM:** Since I’ve had these falls, I’ve noticed I haven’t got the strength in my legs, in my arms to move about. I take twice as long to get my balance right because my legs can go suddenly. I have to be careful how I move my legs and arms so I won’t fall.

**HudsonM:** It’s a terrible feeling, you can’t control your situation. I can’t do what I want as much as I used to. I’m used to getting up and down trees, that sort of things. Now, I couldn’t get up, I couldn’t get on my knees, so I had to give in and get a warden ... It’s not easy relying on others.
Mr Vokes realised that what was once taken-for-granted has disrupted his lifestyle, in terms of normal everyday activities. Similarly, for Mr Tuck, falls brought upon the realisation of his functional limitations. This supports Bury’s (1982:176) observation that the ‘taken-for-granted world of everyday life becomes a burden of conscious and deliberate action’. Similarly, Mr Tuck talked about needing time to get his balance right, which was a conscious and deliberate action. Mr Hudson’s experience of being out of control typifies the fears expressed by some older people as they construct the meaning of falls in relation to their increased dependency, drawing attention to their physical functioning and appearance, fuelling feelings of self-consciousness. This concern was also voiced by others:

**DenchF:** Well, because of my falls, I am a bit scared of walking for a while ... I rely on my son and daughter-in-law to take me out. When they take me out, they put me in a wheelchair or else I won’t be able to go to the shops. You see, I have to rely on my family, can’t do it [shopping] on my own.

**CottonM:** I can’t go shopping on my own these days, I haven’t the confidence to do it on my own, so my niece has to take me out to the shops. She doesn’t mind it but I do feel awful having to rely on her. She’s so busy herself. I just wish I can do more for myself but Audrey [niece] reminds me that I’m not as young as I used to be.

**VokesM:** I do try and do as much for myself but since these falls, eh she’s [his daughter] been helping out more, help with the cleaning. I don’t really want to be a burden on anybody. I do want to be as independent as possible.

**ChardM:** I can’t do as much as I used to. I want to be independent, but with these falls, I am scared of moving around in this flat. So Karen [daughter] comes in to help me. I can’t get out of the flat to the dining room downstairs without help because if I do, I am sure to fall. I know I shouldn’t walk on my own, so I always have to have someone to accompany me.

From Mrs Dench’s viewpoint, falls represent a disruption in that she now has to be in a wheelchair when she goes shopping with her family. The change in dependency reported by these respondents as a result of recurrent falls meant a change in status into having to rely on others. For some older people, it also meant becoming passive recipients of care, less able to change or exercise control over their situations, as illustrated by Mrs Dench and Mr Chard.
The above illustrates the way in which recurrent falls represents a 'biographical disruption' because falls were regarded as associated with stereotyped notions of being old and frail. Coupled with this, older people who have had falls found the experience a threat to their personal and social identities because of their loss of power, control and autonomy, although Hockey and James (1993) maintain that elderly people may succumb to increased dependency and the associated stigma. For some, the increase in dependency following their falling events has meant a change in status; as one of the male respondents, Mr Thorn, puts it 'you belong to a dependant group'.

This section has drawn attention to the conceptualisation of falls as a 'biographical disruption' that impacts upon the social construction of falls by older people, particularly in relation to their notions of dependence. Having falls represents a biographical disruption for two reasons. Firstly, experiencing recurrent falls leads to the realisation of functional limitations, which in turn, result in an increased dependency. This change in dependency meant a change in status to one of having to rely on others as a result of falling, with older people more likely to become a passive recipient of care, less able to change or exercise control over their situation. Secondly, as a result of having recurrent falls, older people experienced embarrassment, and became aware of how people might look at them. Falls were regarded as associated with stereotypical notions of being old and frail. The study also shows that both the functional limitations and the embarrassment resulted in older people making conscious and deliberate actions, including deciding to restrict their activities, especially not going to public spaces.

6.4 Conclusions

This chapter initially examined the meaning of falls in relation to how older people defined falls. There were specific ways in which the term 'fall(s)' was used, and these were reflected in the interchange of related terms such as 'trips', 'slips' and 'stumble' in contrast to 'falls', that were caused by intrinsic factors that are linked to
physiological changes. This study indicates that the social meaning of falls constructed by older people who have had falls evolves around three inter-related components: the language of falls, the gendered stigma associated with private compared with public falls, and the perceived disruption resulting from falls, which encompasses personal biographies and biographical disruption.

The chapter has also examined the extent to which the location of falls might have influenced older people’s notions of stigma. It is suggested that falling in public spaces compared to falling in private spaces emits messages of embarrassment, of attention by others, and of discredit. The negative connotations attributed to falling in public spaces by older men, coupled with the discrediting experiences reported by older men, suggest that falling is more stigmatising for men because of its threat to the public masculine self. Falling in public influences the ‘virtual social identity’ and the ‘actual social identity’ of the person who has experienced falls. This view was supported by key family members. When older men fell, they were more likely than older women to be assumed to be drunk showing that the experience of falling is gendered in terms of the resulting stigma. That is, it is more stigmatising to fall for older men, raising the salient concern of the legitimacy of falling.

Finally, this chapter illustrates that, within a lifecourse perspective, the meaning of falls can be conceptualised as a biographical disruption. Experiencing falls led to a realisation by older people of their functional limitations, and often resulted in an increased dependency. Because of the embarrassment that accompanies recurrent falls, older people are conscious of how people might perceive them. The biographical disruption of recurrent falls brought about a change in status to that of having to rely on others.
The Meaning of Risk: Older People and their Key Family Members’ Perspectives

This chapter will answer the question: how is the meaning of the risk of falling constructed by older people who have had falls and by their key family members? To do so, it will extend the work of Martin (1999) which explores the construction of the risks of falling among older people from lay and professional perspectives, and Wynne-Harley’s (1991:1) work on the extent to which risk is incorporated in older people’s daily lives’. Whilst a particular concern of Martin’s (1999) study was to identify the potential for primary prevention of falls, Wynne-Harley’s work focused on voluntary risk-taking in the context of daily life.

The initial discussion in this chapter focuses on the perception of risks by older people who have had falls and how they use other related terms such as ‘hazard’, ‘danger’ or ‘safe or safety’. An examination of the notions of risk and risk-taking behaviour will be provided, with a particular focus on how gender impacts upon these perceptions and subsequent risk-taking behaviours. Perceptions of key family members will be examined in a later section of this chapter.

7.1 Meaning of Risk: Older People’s Perspective

7.1.1 Risk, Hazards and Safety: Older People’s Persective

In this study, older people’s perceived risks of falling were gleaned from their notions of what they thought made them more likely to fall than others of their age. Questions relating to their health and or medical problems, medications, home environment, and their daily activities were also posed. The respondents were asked how confident they felt about walking indoors and outdoors, and what they thought they should or could
have done to stop themselves from falling again. The word ‘risk’ was never directly mentioned by the researcher.

This study identifies the specific ways in which older men and women report about ‘risk’, suggesting that there is a gender difference in how risk is perceived. Not only were older people spontaneous in their accounts relating to the risk of falling, they also indicated that risk-taking is associated with personal responsibility, and the responsibilities of others.

More than half of the sample of men spontaneously articulated words like ‘risk’ and ‘risky’ compared to only one woman:

**SmartM:** I think I’m at risk of falling...I have low blood pressure and I suffer from giddy spells, especially if I get up too soon.

**ThornM:** To be honest with you, I’m a liability. I’m not safe to be alone ... what with my angina and dizzy spells ... I can fall anywhere and any time without much warning.

**HallM:** I feel I am too risky to be going out on my own, to the clubs like, I need my wife to be with me when we go to the clubs [day centre, etc]. I just don’t feel safe in this sort of places without her around.

**EdeF:** If you’re a sensible person, it’s no good taking risks, I mean I don’t even go to the dustbin. I’m not very good now carrying that sort of thing you see. So I got a little plastic bag, on a chair, and my daughter comes in the morning and she takes it and empties it in the dustbin for me.

How older people who have had falls assessed their own risk in relation to falls reflects their awareness of the risk of falling, which in turn impacts upon their notion of ‘risk taking’. Several older people, like Mr Smart and Mr Hall acknowledged that they were at risk of falling, or were not safe to be on their own. Their spontaneous use of words relating to risk suggests that older men in particular had no difficulty in articulating words such as ‘risk’ or ‘risky’, ‘liability’, ‘safe’ and ‘taking risk’; it challenges Martin’s (1999:41) claim that risk perceptions were not clearly defined, and might be ‘difficult to articulate’. The range of words articulated by older respondents in this study was consistent with Alaszewki’s (1998) model of words related to risk (see Chapter 3).
Table 7.1 provides a breakdown of the terms associated with risk spontaneously mentioned by older people who had had falls.

Table 7.1  
Number of spontaneous mentions of the term ‘risk’ and other related words by older people

<table>
<thead>
<tr>
<th>Risk and related terms</th>
<th>Older Men [n=20]</th>
<th>Older Women [n=20]</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Risk’, or ‘risky’</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>‘danger’</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>‘hazard’, ‘hazardous’</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>‘safe’, ‘safety’</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>‘liability’</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>6</strong></td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>1.25</strong></td>
<td><strong>0.3</strong></td>
</tr>
</tbody>
</table>

As shown in Table 7.1, the term ‘risk’ was mentioned by the majority of older men (n=11) but only one woman. The table also shows that a greater diversity of words was used by older men than older women; for example, ‘safe’ or ‘safety’ was expressed by 5 older women and 9 older men, whilst ‘liability’, ‘danger’, or ‘hazard(ous)’ were only articulated by older men and not by older women. Older men mentioned an average of 1.25 terms related to risk, compared to an average of 0.3 by older women.

The analysis of the data also indicates that older people perceive their risk of falling or the factors that might contribute to their falls as either ‘intrinsic’ or ‘extrinsic’ or both. Intrinsic refers to risks related to the physiological changes associated with ageing, as in the case of Mr Smart and Mr Thorn, whilst extrinsic risk refers to external factors such as their daily activities or the environment. In Mrs Ede’s case, emptying her rubbish into the dustbin was seen as putting her at risk of falling; this was a perceived extrinsic risk factor. Thus, older people tend to articulate aspects of their lifestyles or activities of daily living, and their health and medical conditions, that might make them more likely to fall than others of their own age. Invariably, both intrinsic and extrinsic risk factors were seen as putting them at risk of falling.
Below are some examples of the risk factors identified by older people:

**HopkinsF:** Uneven pavements or bad shoes. The road outside here is very bumpy, very uneven, and I am wary when I walk out of this house just in case I fall ... My legs, they are not as good as they used to be, so they do sometimes just give way. I suppose they are just as likely to make me fall.

**CottonF:** I think using the stair case is more likely to give me the feeling that I might fall. Other than that, I can’t think what else might do that.

**WeeksM:** You lose your balance very quickly, you have to be careful when you get up, you have to stand there a couple of minutes to get equilibrium or you tend to fall one way or the other.

**TibbsM:** No ragged carpets or anything like that. I don’t think there are any things hazardous in here. I’ve kept my furniture to a minimum so that it is not cluttered in here.

In general the risk factors identified by older people support those identified by health professionals, among whom the consensus is that a combination of several factors contributes to a fall, and these include health status, vision and environmental hazards (Ivers et al, 1998; Sattin et al, 1998; Lord and Dayhew, 2001). The above accounts also suggest that older people’s notions of risk and assessment of their risk of falling can influence their actions or behaviours. For example, Mrs Hopkins was aware that uneven pavements and her weak legs might put her at risk of falling, and this caused her concern when she left her house. Similarly, Mr Weeks identified the loss of balance as a risk factor for falls, and indicated that he needed to be careful when standing. It could be argued that the type of environmental challenges that an older person chooses to expose themselves to, or the extent of a person’s risk taking behaviour would have an important impact upon their subsequent actions to prevent future falls. It is suggested that the types of perceived risk factors, intrinsic or extrinsic, could have an influence on the extent to which older people thought they had any control in order to reduce the risk. For example, extrinsic factors would be more likely to be considered as ‘controllable’; a home environment may be modified, whereas an intrinsic factor like dizziness may be less controllable because of the physiological changes in the body. Further examination of these actions will be discussed in Chapter 8.
Table 7.2  Perceived risk factors identified by older people who have had falls

<table>
<thead>
<tr>
<th>Perceived risk factors</th>
<th>Older Men (n=20)</th>
<th>Older Women (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intrinsic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical/health problems</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Age</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Sight</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Extrinsic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environment: Home</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>: Public spaces</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td><strong>Daily activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e.g. bathing, getting up in the night)</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total mentioned</strong></td>
<td>42</td>
<td>22</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>2.1</td>
<td>1.1</td>
</tr>
</tbody>
</table>

* An older person may identify more than one risk factor.

A breakdown of the range of risk factors identified by older people can be seen in Table 7.2 showing that both older men and women identified medical and/or health problems. This supports El-Faizy and Reinsch’s (1994) study which found that with advancing age, health factors featured more prominently as risk factors or causes of falls. Whereas, over twice as many older men (n=13) as older women (n=5) identified extrinsic factors associated with the home and public environment as representing a risk to falling. More than twice as many men (n=14) as women (n=5) considered their daily activities contributed to their risk of falling. This supports Lord et al (2001) who found that forty percent of falls happen during activities essential for independent daily living. Four men and two women indicated that age was one of the risk factors, while only one man and two women thought their poor eyesight put them at risk of falling. It was interesting to note that although nearly half (n=18) of the respondents (n=40) took four or more
types of medications, none of the respondents considered this to increase their risk of falling.

Table 7.3  Number of risk factors identified by older men and women

<table>
<thead>
<tr>
<th>Number of risk factors identified</th>
<th>Older Men (n=20)</th>
<th>Older Women (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>4 or more</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total number of factors</td>
<td>42</td>
<td>22</td>
</tr>
<tr>
<td>Average</td>
<td>2.1</td>
<td>1.1</td>
</tr>
</tbody>
</table>

A breakdown of the number of risk factors identified by older people in relation to their likelihood of falling can be seen in Table 7.3. There is a distinct gender difference, with more older women (n=7) citing no risk factors, and older women reporting fewer risk factors. Older men who have had falls identified an average of 2.1 risk factors compared with an average of 1.1 identified by older women.

This section has highlighted that older women articulated less awareness than older men in relation to identification of the risks that might make them fall. This contradicts Lupton’s (1999:161) claim that women’s notions of risk-taking are highly associated with assumptions about femininity which are likely to depict ‘the careful avoidance of danger and hazard as important’. However, it could be argued that women’s notions of risk-taking are reflected in their ‘ongoing activities’, that is, they have always carried out these activities but do not articulate them as ‘risk-taking behaviour’.

It was interesting to note that a loss of balance was not identified as a risk factor for falls by older people who have had recurrent falls. Yet, eleven of the older respondents (6
men and 5 women) attributed loss of balance as one of the causes of their falls. Other causes perceived by older people as leading to falls included age, own carelessness, and destiny. For example, 7 older women cited their own carelessness as one of the causes of their falls, whereas none of the older men did so. This indicates a readiness on the part of older women to self-blame. However, two older men viewed their falls as being in the hands of God:

ColsonM: Depends what the bloke upstairs [God] has got for me. As far as I know I’m not going to have another fall.
Int: To what extent can you avoid it?
ColsonM: If He [God] says I’ve got to fall again, I shall. I don’t control it.

TibbsM: That’s up to God whether I fall or not.

This fatalistic view is not peculiar to people confronted by health risks, as Denscombe (1993) suggests. It reflects a perceived lack of personal control by these individuals, implying that their falls were not their ‘fault’ and that they had no control over their falls. It is suggested that a person with fatalistic views may perceive their risk of falling as ‘chance, luck or fate’, a term expressed by Rotter (1990:489) when referring to a person’s expectation that his personal outcome may be under the control of powerful others, or ‘unpredictable’. Such a view about the risk of falling can impact on their subsequent actions to prevent falls, suggesting that they instigated little actions, because of their perceived lack of control of the situation. This, in turn, is related to their perceived self-responsibility, which is discussed in the following section.

7.1.2 Risk-taking: Gendered Responsibility

The focus of this section is on older people’s notion of risk-taking in relation to their experiences of falls. It draws upon the work of Kemshall and Pritchard (1996:10) who argue that risk-taking ‘has to be balanced against exposing self, others or their property to unnecessary harms and dangers’. The authors also recognised that individuals ‘treat risks differently depending on how they frame situations’ (Kemshall and Pritchard, 1996:16). Thus, in this study, the risk-taking behaviours of older people were gleaned
from their accounts of how they responded to their experiences of falls, and what they considered they could or should have done.

This study supports the work of Kemshall and Pritchard (1996) who argued that risk perception is influenced by how individuals frame their situation. Older people who have had recurrent falls 'frame' or make sense of their falling events by taking into account their own self-expectation, and that of others. It is likely that the benefit of hindsight about what caused them to fall, assisted them in putting into context what they expected of themselves and of others, and deciding which aspects were relevant or not (Kemshall and Pritchard, 1996). This study indicates that older people, in particular, most of the older men (n=16) portrayed themselves as 'responsible' and 'rational' individuals:

TibbsM: I don’t deliberately put myself at risk you know. Certainly not at my age.
Int: What sort of risk did you have in mind when you said you didn’t deliberately put yourself at risk?
TibbsM: Oh anything that you shouldn’t be doing if you know that’s going to make you fall. Like if I know that getting up too soon will make me fall, then I jolly well make sure I mustn’t do that.
Int: And what else would happen if you did put yourself at risk?
TibbsM: I could hurt myself badly, then I would be no good to anyone. I like to do as much as I can for myself.
Int: If you hurt yourself badly.
TibbsM: Yes, if I hurt myself badly, then I’ll be needing more help from the district nurse, I might not be able to walk down again, who knows.

At the age of 92 Mr Tibbs considered it was his responsibility to deliberately not put himself at risk. His responses to the risk of falling were to avoid doing things that he thought might make him fall. His desire to protect his own independence and autonomy can be seen through his own deliberate and careful analysis of how he ought to get up slowly, which supports Wynne-Harley’s (1991) finding that the maintenance of independence and autonomy by older people influences the way they set limits and restrictions. Wynne-Harley (1991:29) notes that:

Reasonable, informed and calculated risk-taking play an important part in contributing to the quality of life ... this is a matter of choice, demonstrating an individual’s right of self-determination and autonomy.
This is also illustrated by Mr Finn’s and Mr Hart’s comments:

**FinnM:** It’s a matter of assessing your risk, and you start looking around the home environment and work out which might cause you a problem, or pose a danger really. I have already installed this special BathKnight, which is brilliant, it takes away that problem of having to get out of the bath, and worrying about falling about in the bathroom.

**HartM:** I don’t feel safe to go up on the bus myself, I don’t feel safe to go out on my own anymore. It’s strange, I know I shouldn’t because I can walk quite steadily with this frame now, but at the back of my mind, I still feel uneasy, just in case I should land on the ground again ... If that happens, I should hate to be in hospital and then who knows, they might put me into a home. Now that’s something I wouldn’t like to be in. Nope, not a nursing home.

Mr Finn made sense of his falling events by assessing his own risk through looking at his own home environment and identifying what posed a ‘danger’. His response to risk-taking was to be responsible and pro-active by having a bathing aid installed to eliminate the risk of falling in the bathroom. Like most men in this study, his exertion of personal control and decision making reflects the masculine identities of these men. Likewise, Mr Hart’s self restriction was imposed after consideration of the likely consequences should he fall again. The perceived consequence of falling can be said to have influenced his risk-taking. Many of the older respondents decided on their own restrictions and personal limits as strategies for maintaining their independence, as Wynne-Harley (1991) suggests.

The threat posed by falls or the risk of falling may have led older men who have had falls to examine how and why they had fallen. This analytical orientation guides them to identify what it is that they do or what is wrong with them medically that potentially makes them fall. This concurs with Gradman (1996:107) who suggests that gender-appropriate attitudes such as ‘instrumental orientation’ (focus on getting the job done) and ‘analytical orientation (relying on step-by-step logic) are often emphasised by older men’. Nonetheless, the study suggests that the risk of falling is salient to older people who have had falls, but is articulated more explicitly by older men than women. This differs from Martin’s (1999:25) finding that shows falls to be construed as a problem for
the future and not perceived as a ‘salient current risk’. Indeed, it underlines older people’s perceptions of their risk of falling, which may impinge upon how older men and women differentially constrain their behaviour or risk-taking.

Like older men, some older women considered risk taking to mean restricting some activities, and thus exerting personal control. Nearly twice as many older men (n=12) as women (n=7) said that they undertook self-restricting actions (this is discussed in more detail in Chapter 8), including not going out on their own, foregoing housework and house maintenance. These self-regulating activities reflected their attempt to maintain their independence. The self-imposed restrictions of activities by older women were similar to those of older men, for example:

**WoganF:** But I can’t get up to clean my windows, I can’t get up and change my curtains. If I did that, I probably would fall. Well, bending down and holding a heavy dish, I could topple over.

**WallM:** Now if you ask me to clean my windows ... no way. It’s too risky ... If I leaned back too much, I would lose my balance, and bang, I would be on the floor.

Even though Mrs Wogan did not articulate the word ‘risk’ or other related terms, it is obvious that her concerns were about taking risks. Her personal limits included not cleaning her windows, changing curtains or holding a heavy dish, because these tasks were seen as increasing her risk of falling. Similarly for Mr Wall, he did not want to take the risk of cleaning his windows for fear of losing his balance and falling. Lupton (1999:20) suggests that ‘people often feel that knowledge about risk, including their own, are so precarious and contingent that they simply do not know what course of action to take’. In this study, older people, in particular older men, who portrayed themselves as ‘rational’ individuals, and some older women, clearly articulated the course of actions they would take to prevent future falls.

Whilst most of the older men saw themselves as rational and responsible, older women were more likely to view risk-taking through their own expectation of self and of others:
CrickF: A lady upstairs [in sheltered housing] goes round with a zimmer frame but you wouldn’t think there was room in these houses. You have to think of things like having too much furniture when you’re old, and having a microwave to heat food. I have a friend who fell off a chair and broke her arm. She was stupid to go on the chair.

Int: Why was it stupid of your friend to go on the chair? What was she doing?
CrickF: Cleaning windows [laughs]. Oh no, not a chair, no. When my husband was alive he bought me a little step ladder to clean the windows, but it had handles on the side. But I would never dream of getting on a chair to clean my windows.

DenchF: There’s a lady here [in same sheltered housing], Mrs B who keeps falling, always ends up in hospital. She lives downstairs. Do you know, she still gets about with her sticks, silly really. I think she shouldn’t be walking about like that, she’s bound to fall. No wonder she keeps falling. She should be in a wheelchair really.

Mrs Crick and Mrs Dench are two of the six older women who were critical of other people, who they saw as taking “careless risks”. This supports Green’s (1997a:469) study which found that ‘for the girls, peers who took careless risks were not celebrated or supported, but reported to be subject of contempt’. The moral expectation of others to restrict or avoid certain activities may impact upon older people’s willingness to take risks for fear of being perceived by others as ‘stupid’. Mrs Dench’s comment on Mrs B’s falls and use of sticks reflects her expectation of how someone should behave to avoid the risk of falling. It is notable that none of the twenty older men were critical of other people’s risk-taking behaviour.

Green’s (1997a) study of children’s knowledge about accidents and risk-taking found gender differences. Girls were more likely to emphasise the importance of ensuring the safety of others in their care and taking the appropriate actions to avoid and prevent accidents, while boys were more likely to deny that the safety of others was their responsibility. This could be explained by the ‘taken-for-granted part of dominant femininity’ (Lupton, 1999:159), and the expectation of girls from an early age to be ‘more adult’ than boys by conforming to adult rules and being responsible for other’s well-being (Crawford, 1992).
It is argued that older people's awareness of risk and the responsibilities involved with risk taking influence the extent to which certain activities are considered appropriate or not, and these are 'constantly constructed and negotiated as part of the network of social interaction' (Lupton, 1999:107).

Not all older people take calculated risks because many aspects of everyday life are habitual, and hardly thought about. For instance, an older person may have lived in their existing home for a long time and are therefore used to being in that familiar environment, and would not have recognised some home environmental hazards. There is the possibility that 'familiarity breeds contempt', a term used by Denscombe (1993) when he referred to people who tend to underestimate risks that they face routinely compared with the risks they face occasionally. Older people may be used to having rugs around, that they are routinely 'exposed' to these and, therefore, underestimate their risk. However, there are some older people who have had falls who are aware of their environmental hazards, but are willing to take the risk, as shown by Mr Hart:

**HartM:** Tripping over the mat or something. I am aware of this but I am taking the risk I know. I am just more careful about it when I am walking near this mat here. I know it is no good but it’s been there to cover up the worn patch underneath. I reckon so long as I am careful it should be alright.

Mr Hart was aware that by having the mat on the floor he was taking a risk, but he considered that as long as he was careful, he would not be at risk of falling. This is not uncommon among older people, as supported by Sattin et al (1998) who found that older people with thrown rugs regard them as hazardous but are especially careful around them or put them in nonhazardous areas, or use them to cover wires which would otherwise be a greater potential hazard. This could be seen as a ‘trade-off’ because the older person may prefer to have a mat than to be confronted with the potential hazard of tripping over a wire, and in addition, as Sattin et al. (1998) suggest that the mat may ‘cushion’ the impact of a fall. This finding supports Clemson et al’s (1999) observation that older people’s understanding of environmental risks and their decision whether to curtail actions is related to their past experience or behaviour in a specific environment, which in this instance, is being used to having a mat on the floor.
This section has examined the way in which the meaning of risk is constructed by older people who have had falls. It complements the majority of research on the perception of the risk of falling, which is often drawn from the professionals’ perspective, highlighting the need to focus on the perspective of older people. It has been shown that the use of terms such as risk, hazards, danger and safe/safety are varied, and that older men who have had falls tended to articulate these terms more spontaneously than older women. Where risk factors for falls are concerned, older people’s identifications of these were congruent with those identified in medical literature. However, there are some differences; for example, older men were more likely than older women to identify environmental factors and daily activities necessary for independent living as risk factors. Older men also identified more risk factors than older women, which seems to reflect their greater awareness of the risks of falling.

An examination of older people’s perceptions of risk-taking indicates that older men are more likely than older women to consider themselves as rational and responsible in risk-taking, because they perceived it was their responsibility to deliberately not put themselves at risk. However, this does not explain why none of the men blamed themselves or others for the falls they had had. In contrast, older women were critical of those who took risks, but they also tended to blame themselves and others for their falls. It is suggested that these perceptions may impinge upon older people’s subsequent actions, which is the focus of Chapter 8.

7.2 Meaning of Risk: Key Family Members’ Perspective

Where family members are concerned, there may be generational differences in how risk is perceived, with those in the younger generation being more attuned to the debate relating to the risk associated with sports and motoring (Adams, 1995). Indeed, Green and Hart’s (1996:6) exploration of children’s perceptions of how accidents happen and accident prevention, had found the children in their study were ‘knowledgeable about accident risks and competent at managing those risks’.
This section examines the perceptions of risk among key family members of older people who have had falls, and how these might impact upon the older person’s meaning of falls. It extends the work of Manthorpe and Alaszewski (2000) who found that informal carers perceive risks in relation to negative outcomes; and that they considered the external environment as particularly dangerous. In this section, where appropriate, comparison will be made with the views of older people who have had falls. As in the interviews involving older people who have had falls, the word ‘risk’ was never initiated by the interviewer so that it would not influence the key family members’ perception. Instead, all key family members interviewed were asked to consider what might make their relative more likely to fall, with no prompts given by the interviewer.

### 7.2.1 Defining Risk

The discussion is based on data generated from interviews with twenty-three female and twelve male relatives of older people who have had falls, as follows:

- 17 daughters (aged between 40-65)
- 2 nieces (aged 50 and 51)
- 4 wives (aged between 73 and 83)
- 11 sons (aged between 27-70)
- 1 brother (aged 87)

The following illustrates the similarities and differences in the spontaneous articulation of the word ‘risk’ and other related terms. None of the four wives or the two nieces articulated any of the terms related to ‘risk’. Whereas, sons and daughters used the terms interchangeably:

**S.JohnsM:** But there is always the risk and I think when you do break bones the elderly take a very long time to recover...They’ve put themselves at risk...Just because he’s [father] got to negotiate those sort of hazards now...put himself to such risk.
SMalkinF: I don't think there are things in her [mother] flat that are risky now you know. I’ve tried my best to watch out for the hazards, I’m doing my best, and I think her flat is not as risky as it used to be.

DChardM: There are no obvious hazards. You might look for a rug that has lost its edging and may become a safety hazard ... but he [father] doesn’t really have them. He has all fitted carpets. Nothing you could go into the house and say ‘that’s a hazard’ or ‘that’s dangerous, he might fall’ You try to make sure he’s not at risk.

Mr Johns’ son perceives his father’s risk of falling in terms of broken bones, with the recovery from falls being longer compared to younger people who sustained fractures. In relation to his father’s risk of falling, Mr Johns’ son perceives that his father has to negotiate various situations or objects which have the potential for injury. His concerns are shared by other key family members, for example, Mrs Malkin’s son and Mr Chard’s daughter. Mrs Malkin’s son perceives that his mother’s flat used to be more ‘risky’ than it is now. The hazards which potentially caused his mother to fall were considered ‘risky’. In Manthorpe and Alaszewski’s (2000) study, they found that potential negative consequences often influence informal carers’ perception of risk. In this study, key family members identified the environment as containing potential hazards or dangers, as also indicated by Manthorpe and Alaszewski (2000). Mr Chard’s daughter considers all the potential hazards in her father’s flat that might make him more likely to fall. As with many of the other key family members’ accounts of risk perceptions, it was noticeable that the term ‘risk’ or ‘risky’ was used interchangeably with other terms like ‘hazards’ and ‘dangers’.

The four wives of older men who had had recurrent falls were not articulate in the use of the term ‘risk’ or associated terms; similarly older women who had experienced falls were less articulate than their male counterparts. The reason for such a gender difference is speculative. The ‘normative’ pattern of husband as breadwinner and wife as home maker (Connell, 1987:52) for most of the older people in this study means that these women probably held a more subordinate role than their husband. This may have been the norm for this cohort of older women. Since risk-taking can be seen as an expression of personal freedom (Reed, 1998), it is likely that these older women may not have
considered that it was appropriate for them to express a need for personal freedom. It is possible that the older women of this particular generation might have different perceptions of risk compared to younger generations of women who may be more ‘exposed’ to varied notions of risk. This has already been highlighted by Lupton (1999:115) who argued that ‘young people now, compared with those twenty or thirty years ago, are faced with a greater range of uncertainties and choices to make about how to conduct their lives’. This suggests that risk perception may be gendered and there may be generational differences.

A breakdown of the terms used by all key family members in relation to their articulation of their older relatives’ risk of falling can be seen in Table 7.4, illustrating the similarities and differences, according to the gender of the dyad.

**Table 7.4** The use of the term ‘risk’ and other terms by Key Family Members according to relationship with their older relative

<table>
<thead>
<tr>
<th>Risk and related terms</th>
<th>Male key family members of older men who have had falls (n=2)</th>
<th>Female key family members of older men who have had falls (n=17)</th>
<th>Male key family members of older women who have had falls</th>
<th>Female key family members of older women who have had falls (n=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Brother n=1</td>
<td>W* n=4</td>
<td>Sons n=10</td>
<td>D* n=5</td>
</tr>
<tr>
<td></td>
<td>Son n=1</td>
<td>D* n=12</td>
<td>n=5</td>
<td>N* n=1</td>
</tr>
<tr>
<td>‘Risk’</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>‘Hazard’</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>‘Danger’</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>‘Safe/safety’</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1</strong></td>
<td><strong>8</strong></td>
<td><strong>12</strong></td>
<td><strong>5</strong></td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>1</strong></td>
<td><strong>2</strong></td>
<td><strong>1.2</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>

Key: *W* - Wives  
*D* - Daughters  
*N* - Niece
Table 7.4 shows that among the key family members in this study, sons articulated the term ‘risk’ and related terms more frequently. This was closely followed by daughters caring for older men and women who also made frequent spontaneous reference to risk and other terms related to it. Sons and daughters used these terms interchangeably. Only the wives and nieces made no verbal reference to risk or other related terms.

7.2.2 Frequency of Falls and Impact on Risk Factor Identification

This section examines two key aspects that could impact upon the social construction of the meaning of risk by older people who have had recurrent falls, and by their key family members. First, the extent to which older people’s experience of falls impacts upon their recognition of the risk associated with falls.

In this study, among older people who had experienced two falls in the past year, the average number of risk factors mentioned was 0.5 compared to older people who had had five or more falls where an average of 3 risk factors were identified, as shown in Table 7.5. It indicates that among key family members of older people who have had 2 falls, the average number of risk factors identified was 2.6, compared to key family members whose older relatives experienced 5 or more falls, where an average of 5 risk factors were identified. Table 7.5 also shows that the average number of risk factors identified by key family members was higher than those identified by older people who have had recurrent falls.

This finding supports Denscombe’s (1993:507) assertion that ‘where someone has personal experience of the potential danger then the risk tends to become more vivid and foreboding to them’. It is also suggested that through their experience of recurrent falls older people’s awareness of the risks of falling was enhanced. This greater awareness could impact upon their subsequent actions to prevent future falls which will be discussed in detail in Chapter 8.
Table 7.5  Number of falls experienced by older people compared with the average number of risk factors identified by older people and their key family members

<table>
<thead>
<tr>
<th>Number of falls reported by older people</th>
<th>Number of older people</th>
<th>Average Number of Risk Factors identified by older people</th>
<th>Average Number of Risk factors identified by key family members</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>9</td>
<td>0.5</td>
<td>2.6</td>
</tr>
<tr>
<td>3</td>
<td>16</td>
<td>1.3</td>
<td>3.4</td>
</tr>
<tr>
<td>4</td>
<td>10</td>
<td>2.1</td>
<td>3.2</td>
</tr>
<tr>
<td>5 or more</td>
<td>5</td>
<td>3.0</td>
<td>5.0</td>
</tr>
</tbody>
</table>

This study suggests that caring for an older relative who has experienced more falls is likely to enhance the awareness of key family members in relation to their risk of falls. Therefore having more falls can impact upon the number of risk factors identified by older people and their key family members.

7.3 Older Relative’s Risk of Falling: Key Family Members’ Perceptions

This section extends the discussion in section 7.2 by examining key family members’ perceptions of their older relatives’ risk of falling. It is suggested that these perceptions may impact upon key family members’ actions in trying to prevent future falls. For example, if a family member thinks their older parent is at great risk of falling s/he may be more protective towards his parent and be pro-active by instigating changes to the home environment. The study will draw on the work of Manthorpe and Alaszewski (2000) on informal carers’ view of risk, as discussed in Chapter 3. The extent to which gender impacts upon these perceptions is examined, with comparisons being made between those of male and female key family members.

All key family members were able to identify at least two risk factors that predisposed their older relative (or spouse) to fall. Like older people who have had recurrent falls,
key family members identified both intrinsic factors such as medical conditions, age and sight, and extrinsic factors such as the home environment. However, there were other factors that were not identified by older people and these included lack of exercise, lack of confidence, not using walking aids, being too independent, clumsiness, and hearing problems. The range of factors identified by key family members is more varied than those identified by older people who have had falls, although the similarities support Wynne-Harding’s (1991:7) finding that ‘the main areas of recognised risks remain associated with everyday domestic living. These include the house and garden, domestic equipment and shopping’. Two common themes relating to key family members’ perception of their older relatives’ risk of falling emerged from the analysis of interviews: the home environment as a ‘hazard’, and trying to maintain independence was seen as putting older people at risk of falling.

7.3.1 Home as a ‘Hazard’

In this study, nearly half of the key family members (12 daughters and 4 sons) identified the home environment as a ‘hazard’ that put their older relative at risk of falling:

DHullM: He [father] has got mats round his chair, that’s a hazard. He has a mat in the bathroom, in the kitchen, in his bedroom. He put them there himself... Basically now, it’s a hazard, the carpet. I myself, I don’t like bits of mats here and there. They are just not practical really. I’ve heard, my friend’s mum, she’s as old as dad, and she’d tripped over them. She’s just like Dad, I mean, old people, they seem to like mats and rugs, you know, it’s just the way they were used to. But Sheila’s [friend] mum, she tripped over a rug in her flat and broke her wrist. It’s only not so long ago, Dad knows that because I told him about it.

DPayneF: I can honestly say that her house is a hazard. It’s true, it’s a risk in itself. I know it is, because the number of times I myself nearly trip over and I am young as well. She’s just not very good at keeping her place tidy, I mean, you can see for yourself, there are just bits and pieces everywhere. When you walk into the house, the hallway - it’s so cluttered with tins of food, newspaper, all sorts of junk stuff. She’s just not a tidy person and I’m not surprised at all that when she told me some time ago that she’d fallen. She’s more likely to fall again than I am.

Int: What happened?
DPayneF: Oh, she was trying to answer the phone, and somehow tripped over the pile of newspaper over there [by the door that leads to living room]. She banged her head on the radiator.
Int: I see, and you think she’s more likely to fall than you?
DPayneF: Yes, I mean, I’m much younger and if I know I could trip over in her place, and I’m more, um much more alert and more likely to be able to balance myself than she is.

These daughters considered their older relative’s home as an environmental hazard based on other people’s experience and their own experience. Mr Hull’s daughter’s awareness of her father’s risk of falling was based on her learning from other people’s accounts that the home can pose a risk to older people. Mrs Payne’s daughter’s own experience of nearly tripping in her mother’s house increased her awareness of her mother’s risk of falling. Her mother’s experience of falling over in her own home confirms that her daughter’s judgement was right. This view has also been supported by sons of older people who have had falls within their own home:

SBrookF: I think stairs are a hazard because she’d fallen down the stairs once. I’ve told her about being careful when she goes up and down the stairs ... Basically the home is a potential hazard, I mean, she could slip on the kitchen floor, trip over a mat in her bathroom. Yes, I don’t think it’s a safe place for her any more, since she’d had that nasty fall.

Because Mrs Brook had had a fall down the stairs at home, it led her son to believe that the home environment is a ‘hazard’. That fall had resulted in Mrs Brook sustaining a head injury, and she was hospitalised for a week. This concurs with Manthorpe and Alaszewski (2000) who found that carers perceived risk in relation to the negative consequences. My study suggests that in this context, gender did not impact upon how male and female key family members perceive the home as a hazard for their older relatives; in order words, it did not impact upon key family members’ perceptions of their older relatives’ risk of falling.
7.3.2 ‘Maintaining Independence’ as a Risk of Falling

Key family members perceived that their older relatives’ need for maintaining their independence was one of the key factors that put their older relative at risk of falling. Key family members believed that there were certain domestic activities that older relatives undertook that should have been avoided because of the risks associated with these activities in old age, and these included:

- getting in and out of bath
- gardening
- climbing on chairs
- bending down too low
- vacuuming
- changing a light bulb
- getting up in the night to use the toilet

These activities were highlighted by half the sample of key family members, (45% of male key family members and 65% of female key family members). The modest difference in the percentage between the sexes does not suggest that gender impacted upon the types of activities identified by key family members as putting their older relatives at risk of falling. However, the above activities were perceived by key family members as ways in which their older relatives maintained their independence:

DHopkinsF: There are certain things that I know I wouldn’t do if I was at mum’s age. It’s just commonsense. It’s simple tasks like vacuuming. I mean, she could have waited till I go round at weekends to do it for her but she still thinks she could do it. I do worry about it sometimes, in case she trips over the wire. It’s just too much of a risk. I know she likes to stay as independent as possible, but there are times when she’s got to realise she can’t any more.

SDaleF: I am not very happy with her doing some housework round her place. She’s got Shirley [his wife] to help with the vacuuming, and we do her shopping whenever we can. She shouldn’t be climbing on them chairs to change her curtains. All she has to do is ask and we’ll help her. But she thinks she is still independent. It’s not nice when you get to that age, I know but you’ve got to face it, you know, that you’re not going to be able to do certain things like you used to do when you were younger. I wouldn’t put myself at risk, if I was her age.
These accounts illustrate key family members’ perceptions of their older relative’s desire to remain independent, so much so that they accepted their relative continuing to undertake activities that were deemed to be a ‘risk’ by their key family members. This view is in contrast to the perceived responsible approach by older people themselves, as indicated in Section 7.1.2, which showed that some older people undertake self-regulating activities in order to maintain their independence. For instance, by restricting their own activities, some older people who have had recurrent falls, felt they had acted in a responsible way because the consequence of falling might mean a loss of independence because they would be put in a care home. Older men’s portrayal of themselves as ‘rational’ individuals, as discussed in Section 7.1.2, suggests that views among older people and their key family members are not in congruence with each other. This indicates generational differences in relation to what extent domestic activities are perceived as leading to a risk of falling. This difference is also illustrated in the perceptions of key family members about their older relative not having the ‘intellectual’ capacity to make sense of the risks involved in undertaking domestic activities. This, in turn, could impact upon key family members’ subsequent actions to try to prevent their older relative’s future falls which is the focus of discussion in Chapter 9.

In relation to other activities, this study found that ‘not using a walking aid’ was identified by some key family members as putting their older relative at risk of falling. Key family members believe that it was their older relative’s responsibility to use a walking aid to avoid falling:

**SPalmerF:** I think she [mother] should use her frame at all times. She is dodgery, and she needs to use a walking frame to balance herself which we [him and his wife] have been telling her and she wouldn’t. If she had the frame when we told her to, she wouldn’t have broken her hip, I think.

**Int:** Why do you think she doesn’t want to use the frame?

**SPalmerF:** Well, if she had the frame she couldn’t go out with it, could she? She would find it difficult to take it to Sainsbury’s ... I don’t think she wanted to be seen with a frame. People would think she was getting older and incapable.
WColsonM: I think if he doesn't use a stick. If only he would, it would help him really, I mean his balance. He's got a stick but he just wouldn't use it, he don't like using it. But he uses it now because well, I mean, he's had these three falls.

Int: Why do you think he doesn't like using it?

WColsonM: Well, I think he likes to think he's fit you see. He doesn't like to realise his limit like he still thinks he can do things now.

Not using a walking stick or frame is perceived primarily by sons and spouses as putting an older person at risk of falling since walking aids help to transfer weight from the upper limbs to the ground in order to aid balance (Hayes and Yohannes, 1998). As with domestic activities, key family members believe that some of the falls experienced by their older relatives could have been avoided by using walking aids:

SDayF: If she [mother] can't stand straight, sort of walk dodderly and lean forward a bit, that must affect her balance, and I think it is a risk. When you see her walk, the way she leans forward, you think she's bound to lose her balance and topple over. Being old doesn't help it either, I mean, the balance. You see them hunched over. Now, if she uses a frame or a stick, it wouldn't be so bad.

Mrs Day's son's account outlines that not using walking aids puts older people with balance problems at greater risk of falling. This study also highlights that key family members recognise that their older relative may be exposed to more than one risk factor, and that some of these risk factors could have been reduced by older people themselves. However, reports from Mrs Day indicate that perceptions between her and her key family member differ:

DayF: Oh the doctor say it's to do with the muscles in my legs, 'nothing serious' he said ... Other than that, there's nothing wrong with me really. I think I might have turned too quickly sometimes, like I turned too quickly to answer the phone and bang, I was down. My son thinks it's my balance, but I think to myself, it can't be my balance, I can still stand and walk.

Mrs Day's account demonstrates how risk factors for falling might differ between the viewpoint of older people who experience falls, and of their relatives. It is suggested that this difference may impact upon the subsequent actions or risk-taking behaviours of
older people as well as their key family members, (discussed in chapters 8 and 9 respectively). Avoidance of using walking aids was perceived by key family members as their older relatives’ attempt to maintain their own independence and retain their autonomy, thus avoiding the stereotypical images of old age and disability. The dilemmas faced by key family members are illustrated below:

**SDayF:** I could stop her [mother] from getting out and do all the things for her but it would mean taking away her independence, which I think is important. If she continues to be independent she could be careless and fall.

**SJOHNSM:** It’s difficult, I mean, if you’re living on your own and if you want some form of independence and I can understand him [father] wanting to get up and do that sort of thing [going to the local shop] but I mean, all he actually has gone for was a loaf of bread ... So he risked if you like, those conditions for a just a load of bread.

**DTUCKM:** He [father] is independent in that he can get from A to B. Unless he’s in a chair for the rest of his life, then he wouldn’t be falling but I wouldn’t wish him to be like that for the rest of his life. It would be awful to be confined to a chair for the rest of your life.

These risk perceptions suggest key family members were aware of the ‘trade-offs’ as described by Wynne-Harley (1991), and support Denscombe’s (1993) notion that ‘familiarity breeds contempt’ because older people were seen to tend to underestimate risks they face routinely. Earlier discussion in Section 7.1.3 has indicated that not all older people would take a calculated risk because of their habitual lifestyle, therefore not recognising some home environmental hazards. Key family members realised that taking away the older person’s independence was far from ideal, and that the risk associated with it had to be considered. Key family members may find it difficult to tread ‘a fine line’ since reduced independence can be seen as a consequence of a fall, whereas being independent, on the other hand, may increase the risk of a fall (Johansson, 1998). Conceptually, the value of independence is pertinent to this study in that key family members perceive the independence maintained by their older relatives poses a risk of falling. This can be said to influence key family members’ perceptions of their older relatives’ risk of falling, which in turn, may influence the type of actions taken by key family members to prevent the older person’s future falls.
This section has examined older people’s risk of falling from the perspective of key family members. Key family members on average identified at least two risk factors that predisposed their older relative to fall. Like their older relatives who have had recurrent falls, key family members similarly identified extrinsic and intrinsic factors, although their range of articulated risk factors was greater, which included eye sight, hearing impairment, and loss of balance. Other domestic activities were identified by key family members as contributing to their older relative’s risk of falling. This section also examined the extent to which the gender of family carer and/or older person impacts upon these perceptions, and suggests that it did not. In general, key family members perceive that maintaining independence may put their older relative at greater risk of falling, the dilemma being whether to encourage independence which might result in their older relative having falls, or making older people more dependent in order to prevent falls, but this was considered to undermine their self confidence.

7.5 Conclusions

This study initially examined the construction of the meaning of the risk of falling from the older person’s perspective. Older men who have had falls not only spontaneously used the term ‘risk’ or ‘risky’ and other related terms such as ‘danger’ or ‘hazard’ or ‘safe/ safety’ but also identified more risk factors for falls than older women.

Older men were more likely than older women to portray themselves as ‘rational individuals’ in relation to their risk-taking. For instance, older men exercised greater control and demonstrated their responsibility to avoid putting themselves at risk, this included being pro-active and being more likely to eliminate potential hazards such as installing bathing equipment, or restricting activities that they considered were ‘risky’. Older women’s notion of risk-taking tends to be influenced by their own expectations of self and of others, as illustrated in some of the women’s critical comments about those who took ‘careless risks’. In relation to the home environment, older men showed
greater awareness than older women; this is reflected in their greater reported desire to protect their independence and autonomy through deliberate and careful analysis of what to do. Although the risk of falling is salient to both older men and women, it is more so for older men because of the potential negative impact of falls, as highlighted in Chapter 6.

Some explanations for these gender differences can be gleaned from the perceptions of older men. Older men's portrayal of themselves as 'rational individuals', therefore, articulated that they would not put themselves at risk of falling, can stem from their propensity to display 'an apparent self-sufficiency' in that they have 'learned to be independent' (Whitehead, 2002:157), which may explain why they analytically identify factors that make them more likely to fall than others of their age. It could be argued that because of the stigmatising impact associated with falling, particularly in public places, older men are keener to 'sustain' their masculinity since their 'public' self is more likely to be threatened when they fall in public places. It is in their own interest to minimise any risk of future falls.

The risk perceptions of older people and that of their key family members suggest that the frequency of falls influences the number of risk factors identified by both older people and their key family members. The more falls experienced by older people, the more risk factors were identified by both the older person and by their key family member, suggesting that when 'exposed' to the experience of falls or having a relative who has had falls, skills are acquired, enabling them to become more attuned to the risks of falling. This supports Denscombe's (1993) observation that risk becomes more vivid and 'foreboding' when someone has greater personal experience of the potential danger.

Finally, this chapter indicates that the gender of key family members does not impact upon the perceptions of key family members about their older relative’s risk of falling. Both intrinsic and extrinsic factors were identified by male and female key family
members. Both male and female key family members reported medical and health problems, and loss of balance as potential intrinsic factors. The undertaking of certain domestic activities by older people who have had recurrent falls was perceived by key family members as attempts by older people themselves to maintain their independence, which in turn, may be perceived as putting their older relatives at risk of falling.
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Chapter 9

Key Family Members’ Actions To Prevent An Older Relative Falling

This chapter discusses key family members’ actions to prevent their older relative’s future falls. It furthers the work of Alaszewski and Alaszewski (2000), who examined nurses’ actions in relation to risk management and risk taking by developing a typology of actions undertaken by family members. Each type of action will be examined with examples drawn from the key family members’ accounts. A broader perspective will be given by also comparing older people’s accounts with the accounts of actions taken by their key family members. The extent to which gender impacts upon the types of actions taken by key family members in relation to the prevention of future falls will be examined. In particular, this chapter discusses how the types of actions differ between older father/adult daughter, older mother/adult son, and older mother/adult daughter dyads, focusing on how the gender of the older person and the gender of the key family member interact. The implications of the nature of the dyadic relationship in terms of control, autonomy and power will be explored.

Morgan and Kunkel (1998:235) note that the gender of parent and child influences the relationship between them:

Mother/daughter dyads are typically closer than any other combination, with more daughters acting as confidantes and fewer likely to disappoint their mothers ... The relationship most likely to experience conflict is that between a father and son, with cross gender dyads (mother/son, father/daughter) falling somewhere in between.

Silverstein et al. (1995:473) suggest that in family caregiving daughters provide support because of the traditional kinship role, whilst ‘sons help their parents out of a sense of obligation’. Hence, in relation to older people who have had falls, it is likely that gender will impact upon the types of actions taken by both parties in the dyad, in fall prevention.
9.1. A Typology of Subsequent Actions by Key Family Members

A typology of the subsequent actions by key family members in relation to the prevention of falls by their older relatives emerged from the data, which comprises five distinct categories of actions: protective, coercive, ‘mutual respect’, negotiating, and engaging. *Protective actions* are those that were intended to ‘protect’ the older person from ‘harm’ or ‘danger’. *Coercive actions* are considered to ‘force’ or ‘compel’ their relative to do something, with the implicit notion that there is little negotiation. *Negotiating actions* reflect those where an element of negotiation occurs between two persons, while *engaging actions* involve negotiation but also provide an individual with greater choice, autonomy and control. The last category, ‘mutual respect’, is where the two parties hold mutual respect for each other, which results in little action being taken. Each of these categories will be examined in detail in this chapter.

9.1.1 Protective Actions

In the context of this study, protective actions are those which aim to protect the individual from harm or danger. Because risk was perceived as hazard (see Chapter 7), key family members’ perceptions underpin their actions to ‘protect’ and/or ‘coerce’ their older relatives.

There is no element of negotiation between the parties concerned, resulting in the older person not having a say or any control in the decision making. Protective actions are considered paternalistic. They were taken by 9 out of the 10 sons caring for older mothers (see Table 9.1) but did not occur among any other key family member.
Table 9.1 **Key family members taking protective or coercive actions: number of actions**

<table>
<thead>
<tr>
<th>Sons of older women (n=10)</th>
<th>Protective Actions</th>
<th>Coercive Actions</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNicholsF</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>SMalkinF</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>SPalmerF</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>SBickleF</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>SDayF</td>
<td>4</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>SBrookF</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>SDaleF</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>SDenchF</td>
<td>5</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>SLongF</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>SHareF</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td><strong>18</strong></td>
<td><strong>41</strong></td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>2.3</strong></td>
<td><strong>1.8</strong></td>
<td><strong>4.1</strong></td>
</tr>
</tbody>
</table>

Most of the sons interviewed felt the need to ‘look after’, or to ‘protect’ their elderly mothers from ‘danger’ or ‘risky situations’, as shown below:

**SHareF**: I have to live with my conscience, supposing I didn’t stop her [mother] from doing something which might be a *danger* to her, then I cannot forgive myself ... Just being there for her, and taking over the situations when she’s not able to do so ... When my father passed away, my mother had lived quite a sheltered life in that my father was the person who makes the final arrangement, that sort of thing, what to buy ... She sort of hasn’t got to make that sort of decision, and I feel I had to take over that aspect you see. Perhaps I am just being *protective* of her.

Mrs Hare’s son highlighted the ‘sheltered’ life his mother had led during her married life, and perceived that following widowhood, it was his role to ‘take over’ where his father had left off. He justified his actions as protective towards her, and the need to curtail her risk taking by ‘stopping her from doing something which might be a danger to her’. The rationale to keep harm or danger to a minimum is also a concern expressed by some of the health care professionals in Alaszewski and Alaszewski’s (2000) study. In their study,
they found that mental health nurses saw their role as being to identify the hazards and to minimise harm to clients and others. This could be interpreted as the need to protect their client and others from harm.

Another example of how sons felt the need to protect their mothers is reflected in Mrs Long’s son commented:

**SLongF:** I am her [mother’s] only son, no brothers or sisters ... she’s got no other family now...My father used to do everything for her, and now, I think she needs someone to *look after* her. If my father was around she would have been alright, now he’s gone, it’s only me left to see to her, he’s not here to *protect* her.

Like Mrs Hare’s son, Mrs Long’s son was an only child, and this might explain why they were identified as their mothers’ key family member, and why they felt the need to protect their mothers. Both illustrate the older women’s position within the marriage: that their father ‘used to do everything for her’, and that in their fathers’ absence, it was deemed logical that they should resume that protective role. These sons can be seen as ‘doing gender’, which according to West and Zimmerman (1987:126) is about managing occasions so that, whatever the particulars, ‘the outcome is seen and seeable in context as gender-appropriate’. In this study, the outcome is that their mothers are protected, and they the sons are protective, and were seen to be protective. This is not only found amongst sons who were the only child, but also amongst sons who have siblings. Mrs Nichols’s son, one of three sons, and Mrs Malkin’s son who has a brother and a sister, also felt the need to protect their mother:

**SNicholsF:** My dad passed away three years ago, and it’s up to us to *look after* our mum ... I’m the youngest, I think I’m the closest to her. I just need to make sure she’s alright ... If my mum needs anything I will try my best to sort it out. Can’t leave her on her own to sort it out. She’s all we’ve got, and she’s on her own, and we need to *protect* on her.

**SMalkinF:** We [he and his mother] are quite close. They lived with me when my father wasn’t too well, and when he died, I had to continue looking after her ... After these falls, I am more concerned about what she could do to herself. I feel I have to be more watchful, *looking after* her that way ... I’ve got to keep an eye on her. My father would have expected that, and I would too because she’s been a good mother to us all.
In perceiving the need to ‘look after’ their mothers, the sons had taken protective actions to prevent their mothers from falling again. The sons also reported having to ‘keep an eye’ on their mothers, an activity which Matthews and Rosner (1988) characterise as a monitoring component of filial responsibility. Although this can be conceived as positive, protective actions can be seen more negatively since they implicitly encouraged dependence, or as Nolan et al. (1996:33) observe, are ‘counter-productive and covering up dependency’. Protective actions can be deemed as counter-productive because the older person may be ‘de-skilled’. The older mother may be capable of cooking for herself, but as a result of her son’s intervention, was ‘not allowed to cook for herself’ and had to rely on meals-on-wheels or ‘having her meals down in the dining room’, as the following illustrate:

**SDayF:** She [his mother] knows I get cross with her sometimes ... Like I said she should not try and stand on stools. I told her she should really get rid of that mat in her front room and in her bathroom as well. Have you seen it? I told Sandra [his cousin] to get rid of it when she’s not looking, but Sandra won’t have it. She said, ‘if you want it done, you do it’. I did it one day, when I heard from her [his mother] that she nearly tripped up on the mat. So I said to her, ‘That’s it, this is going’. You’re not going to trip up on this again’. I took it and dumped it in the bin ... Sometimes you feel you have to do something drastic like that to make her see sense.

**SDenchF:** She [his mother] likes to get her own meals ready, I don’t think she should. I told her to have her meals in the dining room ... I’ve put a lock in the broom cupboard so she [mother] doesn’t have to worry about it [daily cleaning]. She’s tried to do some vacuuming, you see. Any way, I’ve put the key I a place we know, but she knows the reason why we’ve done that. She knows where the key is, but I don’t think she can reach it ... I try to make sure that she does as little as possible in the way of maintaining the flat. We make sure that she doesn’t really have to do any washing, any cleaning, her meals are catered for ... we’ve bought her various walking aids.

**SBrookF:** I told her it would be best that we [he and his wife] do the shopping for her. I don’t think she’s confident of going out on her own, I might be wrong but I dread to think what she might do to herself.

From the above accounts it is obvious that the protective actions taken by the sons are taking away some aspects of their mothers’ independence. For example, Mrs Day’s son felt he needed to take drastic actions in order to make his mother ‘see sense’ about the hazard of having mats around the house. Mrs Day was not involved in any negotiation
about whether she could keep the mat her son had ‘dumped it in the bin’. It was interesting to note that Mrs Day’s son had tried to coerce his female cousin to discard the mat but she refused. Here it is unclear whether the type of kin relationship and/or gender influences how actions are imposed or taken, but is indicative of the power balance between him and his cousin. Similarly, Mrs Dench ‘tried to do some vacuuming’ but she was stopped by her son. This study suggests that protective actions by sons may prevent their older mothers ‘doing gender’, which creates greater passivity and dependence, and has adverse effects on their mothers’ gender identity. The data also highlights the imbalance in ‘power’ between most of the older women and their adult sons.

Protective actions taken by sons in this study differ from Bowers’ (1987:26) concept of ‘protective care’ which was intended to ‘protect the parent from the consequences of that which was not or could not be prevented’. That is, it was concerned primarily with keeping the person unaware of his or her failing abilities and increasing dependency. These strategies may have been necessary since the carers in Bowers’ study were caring for parents with cognitive impairments, and felt the need to protect the parents’ self-image. This contrasts with the present study where the older person who is ‘acted upon’ is aware of what the family member is doing to them.

The protective role adopted by the sons in this study may have been motivated by their sense of obligation, as found by Silverstein et al. (1995). This sense of obligation meant taking over the role left by their fathers, and may have been accepted by their older mothers who were willing to continue to take on a subordinate role, as they had done in the past when their husband was alive. For these older mothers, it may have become a norm to be ‘protected’ by the male members of the family.

9.1.2 Coercive Actions

Coercive actions are constraining; the person coerced into doing something is ‘forcibly constrained’ or ‘impelled into obedience’ (Concise Oxford Dictionary, 1976:194). Like
protective actions, there is no negotiation between the person who coerces and the coerced. Coercive actions force someone to do something which he or she does not wish to do. Unlike protective actions, coercive actions have an element of threat by the person who coerces, which leads the other party to conform to the ‘rules’ set by the person who coerces. It may tap into the feelings of the other person, so that the older person consequently complies with doing something in order to please the person who coerces.

Coercive actions were taken by 7 out of the 10 sons of older women (see Table 9.1 and Table H.4 in Appendix H), but no daughters of older people, thus indicating that these actions are highly gendered:

**SBrookF:** She [his mother] says you can go away and leave me here, and I’ll be alright but that’s not the point. We couldn’t sleep. We took her with us to see my son in Cornwall, and it made you realise how difficult it is taking her to places. We had to borrow a wheelchair to enable us to go where we wanted. There’s no choice really.

Mrs Brook’s son had insisted that his mother sat in a wheelchair whenever they went out together. His indication that there was ‘no choice’ reflects the lack of negotiation within this mother-son relationship.

**SHareF:** Because she [mother] can’t stand long enough in the kitchen, and she tends to be dizzy, I’d insisted that she doesn’t do any cooking, but has her main meal in the dining room ... I bought her a microwave oven, so she hasn’t got to stand too long ... I’ve insisted that she uses a stick to help prop her up, and keep her balanced ... bought her this stick ... I was adamant that when she’s up and about, she must have her stick with her ... She knows I get cross with her when I find out she hasn’t been doing her exercises ... I am not keen for her to venture outside on her own ... She really couldn’t get in and out of her bath easily so I told her not to bother about getting in. She should try to have a good wash, and organise to have one, [a bath] downstairs [in the day centre].

Mrs Hare’s son imposed several coercive actions: he insisted that she did not do any cooking, that if she was to cook, she had to use a microwave; that she used the stick bought by him, and that she should not have a bath on her own. These coercive actions suggest the imbalance in power that exists within this mother-son relationship.
SPalmerF: I don’t think she [his mother] had much choice [about moving to sleep downstairs]. Either she lives in her own home or she’ll have to go somewhere to be safer I think ... She grumbled a bit when she got home but I told her there’s no way I was going to move the bed upstairs again.

Mrs Palmer’s son’s account shows that he was adamant that his mother should live downstairs in the dining room which he had converted into a bedroom for her. She was coerced into living downstairs, as her account below indicates:

PalmerF: They [son and daughter-in-law] did it, moved my wardrobe and bed downstairs, did all that while I was in hospital. I haven’t been upstairs since I came home. They didn’t ask me about it and he just said ‘Mum, we think it’s better you don’t go upstairs again’. But if there’s anything I want upstairs, I have to wait for someone to come and get it for me ... probably thinking he was protecting me, stopping me from falling down the stairs, I suppose ... Well, my son said, ‘Mum, if you have another fall, that will be it’ [respondent’s emphasis].

Int: What did he mean?

PalmerF: Well, that you won’t be able to get about at all. I wouldn’t like to be laid up for good, you know, and have to be looked after. I’d hate that.

Mrs Palmer’s account highlights the lack of negotiation that took place with her and her son in relation to the change in living arrangement. Her reluctance is implied by her ‘but if there’s anything I want upstairs, I have to wait for someone to come and get it for me’, suggesting she would have preferred to have not been dependent on others. However, what appeared to tip the balance was her son’s remark: ‘Mum, if you have another fall, that will be it’, which she interpreted as having to be ‘laid up for good’. She had little choice but to accept the change or face the consequence of having another fall and be ‘laid up’, that is, not be able to get about at all and be fully dependent on others. She had become resigned to having to sleep downstairs. The resignation of Mrs Palmer symbolises submission, and reflects a lack of expectation, while the coercive actions of Mrs Palmer’s son, highlight the imbalance in power within this mother/son dyad relationship.

It could be suggested that there is some element of conflict between Mrs Palmer and her son, but not overt conflict. These elements are reflected in Mrs Palmer’s resignation to let her son coerce her. The lack of negotiation, coupled with an imbalance of power, as well
as her perceived need to depend on her son, have led her to believe that there were no other options.

This section has shown that coercive actions are often taken by sons of older women, but not by men caring for men or by women carers. The sons’ sense of obligation towards their older mothers also meant that these sons resorted to coercive measures to minimise or eliminate potential risks or hazards that could lead to their mothers having another fall. The power imbalance within older mother/adult son dyads can be said to influence the types of actions taken by adult sons in trying to prevent their older mothers having future falls.

9.1.3 Negotiating Actions

There are some similarities and subtle differences between negotiating and engaging types of actions. Both types are facilitative in that they have a positive effect in allowing the older person to have some say in the decisions made. The term ‘negotiate’ means ‘to treat (with another) in order to make a bargain, agreement, compromise’ and ‘to arrange, bring about, or procure by negotiation’ (The Concise English Dictionary, 1976).

In this study, negotiating actions are about ‘driving a bargain’ or ‘doing a deal’ with the other person, which implies that there is some degree of compromise. The person is encouraged to ‘co-operate’, that is, working together, which is unlike being coerced or protected. Both members of the dyad have some say in what happens when negotiating actions are used. It could be seen as ‘a process of the testing out of territorial boundaries and of flexibility of roles which was ongoing and interpretive’ as described by Gregory (2000:226). Engaging actions, on the other hand, acknowledge the autonomy of the other person, and ensure ‘the person continues to have or acquires control over his or her own life and all that goes with power and control - freedom, autonomy, dignity and feelings of personal self-worth’ (Hughes, 1995:47). In both negotiating and engaging actions the self-esteem of the older person is retained, and in engaging actions the older person is empowered.
Negotiating and engaging actions undertaken by key family members to prevent falls of their older relative were not taken by any male carers, but were taken by wives, daughters and nieces, see Tables 9.2 and 9.3.

The following illustrates the negotiating actions by female key family members:

**NiCottonF**: Like if she [aunt] needs the window cleaned from inside I would do it. It's like there are some things in the kitchen we've both decided that it would be best if she had them at eye level and so she hadn't got to reach up high for them. The same with things below the work surface. I have moved things and try and accommodate them elsewhere where she can reach them. I might say to her 'oh, by the way, I hope you don't mind, I have put the saucepans in the larder cupboard, so you can reach them easily'. She had no problem with that, and she was grateful that I moved them ... I wouldn't upset her if I know she doesn't like certain things in a particular place. It's her home, she's lived there for as long as I can remember, and I couldn't just go in and change things round without telling her. I know she's nervous about using a step stool so I've put it away in the garage as there's no reason why she should need it. I've asked her about it, and she thought it was alright to keep it in the garage.

It is clear that the niece of Mrs Cotton valued her aunt’s need for independence. To safeguard her self-esteem and her aunt’s right to make choices and decisions, the niece ensured that she consulted her aunt in relation to her actions, for example, ‘I've asked her about it [moving the step stool to the garage], and she thought it was alright to keep it in the garage’. It is worthwhile pointing out that the niece of Mr Wall (see Table 9.2) also undertook negotiating action suggesting that within a niece/aunt or niece/uncle dyad, negotiating actions were considered appropriate by the younger relatives. The negotiating action described above is in stark contrast with Mrs Dench’s son’s protective action of locking the vacuum cleaner away in the broom cupboard with no consultation or negotiation with his mother, and putting the key to the cupboard in a place which his mother could not reach.

Other examples of negotiating actions can be gleaned from the following accounts:

**DCrickF**: I asked her [mother] if she would like the bookcase moved over, and she thought it was a good idea, and my brother and the others helped to move it.
DPayneF: Every visit I sort of suggest to her [mother] ‘why don’t we get rid of this or that?’.

The mother/daughters dyads in the study are in accord with Matthews’ (1979) observation that the supportive character of the mother/daughter relationship is sustained if a balance of some kind is maintained and perceived to exist by both members of the dyad. There is the implicit acknowledgement by most of the daughters and the niece of the older women’s position in her own home in that ‘It’s her home ... I couldn’t just go in and change things round without telling her’ [NiCottonF]. This reflects feminine sensitivity of some key family members. This has analogies that compare favourably with Mason’s (1996b:31) concept of ‘active sensibility’, in that female key family members not only had an intuitive sense of the needs of the other person, but also empathised with them. It could be argued that this is likened to the peerlike relationship reported by Walter (1991) in which both members of the dyad tried to support each other and understand how the situation looked from the other’s perspective. This does not occur in the accounts of any of the male key family members.

Within the following father/daughter dyad, the father’s power within that relationship is acknowledged by Mr Tuck’s daughter who negotiated with him.

DTuckM: It’s like having to listen to what he’s [father] got to say and not brush it aside just because he’s become more disabled since he had that nasty fall ... I go round most weekends to make sure he’s alright, and do anything he wants really ... it’s just he is now not able to do a lot of things for himself, but he’s always quite sure of what he wants, and there’s no way you could argue with him ... I tend to negotiate with him about what he thinks should be done round the flat. I don’t tell him what to do, that’s for sure [laughs].

Despite his apparent increasing disability as a consequence of recurrent falls, her father continued to retain his power and control within the father/daughter relationship. Just as Charmaz (1995:273) argues that ‘men can use uncertainty to retain power and privileges in their home’ when referring to chronically ill men’s identity dilemmas, in this study some older men despite their disability retained power in their own home.
Tables 9.2 and 9.3 provide an overview of the negotiating and engaging actions undertaken by female key family members of older men and women respectively. The tables show that female key family members of older men who have had falls tended to take engaging actions, whilst those of older women who have had falls took negotiating actions. This will be examined later in this chapter.

**Table 9.2 Negotiating and Engaging actions taken by female key family members of older men**

<table>
<thead>
<tr>
<th>Female Key family members (n=17)</th>
<th>Negotiating Actions</th>
<th>Engaging Actions</th>
<th>Average number of actions</th>
<th>Total number of actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Wives (n=4)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>0.25</td>
<td>1.75</td>
<td>2.0</td>
<td>8.0</td>
</tr>
<tr>
<td>WColsonM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WHallM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WGreenM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WRushM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Daughters (n=12)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>0.75</td>
<td>2.1</td>
<td>2.8</td>
<td>34</td>
</tr>
<tr>
<td>DCantM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DChardM</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>DFinnM</td>
<td></td>
<td></td>
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<tr>
<td>DGiggsM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DHartM</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>DHudsonM</td>
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<td></td>
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<tr>
<td>DHullM</td>
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<tr>
<td>DVokesM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Niece (n=1)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>1</td>
<td>0</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>NiWallM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>11</td>
<td>32</td>
<td>43</td>
<td></td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>0.6</td>
<td>1.9</td>
<td>2.5</td>
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</table>
Table 9.3 Negotiating and Engaging actions taken by female key family members of older women

<table>
<thead>
<tr>
<th>Daughters /Niece of Older Women (n=6)</th>
<th>Negotiating Actions</th>
<th>Engaging Actions</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daughters (n=5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>DHopkinsF</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>DCrickF</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>DScarrF</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>DEdeF</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>DPayneF</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Niece (n=1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>NiCottonF</td>
<td>4</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Average</td>
<td>2.3</td>
<td>1.0</td>
<td>3.3</td>
</tr>
</tbody>
</table>

This study indicates that negotiating actions are gendered; only female key family members undertook negotiating actions, and these protected the older person’s self-esteem and reflected feminine sensibility. It shows that women carers were ‘sensitive’ to the need to preserve the self-esteem and control of their older relative, and allow their older relation to retain/maintain control.

9.1.4 Engaging Actions

Engaging actions recognise the autonomy of the other member of the dyad, and attempt to facilitate autonomous decision making resulting in the person being enabled to maximise their self-esteem. Wives, daughters and nieces in this study took engaging actions to help the older person to prevent the likelihood of future falls. However, daughters of older men who have had falls were more likely to take engaging actions than daughters of older women who were more likely to take negotiating actions (Tables 9.2 and 9.3 respectively).
Table 9.2 shows the detail of actions taken by each female key family member of older men in this study. It is notable that all the 12 daughters of older men took engaging actions to prevent falls, an average of 2.1 engaging actions versus 0.75 negotiating actions, whereas 5 of the 6 daughters of older women took engaging actions, an average of 1.0 versus 2.3 negotiating actions (Table 9.3).

The four wives in this study took mostly engaging actions (on average, 1.75), with the exception of Mrs Hall, who took only negotiating actions (see Table 9.2):

**WGreenM:** I think it’s up to him [husband] to slow down, mind the step. I can’t change the way he does things, oh no. I might make suggestions but I know he’s just as capable of making his decision, he knows what’s best for himself. You see, he knew he needed to rest after that fall while we were on holiday. I didn’t say he needed to, he thought it was wise, and I supported his decision. Having said that, recently we did discuss whether we got to get somebody to help do the garden, you know, the odd hour here and there. That way, he needn’t push the wheelbarrow, and try and do too much. You see, some parts of the garden, it’s not very even, and we think he might fall whilst working in the garden.

**WColsonM:** He [husband] gets tired I think, you generally have to know when he look tired and make sure he doesn’t get too tired. I generally try and encourage him. I don’t try and boss him about, how can I? We’ve moved our furniture round when my son was around. We were just talking about the living room, and I said to him [son] that I didn’t think the nest of tables should be there, sticking out in the way. Then I asked John [husband] what he thought. He thought about it, and suggested that perhaps they ought to be put nearer to his chair, out of the way round there, and Colin [son] moved them. It was alright then, and I felt better about where they are now. He [husband] didn’t mind it because he knew he couldn’t have done it on his own, and I didn’t want to bother him in case he loses his balance.

Mrs Green undertook engaging actions to try to prevent her husband’s future falls. Mrs Green indicated that she could make suggestions but that her husband knew what was best for him and was capable of making his own decisions. However, she also reported a discussion between herself and her husband about getting someone to assist him in the garden. Mrs Colson described how she engaged with her husband in the family discussion about where to move the nest of tables. She had provided her husband with the opportunity to problem-solve and, at the same time, exert his ‘power’ and authority about where the furniture should be moved. Her account illustrates how women can ‘empower’
their relative in making decisions, and help them retain their dignity and self-esteem. Indeed, Charmaz (1995:272) noted that the wives of husbands with chronic diseases were perceived by the husbands as being supportive and helpful, that in Charmaz’s words ‘their wives had provided the essence of being there for them’.

Accounts from daughters also demonstrate that engaging actions provided their older parents with support, as shown here:

**DFinnM**: He [father] has got a stick, actually I asked if he would find it easier to have a stick to lean on ... He thought about and said ‘yes’. So my husband and I bought him one, and he’s found it helpful ... He’s looked into ways of making the house more adaptable for himself; the garage door, he found difficult to lift up and down, so he got the remote control. He thought of that himself, all I have to do is encourage him, like ‘what a brilliant idea’... He’s always been like that, very responsible sort of person ... When he decides on something, he carries it out, no two ways about it, he just gets on with it ... He’s resourceful, I mean, I thought it was very good of him to find out about all the gadgets for the bath ... You see, him having falls, it doesn’t mean he can’t think for himself. He’s very capable of that, and I will continue to support him in whatever way he thinks...One day I said to him ‘what do you think we ought to do about the driveway? Look at it, the moss’. Then he said suddenly, ‘I know what we can do, let’s steam cleaned all that’ so we washed it to get all the moss off.

Mr Finn’s daughter talked about encouraging her father to make decisions relating to environmental modifications. She engaged him in a facilitative way by asking him what he thought could be done about the driveway which was covered in moss. So, instead of coercing him into doing something he might disagree with, she engaged him, which resulted in her father thinking of the solution to get the driveway steam cleaned. Similarly, Mrs Payne’s daughter engaged her mother into assessing the environmental hazard in her mother’s home:

**DPayneF**: I do know that you have to look out for hazards in her [mother’s] house, I mean, you only have to look in the hall way, and see the rubbish she hoards. Every visit I sort of suggest to her ‘why don’t we get rid of this or that’? She’ll think about it for a while and then she turned to me and said: ‘let’s get rid of that pile over there, yes, let’s bin it’. It’s great that she’s able to make decisions like that, but I can’t make her do things without her wanting and willing to do it. I wouldn’t do it to anyone. It’s not me ... Another possibility we did talk about is a mobile phone. We talked about how she might get help if she falls out in the garden, or some where else, but at least if she has a mobile phone, she can
summon help easily. I think that bothered her a lot, falling and not being able to get help you see.

The feminine sensitivity of Mrs Payne’s daughter is evident in not coercing her mother into doing something she did not want or was not willing to do. The daughter’s perceptiveness of her mother’s worry in not being able to summon help following a fall again illustrates the close relationship within the mother/daughter dyad, as suggested by Morgan and Kunkel (1998).

This section has discussed the engaging actions undertaken by women caring for older people who have had falls. Unlike negotiating actions, engaging actions empower older people in their decision making, thus enabling them to retain their self-esteem, and identity. In this study female key family members were ‘sensitive’ to the power and control retained by older men, despite the older man’s increasing dependency and disability as a consequence of recurrent falls. Older men continued to retain their power and control within the family, with their female key family members tending to continue to perceive the older man as head of the family, and considered it ‘gender-appropriate’ to empower them in their decision making. In addition, daughters did try to empower their mothers but to a lesser extent.

9.1.5 Mutual Respect

Being respected is having a valued place amongst a network of people (O’Brien, 1987). In the context of this study, mutual respect implies that both members of the dyad value each other and look up to each other. However, Thompson and Pickering (1998) argue that without self-respect a person will not gain respect from others. Among the two male dyads, it was found that the individual displayed mutual respect for the other party and did not initiate or discuss any actions to prevent falls. There was mutual respect between both parties, which resulted in key family member taking minimal actions, presumably for fear of potential conflict.
The only father-son dyad in this study showed that there was little conflict between them. This was opposed to Morgan and Kunkel’s (1998) suggestion that the relationship most likely to experience conflict is within a father-son dyad. No protective or coercive actions took place with only mutual respect exhibited between both parties:

**JohnsM:** My eldest son, David, came and see me, and when he’s here I generally stay in my flat and we catch up on the things. He is very thoughtful, very caring, and I appreciate his concern. He doesn’t interfere, you know. Well, I’ve been on my own for many years now, and had to make my own decisions ... He’s come to see me more frequently since he’s known about my falls

**SJohnsM:** It’s difficult, I mean, if you’re living on your own and if you want some form of independence, and I can understand him wanting to get up and do that sort of thing [going out to the shops] ... I think it’s a good thing whilst he can remain independent obviously. Like today, when I arrived he was out watering all the plants. Then he came in and said ‘you know, the heart is going a bit, and I shouldn’t have done so much’. So he knows he shouldn’t be doing too much, but he just carries on and does things...He’s quite independent, and he still copes perfectly. It’s amazing really...He looks after his own finances, and with all respect, he doesn’t impose himself or ask us to do anything in particular...Our relationship is not particularly close, well since I went to live with my mum when they divorced, but I guess it’s out of respect rather than traditional closeness.

Neither Mr Johns nor his son mentioned any specific preventive actions by the son, which were aimed at preventing future falls. This may be due to a fear or realisation of possible conflict arising from any drastic actions, with each male partner in the dyad wanting to retain his own power and authority. Both Mr Johns and his son seemed to hold similar views such as the value of independence, and each respected the other. The relationship between the older father and adult son was one of mutual understanding, as suggested by Nydegger and Mitteness (1991) who noted that older fathers found it easier to understand their adult sons than their daughters. It is difficult to make any generalisations from this one father/son dyad, particularly as the older parent was divorced, and which could have influenced the existing relationship.

Mutual respect also occurred within the relationship between an older man and his younger 87 year old brother. Both respected each other’s need for independence:
TibbsM: My brother who lives locally, he’s very good to me. He’s 87 and he’s doing very well. He’s lived on his own for 9 years now, and he gets about alright. He catches the bus from the village to see me. He does my shopping for me. We do get on well.

B TibbsM: I had to go and see him otherwise I have no other means of keeping in touch with him. He won’t have the phone, he won’t have, why, I don’t know but he just won’t have it. I think he’s just frightened of it [laughs] ... I go up and see him about three times a week. But I think he’s doing well for his age. Do you know he’s 92? He still walks to the dining room for his meals. I personally think he is nervous about walking about in his flat but he won’t give up. He thinks it’s good for him to take a little walk. But I know he wouldn’t put himself at risk, he knows getting up too soon will make him fall, so he makes sure he gets up ever so slowly...I collect the pension for him as well as doing a bit of shopping for him. I think he looks forward to my visits very much.

Mr Tibbs appreciates the independence of his 92 year old brother who had had falls, and provides the support as required by his older brother. His knowledge regarding his brother’s risk taking illustrates how well he knew his brother, and respected his wishes in not wanting to have a phone. Both brothers were widowed with no children, which may have brought them closer together for mutual support.

It was surprising to find in this study that none of the four wives displayed mutual respect in relation to the prevention of their husbands’ falls, the previous assumption being that as marriage partners, they would respect their husbands and not interfere. Instead, as indicated in Table 9.2 they undertook primarily engaging and one took a negotiating action. Similarly, none of the sons and daughters had a relationship of mutual respect in relation to the prevention of falls by their older relative.

9.1.6 The Gendered Types of Actions: An Overview

Table 9.4 provides an overview of the average number of different types of actions taken by key family members by type of dyad. These represent the number of different actions to prevent falls taken by key family members reported by either the older person or their key family member categorised into five types of actions. It is clear, that the types of actions instigated by male key family members (sons) are mainly protective and/or
coercive actions whilst those taken by female key family members are negotiating and/or engaging actions. In addition, male key family members on average took more actions than female key family members.

Table 9.4 Average number of different types of actions taken by key family members by type of dyad, to prevent their older relatives falls.

<table>
<thead>
<tr>
<th>Key Family Member [n=35]</th>
<th>Older person who has had falls [n=35]</th>
<th>Coercive Actions</th>
<th>Protective Actions</th>
<th>Mutual Respect</th>
<th>Negotiating Actions</th>
<th>Engaging Actions</th>
<th>Average number of actions</th>
<th>Total number of actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male [n=10]</td>
<td>Female</td>
<td>1.8</td>
<td>2.3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.1</td>
<td>41</td>
</tr>
<tr>
<td>Male [n=2]</td>
<td>Male</td>
<td>0</td>
<td>0</td>
<td>2.0</td>
<td>0</td>
<td>0</td>
<td>2.0</td>
<td>4</td>
</tr>
<tr>
<td>Female [n=6]</td>
<td>Female</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2.3</td>
<td>1.0</td>
<td>3.3</td>
<td>20</td>
</tr>
<tr>
<td>Female [n=17]</td>
<td>Male</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.6</td>
<td>1.9</td>
<td>2.5</td>
<td>43</td>
</tr>
</tbody>
</table>

Sons caring for mothers reported an average of 4.1 actions, see Table 9.4. Of these, the majority (2.3) were protective actions and 1.8 were coercive actions. The least actions were reported by the two men caring for men, who did not take any overt actions and are categorised as having mutual respect (2.0). A low number of actions were taken by women caring for older men (2.5), the majority of these were engaging, 1.9 on average, and 0.6 were negotiating actions. This contrasts with the majority of actions by women caring for older women which were negotiating (2.3) and fewer were engaging (1.0).

The typology of actions shown here bears some resemblance to actions identified by Alaszewski and Alaszewski (2000) who explored the ways in which nurses define risk, and how these influenced their actions or decisions relating to client care (see Chapter 3). The rationale by adult sons for undertaking protective and coercive actions was mainly to minimise danger or harm to their elderly mothers, and to 'keep an eye' on them. It could be argued that these actions could be seen as a consequence of how they perceive their role. This role could be considered as ‘manager of the hazards’, like those identified by
some of the mental health nurses in Alaszewski and Alaszewski’s (2000:41) study. In contrast, the actions by female key family members in this study were primarily concerned about maintaining their older relatives’ autonomy and independence - this supports the thoughts of nurses caring for older people who mostly wanted to ‘balance the possibility of accidents, especially falls, against positive objectives, such as maintaining the older person’s autonomy and independence’ (Alaszewski and Alaszewski, 2000:43).

9.2 Gender, Care and Control

The above discussion has described a typology of actions undertaken by key family members of older people who have had falls. The controlling and paternalistic approach adopted by male key family members within mother/son dyads is reflected in that they predominantly undertook protective actions and coercive actions. It indicates that sons tended to feel the need to ‘protect’ their older mothers from ‘harm’ or ‘danger’, and this resulted in them taking the initiative and not negotiating with their mothers in relation to the prevention of future falls. In contrast, female key family members took mainly negotiating and engaging actions, with female key family members primarily taking engaging actions when caring for older men, and mainly negotiating actions when caring for older women. However, within the father/son dyad, and brother/brother dyad, the presence of mutual respect between both parties has led to minimal actions being executed in the prevention of future falls. The discussion also indicates that gender of both the older person and that of the key family members impacts upon the types of actions taken by key family members. This is summarised in Figure 9.1
The gender differences in the actions taken by key family members raise issues in relation to power imbalance and control. The power imbalance between adult sons and their older mothers has resulted in mothers being coerced and protected. It is argued that adult sons in this study adopted a protective role because of their perceptions of what they considered as gender-appropriate. In this sense, it is suggested that despite their motivation and obligations to support their mothers adult sons lacked the 'feminine sensibility' of female key family members. Many of the adult sons coerced their mothers into relinquishing actions, such as giving up cooking or vacuuming, despite the fact that these may be important for maintaining the older women's gender identity. This contrasted with older fathers who appeared to continue to retain their power within the family, as the following remarks by daughters indicate:

DThornM: Even if he's [father] disabled I think my dad would still get his own way ... He said, 'I'm going to do as much as I can' and I think 'that's fair enough'. No one in the family would dare tell him what to do. David [her husband] might have some influence. I think Dad might listen to him, he would take it better from a man.
**DCantM:** I can’t tell him [father] what to do, he’s always been the one who makes decision in the family. And I don’t think I’ve got a right to, to be honest. That’s up to him.

**DHullM:** He [father] is very much a family man himself, and still thinks he is, you know....I’d rather get rid of the chairs to make more space, but dad had insisted on another set, a smaller set of table and chairs.

Mr Thorn’s daughter acknowledges the position still held by her father, even though she is a married woman with her own family, she continues to see him as ‘head of family’. The power that female family members ascribed to their parents was illustrated, as Mr Cant’s daughter said: ‘He’s [father] always been the one who makes decision in the family’. Mr Hull’s daughter’s remark underlines the position that older men retain despite their widowhood and in some instances, their disability. Such remarks validate these older men’s identity as head of the household, as Charmaz (1995:272) notes:

> These men received identity validation that not only confirmed positive social identifications and private self-definitions but also implicitly affirms their gender identities as men in the household.

The study highlights the enabling skills of women to assist their fathers/husbands to continue to retain their positions within the family. Women carers initiated actions which represent ‘doing gender’, that is, what they considered as the gender appropriate thing to do; letting their male family members decide what they know best, and letting them have their say, suggesting that their actions are gendered. However, these women’s actions can be construed as ‘sentient activity’, a concept used by Mason (1996b) to describe the thinking and feeling behind activities that relate to family care, which are sometimes invisible because the carer is not consciously aware of it. In this study female carers not only have ‘active sensibility’ but were also engaged in ‘sentient activity’, that is, thinking and feeling around the needs of their older male relatives, in particular, of their need to retain power despite increasing frailty and dependence. This contrasts with male family members whose conscious protective and coercive actions were evident in the physical aspects of care, and in decision making.
To be able to control means having the power to do so. This study highlights the power imbalance within the younger male/older female dyads, the older women can be said to ‘permit’ the protective and coercive actions by their sons. However, in the two male/male dyads (father/son, and brother/brother) mutual respect occurred resulting in minimal actions to prevent falls. It is suggested that because of the awareness of the potential conflict that could arise between these two parties, each perceiving themselves to have control and power, resulted in this conciliatory position of mutual respect. The awareness of the other person’s potential power and control led to little actions being taken.

The power imbalance between daughters and fathers resulted in the female carers undertaking mostly engaging actions and fewer negotiating actions. The power retained by the older male within this dyad relationship was reinforced by these younger female carers who were being ‘actively sensitive’ to the older man’s power and control, enabling the older men to continue to play a more active role. Whereas between daughters and their mothers, the younger female members undertook mostly more equal negotiating actions.

9.3 Conclusions

This chapter has presented a typology of actions taken by family members of older people who have had falls. The gender of the dyad and the power imbalance between men and women impact upon the types of actions taken in order to prevent falls by older people. It was shown that the power imbalance between younger men/older women dyads resulted in the younger male undertaking protective and coercive actions, and the older mothers having a more passive and submissive role. This contrasted with the power imbalance between older male/younger female dyads which resulted in daughters undertaking mostly engaging and fewer negotiating actions in relation to their fathers. The power imbalance retained by the older male within this dyad relationship was reinforced by these younger women carers who were ‘actively sensitive’ to the older men’s power and control, enabling the older men to play a more active role. Wives undertook mostly engaging actions, with the exception of one who took only negotiating actions, illustrating how women can ‘empower’ their spouse in making decisions, and help men retain their dignity.
and self-esteem. This supports Charmaz’s (1995:272) observation that ‘their wives had provided the essence of being there for them’.

This study indicates that despite their increasing dependence and disability older men are more likely to continue to retain power and control, illustrating this power imbalance. The findings show that despite their ‘stigmatising’ experiences of falling in public places, older men within the private sphere of the family realm, continued to maintain their gender identities as ‘men in the household’. Their family members validated these self identities that enabled older men to feel in ‘control’ by delegating and/or restricting some of the activities, as shown in Chapter 8.

Where daughters care for their mothers, female sensitivity resulted in the predominance of negotiating, as well as some engaging actions taken by the daughters. Within the father/son dyad and brother/brother dyad the presence of mutual respect resulted in both members of the dyad taking minimal actions in relation to the prevention of falls, due to the potential conflict arising from each trying to retain power and control.
Chapter 10

CONCLUSIONS

This chapter draws together the key findings of the study and discusses their relevance and significance in relation to existing literature. Implications for health policy issues are explored. This exploratory study used a qualitative approach to examine how the meaning of falls is constructed by older people who have had falls, and influenced the older person’s identity and notions of control, dependency, power and stigma. It also examines the way in which the meaning of risk is constructed by older people who have had falls, with a particular focus on how gender impacts upon the notions of risk and risk-taking behaviours. The study has examined the types of actions taken by older people who have had falls and their key family members, and the extent to which the gender of each member in the dyad impacts upon actions in relation to the prevention of future falls. In particular, it explores how the interaction between the gender of the older person and the gender of the key family member influences the nature of the dyad relationship in terms of control, autonomy and dependence.

The three broad research questions posed in the earlier part of this thesis provide a basis on which to structure the conclusions arising from this research and these were:

1. How is the meaning of falls constructed by older people who have had recurrent falls? To what extent does gender impact upon the meaning of falls by older people? How does the experience of falling impact upon an older people’s identity, their notions of control, autonomy, dependence and stigma?

2. How is the meaning of the risk of falling constructed by older people who have had falls and their key family members? How does the meaning of the risk of falling impact upon the subsequent actions taken by older people and their key family members? To what extent is the meaning of the risk of falling gendered?
3. How does gender impact upon the types of actions taken by older people and by their key family members in relation to trying to prevent future falls? How do the types of actions taken by older people and their key family members differ between older father/adult daughter, older mother/adult son, and older mother/adult daughter dyads? How does gender of each partner influence the nature of the dyad relationship in terms of control, autonomy and dependence?

Charmaz (1995:287) advocates comparative research examining the differential experience of men and women with chronic illness since it can 'substantially refine sociological interpretations of the narratives of chronically ill people'. As highlighted in Chapter 2, little previous research has addressed the issues of how older people perceive the meaning of falls and their falling experiences, particularly the gendered experiences of these older people. Because my study involved interviewing equal numbers of older men and women it maximised my ability to compare gender differences; the separate interviews involving key family members provided the study with a broader and comparative perspective to aid understanding of how the nature of the dyad relationship influenced control, autonomy and dependence.

10.1 The Meaning of Falls

In this study, the social meaning of falls constructed by older people who have had falls can be said to evolve around three inter-related components: the language of falls, gendered stigma associated with falls in private and public places, and biographical disruption. Each of these will be discussed in turn.

There has been little research on the way in which the social meaning of falls by older people is constructed and how this differs among older men and women. The limitations of Martin's (1999) study were outlined in Chapter 2, and this study has further developed her work by focusing on the extent to which older people's perceptions of old age, dependence and independence, control and autonomy, and stigma influenced the
construction of the meaning of falls. In brief, Martin’s (1999) study was primarily concerned with the potential for primary prevention of falls, hence she did not purposefully involve older people who had experienced falls.

10.1.1 The Language of Falls

Chapter 6 showed that because of the negative connotation of falling, older respondents were specific about the usage of the terms ‘falls’, ‘trips’, ‘slip’ or ‘stumble’. For example, ‘trips’, ‘slips’ or ‘stumble’ were used by older people to refer to ‘falling’ events with obvious external causes and which could ‘happen to anyone’. These terms were also used to refer to ‘minor’ falls, often non-injurious. Whereas, ‘falls’ were explicitly used by older people with reference to ‘major’ or ‘bad’ falls that were generally caused by intrinsic factors, that is, those linked to physiological changes, and were perceived by older people to result in injuries. This, coupled with the finding that older people also associated falls with being old and frail, and those with a drink problem, supports Martin’s (1999) assertion that the language used by older people to talk about falls is value-laden.

In this study, there was no gender difference in the usage of these terms in relation to those caused by intrinsic or extrinsic factors. However, older men also preferred to use the term ‘falls’ or ‘falling’ with reference to their personal biographies such as their previous participation in the second world war or previous occupation. The legitimacy and expectation of falling is a greater concern for older men than women since falling when they were younger was ‘expected’: it was an occupational hazard that they anticipated when they were at ‘work’. This reference to their previous work underlines men’s sense of masculinities that are reaffirmed at work as suggested by Whitehead (2002). However with increasing age, when a person falls, it challenges their sense of identity, signalling images of increasing frailty and dependence; this was found to be a particular issue for older men.
10.1.2 Gendered Stigma in Public and Private Falls

It was highlighted earlier in the literature review that little is known about the influence of the location of falls experienced by older people on the meaning of falls. This study argues that the location of falls experienced by older people has a bearing on how older people construct their meaning of falls, since falling in public places subjects an older person to public scrutiny and may pose a threat to his/her sense of identity. The findings also suggest that falling at home may not only be ‘hidden from strangers’ but also protects the older person’s identity, supporting Twigg’s (1999:381) assertion that the home is intensely associated with personal life, with certain aspects unknown to strangers. This study has shown that falling in public spaces meant not only drawing attention to the person who fell, but also resulted in the public taking actions on the older person’s behalf, such as giving assistance, or seeking medical attention, this latter consequence was reportedly dreaded by the older respondents in this study because of the negative connotations associated with falling. A higher proportion of older men (n=12) than older women (n=4) perceived it to be more discrediting to fall in public spaces.

Older men reported that falling in public spaces draws attention to their ‘frailty’ and they were discredited as ‘drunks’. This indicates that falling in public influences the ‘virtual social identity’ and the ‘actual social identity’ of the person, supporting Goffman’s (1963:27) description of a stigmatised person: ‘likely to feel that to be present among normals nakedly exposes him to invasions of privacy’. The experience of falling underlines that stigma is gendered, based on the arguments that when older women fell they were rarely assumed to be drunk, compared to older men. For many older men the social impact arising from falling experiences had resulted in them deciding to restrict their activities, such as avoiding to go to the town centre for fear of falling and being labelled as drunks.

As shown in Chapter 7, more men than women reported restricting their social activities in the public sphere because of ‘fear of falling’. It is suggested that because of the less
sympathetic public responses reported by older men when they fell in public places, that older men found falling in public places more stigmatising. This raises their salient concern to legitimise the falls they had had. The extent to which falls are stigmatising is gendered can be said to be embedded in everyday interaction, supporting West and Zimmerman’s (1987) notion of ‘doing gender’ which is seen through the outcome of a fall: when an older woman falls, she is seen as needing help and gets it, whereas, when a man falls, he is more likely to be seen as a ‘drunk’ and therefore, not legitimately in need of help. This study suggests that if falling is associated with shame and embarrassment, then it can impinge on self-identity and reflect feelings of personal inadequacy, as stressed by Giddens (1991:65).

The difficulty in ‘covering’ the visible signs of falls or injury resulting from falls meant that older people became more conscious about their ‘virtual social identity’. This study indicates that older men were more conscious about the social identity ascribed to them by other people. For example, being seen as ‘drunk’ is associated with having abusive and threatening behaviours. A concern was that older men thought other people assumed after a fall that they had been in a fight, for example, because of their bruised eye. This challenges older men’s ‘traditional assumptions of male identity’, leading to an uneasy tension ‘between valued identities and disparaged, that is, denigrated or shameful, ones’ (Charmaz, 1995:286).

In essence, this study has built on the work of Goffman (1963) on stigma, demonstrating that gender impacted upon the felt stigma associated with falls. It further extends the work of Scambler and Hopkins’ (1986) on the notion of ‘felt’ stigma by suggesting that felt stigma can be gendered since it predominantly challenges men’s self-identity compared to older women’s.
10.1.3 Falls: A Biographical Disruption

The meaning of falls, as this study indicates, may be constructed through personal biography, and conceived as a ‘biographical disruption’ (Bury, 1982). This construction in which older people make sense of their falls, reiterates Williams’ (1984) observation that people make sense of events in their lives through ‘narrative reconstruction’, that is, within the context of their personal biography. In particular, older men indicated in their personal biography, events such as participating in the second world war, and their previous occupation. Some of the older men tended to preserve their notions of masculinity through narratives about their past, supporting Charmaz’s (1995:279) finding that older men with chronic illness ‘aim to reclaim the same identities, the same lives they had before illness’. The implication being that it was ‘alright’ to fall when they were fighting in the war, but they did not expect to fall ‘now’. This was found to be so for some of the older men who had experiences of falls during their previous occupation, or while in the army or navy. The finding therefore suggests that older men used their masculinity as a way of resisting the disabled role, as identified by Morris (1993).

Within a lifecourse perspective, this study suggests that not only do older people make sense of events such as falls through their personal biography, but also they consider them as a ‘biographical disruption’ (Bury, 1982). My study argues that having recurrent falls represents a ‘biographical disruption’, for two reasons. Firstly, experiencing recurrent falls leads to the realisation of functional limitations, which in turn result in an increased dependency. Secondly, as a result of having recurrent falls, older people experienced embarrassment, and became aware of how people might look at them. Falls were regarded as associated with stereotypical notions of being old and frail. Both the functional limitations and the embarrassment resulted in older people making conscious and deliberate actions, and restricting their activities. This supports Simon Williams’ (2000) description of biographical disruption, which he views in terms of its practical consequences for individuals and their families. My study shows that with falls, there is disruption of ‘taken-for-granted assumptions and behaviours’ whereby older people who
have had recurrent falls may become aware of their functional limitations and the embarrassment due to the disabilities resulting from falling. The increasing need by older people who have had falls to be more vigilant in how they lift their feet in order to avoid tripping, and to take extra time in moving from one place to another was only obvious after their experience of falls; these became conscious and deliberate actions. These findings also support Bury's (1982:170) notion of biographical disruption in which ‘everyday life structures, its taken-for-granted features, and the tacit knowledge upon which they rest’ are disrupted. Older people reported a disruption within their family network. Their restricted mobility resulted in older people curtailing visits to their family because they had to rely on others to assist them in getting in and out of a car, supporting Bury (1982;1991) who maintains that chronic illness becomes interwoven into the person’s life and identity, so much so that for some older people ‘the simplest outing becomes a major occasion of planning and expedition’.

There has been no previous research on the extent that biographical disruption is gendered. Bury’s (1982) work did not specifically examine this aspect; his study involved 25 women and 5 men, aged under 64 years. My study indicates that ‘biographical disruption’ as a concept provides another dimension through which falls may be perceived by older people. Despite the disruption arising from the falling events, older men’s capacity for mobilising resources such as delegating tasks to their family members underlines the potential relationship between gender and biographical disruption. This is less so for older women. It highlights how gender impacts upon the way in which older men and women ‘managed’ the consequences of their falls, for example, the tendency by some of the older men to preserve their masculine identity because falls were associated with negative notions of frailty as well as dependency. This is arguably a contribution to the literature on biographical disruption, but identifies the need for further research on the extent to which biographical disruption may be gendered.
10.1.4 Falls as Gendered Dependency

This study indicates that experiencing falls resulted in diminished physical activity associated with frail old age, as well as increased dependency, supporting the work of Martin (1999), Berg et al. (1997) and Ashton (1998). This change in dependency meant for some a change in status, as one male respondent crudely put it ‘you belong to a dependant group’, illustrating the ‘ideological role which particular cultural images play in securing a particular framing of dependency’ (Hockey and James, 1993:35).

Having falls often meant becoming dependent on others as a consequence of falls and the fear of falling, which in turn, may result in older people becoming passive recipients of care, unable to change or exercise control over their situations, as suggested by Jefferson and Hall (1998). But this passivity and loss of control were more likely for women than men. For some older women in particular, it meant having no choice but to be pushed around in a wheelchair by relatives when the older person preferred the use of walking sticks in order to have some degree of independence.

10.2 Gendered Responsibility: Risk and Risk Taking

In Chapter 7, the social construction of the risk of falling by older people and their key family members was explored. The risk perception by older people is linked to gendered notions of how ‘at risk’ they were. For example, over half of older men (n=11) but only one woman spontaneously articulated the word ‘risk’ and its associated terms, reflecting men’s greater awareness of how ‘at risk’ they were, and this in turn, impacted upon their risk-taking behaviours. Both intrinsic and extrinsic factors that contribute to falls were identified by older people, however, there were some gender differences. For example, intrinsic factors, that is, those that relate inherently to the person such as age or health/medical problems, were identified by slightly more older men (n=15) than women (n=12). But many more older men than women, 13 and 5 respectively, identified extrinsic factors, that is, those that operate from without, including the home environment, and public places. More than twice as many men (n=14) as women (n=5) considered their
daily activities as risk factors. These activities included getting in and out of a bath, or getting up in the night. Overall, my study found that older men identified nearly twice as many risk factors (n=42) as women (n=22), with averages of 2.1 and 1.1 respectively. It suggests that the perceptions of risk were gendered, with older men showing greater awareness of what factors put them at risk of falling, particularly those relating to the environment.

My study supports Wynne-Harley’s (1991) assertion that the goal to maintain independence and autonomy by older people influences the way limits and restrictions are set; older people did assess their own risk by examining their home environment, and took responsibility to eliminate potential dangers, such as installing a bathing aid, removing moss from the driveway to avoid slipping, and taking deliberate measures to move slowly. However, my study further develops the work of Wynne-Harley (1991) in that older men in particular, portrayed themselves as ‘rational’ individuals when threats to their independence prevailed, and were more likely than women to rely on their own logical and analytical orientation to examine how and why they had fallen. Older men were more likely than women to portray themselves as having the responsibility to deliberately not put themselves at risk. This is congruent with Whitehead’s (2002) argument that men learned to be independent, and are keen to maintain their masculinity.

Older people’s awareness of risk and the responsibilities attached to risk taking influence the extent to which certain activities are considered appropriate or not. This supports Lupton’s (1999:107) observation that these activities are ‘constantly constructed and negotiated as part of the network of social interaction’. In addition, some older people continue to live the way they were used to, for instance, having mats in the house irrespective of whether these impose risks; this extends the work of Denscombe (1993:507) who found that ‘familiarity breeds contempt’ because ‘where people are exposed to a risk frequently the evidence is that they tend to perceive the risk as less likely to happen to them’. This has implications for how risk factors for falling might differ from the standpoints of older people who experience falls, and of their relatives.
In essence, this study argues that the responsibility in relation to risk taking as perceived by older people is gendered. Older men demonstrated their responsibility by portraying themselves as ‘rational individuals’, who make logical and analytical assessments of factors that put them at risk of falling. This resulted in them being more pro-active by eliminating potential risks such as cleaning a slippery driveway or installing bathing equipment to avoid falling. In contrast, older women’s notion of risk taking tended to be highly associated with assumptions about femininity and ageing, and were governed by their own expectation of self and of others. Fewer older women considered hazards in their home environment; the speculative explanation being the potential disruption caused by home modification(s).

The more falls experienced by the older person, the more risk factors were identified by both the older person and their key family members, suggesting that ‘exposure’ to falling events or having a relative who has had multiple falls enabled the person to acquire skills enabling them to be more attuned to the risks of falling. This concurs with Denscombe (1993) who noted that risk becomes more vivid and foreboding when greater personal experience of the danger is gained.

10.2.1 Key Family Members’ Meaning of Risk

This study indicates that the gender of key family members did not impact upon the perceptions of key family members regarding their older relative’s risk of falling. Key family members identified both intrinsic and extrinsic risk factors, and there were no gender differences. However, this study suggests that there may be generational differences since key family members generally identified more risk factors than older people who have had falls themselves. It is possible that these younger key family members were more attuned to the risks around them and that the older people were ‘in denial’.
A key finding arising from key family members’ perception of the risk of falling is their awareness of the ‘trade-offs’ by their older relative. Whilst they recognise their older relative’s need to maintain their independence, key family members also saw that as a risk of falling to their older relative.

10.3 Subsequent Actions by Older People in the Prevention of Future Falls

In Chapter Eight, the subsequent actions taken by older people who have had falls were examined. It has been discussed that falls can involve a disruption of normal taken-for-granted activities of daily living; for example, an activity such as ‘getting about’ may seem to be ‘normal’ and unproblematic to most older adults, but may become a daunting ‘task’ due to a fear of falling. This experience is likened to ‘biographical disruption’ (Bury, 1982), drawing attention to the impact that disability has at a particular time within an individual’s life course.

There were several strategies taken by older people to prevent future falls. A typology of actions undertaken by older people included adaptive and avoidance actions. Adaptive actions were those that involve the older person changing the way they behave or making adaptations or alterations to the home environment, whereas avoidance actions resulted in the older person ceasing to do some things, or curtailing some aspects of their daily activities of living in order to try to prevent future falls.

This study indicates that the types of actions taken by older people are gendered. More men (8 out of 20) than women (2 out of 20) modified their home environment. There were differing ways in which older men and women exerted control in relation to making choices about what increased or decreased their risk of falling within the home environment; for example, older men gave explicit accounts of how they were able to exert control over their home environment, while older women’s accounts were more implicit. Older men drew upon their gender identity and social position within the family, thus demonstrating their exertion of control over what they did to their home.
environment, which was less evident amongst older women. Older men were not only more 'pro-active' in that they initiated more actions but also they were more often encouraged by health professionals and family members to make decisions. This portrayal of their identity is reflective of Aldous (1994:44) observation of men's identity as one of 'doing things for themselves and by themselves often in public places'.

Older men were more likely than women to restrict their activities, as well as delegating tasks to others, to avoid future falls. These strategies are gendered in that the activities avoided by older people were gender-related, such as not changing the curtains by an older woman, and not using a ladder by an older man. The range of delegating actions was also gender-oriented in that shopping, cleaning and ironing were delegated to female key family members, whilst gardening, or using a ladder to male key family members. The study demonstrates that older men drew upon their masculine identity within the family to 'dictate' who does what in the prevention of falls. In particular, older men's wish to continue to be portrayed as a self-responsible and autonomous person illustrates the way in which perceptions of masculinities and femininities influence the types of actions taken.

10.4 Key Family Members' Actions to Prevent Falls of Older People

This study examined the actions taken by key family members in relation to the prevention of future falls by their older relatives who have had recurrent falls. This resulted in a typology of actions as discussed in Chapter 9.

Although the study set out to interview key family members, it had not intended to look at specific types of intergenerational dyads, since key family members were identified by older people themselves. However, what emerged from this study enabled an examination of the extent to which gender impacts upon the subsequent actions of these key family members, and how the gender of the older person and the key family member interact and
influence the nature of the dyadic relationship in terms of control, autonomy and dependence.

Only male key family members of older women who have had falls took protective actions, the intention being that the person being cared for was protected from any harm or danger, in relation to the risk of falls. The older woman being ‘protected’ was aware of what the key family member was doing for them. This portrays a different dimension to the type of protective care, suggested by Bowers (1987), which was conceived as primarily concerned with keeping the person unaware of his or her failing abilities, with the implication that the person being protected may not have been aware of this aspect of care. However, in my study ‘protective’ sons discouraged their mothers from cooking their own meals, or getting in and out of the bath on their own. This concurs with Nolan et al.’s (1996) assertion that protective care may be counter-productive since older people, particularly older women might be de-skilled as they were not encouraged to be independent. This highlights the ‘plight’ of older women, in particular, those with sons as their key family members because their sons were ‘protective’ towards them, thus underlining the ‘traditional’ gender role and identity, and undermining women’s power and control within the family. My study indicated that the treatment by older son carers of older women exacerbated older women’s experiences of being marginalised, changing them into metaphoric children, thus supporting Hockey and James’ (1993) analogy of caring for older people through the metaphoric use of child/parent relationship.

Coercive actions were only taken by sons of older women who had had falls. Given that little is known of the coercive actions within family caregiving situations, this study underlines the power imbalance within older mother/adult son dyads. The lack of negotiation and the threat posed in this type of action can be seen through the older woman’s submissive response or resignation underlining the low/powerless social position occupied by these women. That protective and coercive actions were taken only by adult sons of older women who had had falls and none were taken by adult daughters or nieces provided a contrast. This draws attention to the impact that gender has on the
nature of the kin relationship, and on the type of actions taken by key family members to prevent falls by their older relatives.

Two facilitative types of actions, ‘negotiating’ and ‘engaging’, reflected a different approach in the way in which older people were treated. These actions safeguarded the self esteem of the older person. Only wives, daughters and nieces undertook these types of actions; none were taken by male key family members. However, within these facilitative types of actions, there was a distinct difference in that more negotiating actions were undertaken by female key family members of older women while more engaging actions were taken for older men. This further demonstrates the power imbalance between older men and women, in that most of the older men were ‘allowed’ by their key family members to make decisions, reflecting the older man’s position within the family. My study illustrated clearly that these actions are gendered - that the interaction of gender within caring dyads influences the type of actions taken.

Within older mother/adult daughter dyads, there seemed to be a greater recognition by both parties of the need to participate in the decision making, and there is an ongoing process in which both members strive to ‘do a deal’ with each other, acknowledging each other’s roles and position within the family. This supports Matthews’ (1979) observation of the supportive nature that is sustained within the older mother/adult daughter dyad. That negotiating actions encouraged members of the dyad to work together, with each having some say in what happens, supporting Gregory’s (2000) description of the ongoing process in which territorial boundaries were tested.

One of the key findings of this study centres on ‘feminine sensitivity’, which is an attribute of female key family members. In particular, this study showed that ‘feminine sensitivity’ was lacking in adult sons because most of them perceived their role as being protective of their mother, so much so that they often coerced their mother into relinquishing some activities such as giving up cooking or vacuuming, which can be seen as a double blow to the older women’s self-identity and self-worth. Whereas female
family members seemed to have a more ‘intuitive’ sense of the other person’s needs, and in this study, a perception of the needs of older men for power and control. Although Mason’s (1996b:31,32) concept of ‘active sensibility’ provides me with some insight of the ‘personal relationship’ in relation to caring within the family context, and illustrates that it is ‘an activity of feeling a responsibility for someone else, or a commitment to someone else’, it does not appropriately characterise the ‘feminine’ aspect of the ‘caring work’. The term ‘feminine sensitivity’ goes further and is used to emphasise the socially constructed process of drawing on one’s experience and sensing another’s need(s).

This study therefore provides an analysis of how gender relations and family relationships interact to influence the type of actions taken by key family members to help prevent their older relative falling. For instance, the findings indicated that wives took mostly engaging actions and only one of the four took negotiating action.

Gender influences the nature of the dyadic relationship in relation to the perceived control and autonomy of each member of the dyad. The one brother in this study held mutual respect for his older brother, taking minimal actions. Similarly, the only father-son dyad showed that there was little conflict between them. That men held mutual respect for each other had been one of the distinctive features of the findings, although it is acknowledged that the small sample does not allow for generalisations. In both the male dyads, the study found that both parties held similar views such as the value of independence, and it is this and the perceived control that each party had that resulted in minimal actions being undertaken, which arguably might have been influenced by the fear or realisation of possible conflict from any drastic actions, since each male member wanted to retain his power and authority, and respected this desire. The mutual respect for each other found in the father/son relationship is opposed to Morgan and Kunkel’s (1998) observation that this type of relationship is most likely to experience conflict. But, it concurs with Nydegger and Mitteness (1991) who maintained that mutual understanding occurred in the relationship between older father and adult son since the former found it easier to understand their adult sons than their daughters. What was surprising was that none of the
four wives in this study had a relationship of mutual respect, my previous assumption was that as marriage partners, they would respect their husbands and vice versa.

10.5 Gendered Power and Control

Gender was found to be a major determinant in the social meaning of falls among older people, in the actions taken by older people, and in the decisions made within the caring and family context. Gender influences the social construction of what it means to have falls. Although 'falls' and 'trips' were articulated by both older men and women, older men preferred to use the term 'fall' in reference to their personal biographies. Gender impacts upon the perceptions of older people in relation to what makes them more likely to be at risk. Older men not only identified more risk factors, they also reported taking more actions to stop themselves from falling. Their portrayal of themselves as rational individuals, as mentioned earlier, illustrates the importance they placed upon their masculine identity, that they were brought up to be independent.

Gender impacts on how risk and risk taking are perceived by older people, which in turn impacts upon the types of actions taken by older men and women to prevent future falls. Older men were more articulate about risk and risk taking. For example, the word 'risk' was mentioned 25 times by the 20 men compared to only 7 by the 20 older women. Older men on average identified 2.1 risk factors compared to 1.1 by older women. Because of their gender identity older men were more likely to perceive themselves as rational individuals where risk taking was concerned. They perceived that it was their responsibility not to deliberately put themselves at risk, therefore, they considered their need to protect their independence and autonomy by avoiding doing things that were seen as risky.

Not only did older men take more of each type of action, they also showed greater willingness to exert control. By comparison, older women tended to undertake fewer actions in relation to environmental modifications, actions to enhance their balance,
‘taking care’ actions, self-restricting actions, and delegating tasks to others. Older men’s exertion of control reflects a pro-active approach; they tended to draw upon their gender identity and social position in the family to delegate tasks to their family members, demonstrating the power they continue to retain despite their increased dependency.

Finally, this study has found that gender impacts upon the power balance or imbalance within the family dyads. The gender of the dyad and the power imbalance between men and women impact upon the types of actions taken in relation to prevention of falls by older people. It has been demonstrated that the power imbalance between younger male/older female dyads resulted in the younger male undertaking protective and coercive actions, and the older mother of this dyad being coerced and protected, resulting in her adopting a more passive and submissive role. This underlined the subordinate role of older mothers in their relationship with their adult sons, supporting Matthews (1979) and Talbott (1990) who both indicated that older women lacked power, and experienced low self-esteem, thus making themselves subordinate. Gendered power impacted upon the younger women who took engaging and negotiating actions in relation to their older fathers. This enabled older men to continue to retain some power and control, despite their increasing dependency and disability. This supported Davidson et al. (2000) who noted that men care-recipients exercised greater control than women care-recipients.

### 10.6 Health Policy Implications

Health care professionals need to be aware that older people construct different meanings of falls and of the risk of falling, and that these may be influenced by various factors. Consequently, when an older person has been admitted to hospital because of a fall a thorough assessment is required taking into consideration the usage of language by the older person in relation to their falling event, since use of terms like ‘slips’, ‘trips’ or ‘falls’ differed among older men and women. Because trips were generally considered to be ‘minor’, and because of the severity attached to ‘falls’ older people may under-report these events for fear of the perceived consequences of falling. During an assessment, the
location of the fall should be considered. Falling in public places is perceived to be more stigmatising especially for older men, and can undermine an older person’s confidence to go out on their own. That falls can be perceived as ‘discrediting’ needs to be acknowledged, and helping strategies are necessary to assist older people to overcome the stigma perceived in relation to falling in public places, and to retain their self-esteem, thus maintaining their self identity. In particular, there needs to be a greater realisation of gender difference - that older men might find falls more stigmatising. That falls may have a greater impact upon older men, in particular, should not be ignored. Curtailment of activities by older people needs to be identified, with opportunities made available for older people to talk about their ‘fear of falling’. Through open discussion, risk(s) of falling can be accurately assessed and reviewed.

There is a tendency of older people, particularly older women, to blame themselves for the falls that can lead to feelings of guilt. This may warrant the attention of health care professionals to be ‘sensitive’ to this issue and to be aware that they too could unintentionally engender and confirm such guilt. Health care professionals may assist the older person to review the falling events so that assessment of the older person’s risk factors for future falls may be accurately made. This could take the form of a check-list of hazards to enable older people and their family members to help promote or maintain a safe home environment.

This study has illustrated that having recurrent falls is likely to influence the meaning of falls, thus secondary prevention of falls may need different approaches compared to those required by older people who have experienced only one or two falls. That older people may develop ‘mastery’ at risk identification should not be ignored. However, potential conflict may arise where mastery is ‘present’ in both the older person and their key family member, whereby risk factors for falling may differ from the standpoints of older people and their family members. Health care professionals need to acknowledge that such conflict may arise when trying to act in the interest of someone else, yet at the same time, to recognise the older person’s skill in managing his or her own risk taking.
There is a need to be aware of the ‘cohort’ experience of older people who might have been socialised into a more traditional role, with older women taking a passive and subordinate part and men taking an active and dominant role within the family. Some older people may need reassurance that they have the ‘right’ to make decisions or take risks, provided they have been given sufficient information about the choices and consequences. Some may need the assertive skills to say ‘no’ to being coerced and knowing that they can negotiate and make their needs known.

Health care professionals need to be aware of how the gender of the older person and the gender of key family members may interact and influence the type of actions taken to prevent future falls. For instance, that ‘protective’ behaviours, as well as coercion, may be more likely to be undertaken by sons of older women, and that this must to be recognised and discouraged. Equally salient is the need to recognise and acknowledge that engaging and negotiating actions are more likely to be taken by female key family members.

At the grassroots, health care professionals should be aware of the dynamics in the various dyadic relationships, and recognise the potential conflict that arises from an imbalance of power within a kinship dyad. For instance, they should recognise the type of actions undertaken by adult sons in caring for their older mother, and that these actions can have negative and counter-productive effects on the older mother. However, the part that sons play in helping their older mother should be recognised and supported since they could be blamed for being over-protective and controlling. Nonetheless, these male carers or sons would benefit from advice about how to provide support and how to empower their mother to take responsibility for making informed decisions that affect their lives.

Health care professionals should alert themselves to the potential lack of actions taken by male carers of older men in relation to the prevention of falls, and assist them in identifying ways in which both members of the dyads could engage positively with each
other. This could be achieved through one-to-one sessions with each member, as well as with both members of the dyads so that a consensus of a plan of actions and evaluations can be drawn up. This way, health care professionals can rise to the challenge by providing their skills and expertise by facilitating both older people and their family members to be more pro-active in the prevention of future falls whilst maintaining the dignity and autonomy of the older person.

10.7 Reflections

The qualitative approach taken in this study was appropriate in providing a broader perspective to answer the research questions. The indepth interviews with equal numbers of older men and women enabled me not only to obtain rich data, but also to compare gender differences. Separate interviews with key family members provided me with an understanding of the nature of the dyadic relationship within the family caring context, but also of the impact that gender has on both members.

The small sample and the qualitative approach employed in this study make generalisation to a wider population difficult and inappropriate. However, following Brannen (1992), Williams (1998:211) argued that ‘issues relating to the representativeness of the sample and the generalisability of the findings are not paramount, the concerns being to establish theoretical links with each case, and to replicate findings in other sets of conditions.’ The validity of the findings from this research needs to be assessed in other settings. This study has identified the diversity of intergenerational interactions, and how these impact upon actions of both parties, in the prevention of future falls by older people.

The process by which older people were recruited was appropriate though time-consuming since the aim was to interview equal number of older men and women who had recurrent falls, and lived alone. The use of various sheltered housing and day centres in different locations, including urban and rural settings, provided a diverse group of
older people. Given the ‘sensitive’ nature of the study, the strategies of ‘snowballing’ and ‘networking’ as identified by Lee (1993) were appropriate and effective since they enabled me to achieve interviews with 20 older men and 20 older women. Key family members were identified by older people themselves. Therefore the type of kin relationship and gender of kin formed a convenience sample. This resulted in the small number of older male/male carer dyads, which did not enable me to make effective comparisons with other family dyads. However, this raises scope for future research to examine men caring for older men or sisters caring for sisters, and husbands caring for wives.

The use of loosely structured interviews permitted flexibility in exploring aspects that were important to both sides of the caring relationships. The unstructured interviews were appropriate for exploring in depth the thoughts and perceptions of older people and their key family members. This met the need of older people who preferred a type of interview with a conversational feel (Montazeri et al., 1996). The openness with which most older people and their key family members discussed their experiences and perceptions confirms the usefulness of this type of interview. However, two of the older men in the study (see page 1060 were less open and may have been more comfortable with a more structured interview approach. As an experienced nurse teacher in the care of older people, I felt I possessed the skill to make the older person feel at ease through my initial lines of communication, and that problems of impaired speech or hearing needed careful and sympathetic handling so that feelings of frustrations were minimised.

I am aware of the potential interviewer effects; that being a woman might have influenced what men said about what they do and how they go about it. There is the possible implication that their responses were to impress me. However, this was not the case since invariably, the actions were validated by the key family member. This underlines the importance of being able to cross-validate within the research design. It is also acknowledged that while interviewer effects may compromise the validity or reliability of the responses, it is argued that a structured type of interview that may ‘control’ the conduct of the interviews, does not allow for the spontaneity and enriching data that a
loosely structured type of interview allows. The research experience fully supported Fielding’s (1993) suggestion that respondents may find it easier to confide in a stranger, and that being a female may be less threatening to both female and male respondents.

The potential problem of forgetfulness, poor concentration, a lack of lucidity and confusion, as Martin (1999) had highlighted, could have influenced the older person’s accuracy in remembering the number of falls they had had and what actions they took. The use of special occasions and events such as Christmas, New Year, and Easter helped jot older people’s memory of their falls. However, this was not a major focus of the research which was primarily concerned with meanings and understandings of how older people perceive falls and the risk of falling, and the actions taken by older people and their key family members, which could be less affected by any problems of memory.

In conclusion, the findings of this study indicate that even at the beginning of the twenty-first century, gender continues to be a key factor that influences how a person constructs meanings of events such as falls, and takes actions to try to prevent such future events. Gender pervades in both the worlds of older people and their key family members, influences notions of control, stigma, dependence, responsibility and power. Focusing on both perspectives of older people and of their key family members has enriched this study by highlighting the differing ways of constructing meanings, and how these in turn influence self-identity.
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Appendix A

INFORMATION SHEET FOR RESEARCH PARTICIPANT (Older people who have had falls)

November 1999
Re: Social meaning of falls among older people

Dear .........................

My name is Khim Horton and I am a full-time nurse researcher at the University of Surrey funded by the Economic and Social Research Council. I am writing to invite you to take part in my research project. My study has been given ethical approval by the University of Surrey Ethics Committee, and my supervisor is Professor Sara Arber.

The research project is about older people who have had mishaps such as falls. I am interested to know more about their experience, and how they think it has affected their lives and their family. The research findings will help nurses and others to improve care. This research aims to obtain both the views of older people and of their family members in separate interviews. The interview will last about an hour and a time will be arranged to suit you. This can take place at your home or somewhere else if it is more convenient to you. With your permission the interview will be taped so that I have a record of what you have said.

Your participation is in this study is entirely voluntary. You have the option not to participate or to withdraw from the study at any time. Everything that you tell me will be totally confidential and will be discussed with my supervisor. It will not be discussed with anyone else. Your decision, whether or not to participate will not affect your medical care.

I will ring you in a few days’ time to talk about the research, and will answer any questions you may have. Alternatively you can contact me at work on this number -1483-873961. Thank you for considering this request.

Yours sincerely,

Khim Horton (Mrs)
Appendix B

INFORMATION SHEET FOR RESEARCH PARTICIPANT (Family member)

December 1999

Re: Social meanings of falls among older people

Dear ................................................ .

My name is Khim Horton and I am a full-time nurse researcher, at the University of Surrey. I have been given your name by ..................................(e.g. mother, father, husband) who thought you might consider taking part in the research project in which she/he has been invited to participate. My study has been given ethical approval by the University of Surrey Ethics Committee and my supervisor is Professor Sara Arber.

The research study is about older people who have had mishaps such as falls. I am interested to hear from these people, as well as a close relative about what they think of falls and how these might influence their lives. It is hoped that in time this research would assist nurses and others to improve care. I would like to interview you and this would only last about an hour. I would be happy to come to your home or somewhere else, at a time convenient to you. With your permission the interview will be taped so that I have an accurate record of what has been said.

Your participant in this study is entirely voluntary. You have the option to withdraw from the study at any time. Everything that you tell me will be totally confidential and will only be discussed with my supervisor. It will not be discussed with anyone else.

I will ring you in a few days to talk about the research, and will answer any queries you may have. Alternatively you can contact me at work on 10483-87396. Thank you for considering this request.

Yours sincerely,

Mrs Khim Horton
Appendix C

CONSENT FORM

Re: social meanings of the risk and consequences of falls among older people

I have read and understood the Information Sheet provided. I have agreed to be interviewed by Khim Horton, a nurse researcher at the University of Surrey. I realise that the interview is entirely voluntary, that I am free to withdraw from the study at any time without any explanation. I understand that everything I say will be in the strictest confidence. I also understand that any reports of this study will not be able to identify me in any way. I give permission for the interview to be taped.

I confirm that I have read and understood the above and freely consent to participating in this study.

Name of research participant: .................................................
(BLOCK CAPITALS)

Signed ..................................

Date: ....................................

Name of interviewer: ..................................................
(BLOCK CAPITALS)

Signed ..................................

Date: ....................................
Appendix D

INTERVIEW GUIDE (Pilot Study): Older People

1. Background information

2. Fall History
   - Number of falls
   - What happened
   - Causes

3. Risk of Falls
   Things that they do that make them likely to experience another fall?
   Things around them

4. Perceptions of older people who fall

5. Prevention - actions taken
   - Likely to fall again?
   - Changes in the way they think, do or feel about falls, and prevent falls

6. What does having falls mean to you?

7. Any questions to ask me.
Appendix E

INTERVIEW GUIDE (Pilot Study): with Family Members

1. Background information

2. Family arrangement with regard to care of older relative.

3. Perceptions of falls.
   - History of older relative’s falls
   - Causes of falls
   - Consequences
   - How it affects older relative, and them?

4. Risk of Falls perception.
   - What makes older people more likely to fall?

5. Subsequent actions
   - Done anything different since older relative’s falls?
   - Changes in thoughts and feelings.
   - What older person should and ought to have done?
Appendix F

INTERVIEW GUIDE: With Older People

1. Background information

2. Fall History
   - Number of falls
   - What happened with each fall
   - Causes
   - Falling at home versus falling in public places

3. Risk of Falls
   Things that they do that make them likely to experience another fall?
   Things around them
   Responsibility, control, expectation of self and others

4. Perceptions of older people who fall

5. Prevention- actions taken
   - Likely to fall again?
   - Changes in the way they think, do or feel about falls, and prevent falls
   - What ought or should be done to prevent falls
   - What key family members did

6. What does having falls mean to you?
   Age: would experience be different if they were 70, 80 or 90 years old?

7. Gender
   Would experience be different if they were older men/ women?

8. Any questions to ask me.
Appendix G

INTERVIEW GUIDE: with Family Members

1. Background information

2. Family arrangement with regard to care of older relative.

3. Perceptions of falls.
   History of older relative’s falls
   Causes of falls
   Consequences
   How it affects older relative, and them?

4. Risk of Falls perception.
   What makes older relative more likely to fall?

5. Subsequent actions
   Done anything different since older relative’s falls?
   Changes in ways they do things for older relative
   Changes in what they think of or feel about the older person.
   What older person should and ought to have done?

6. Perceptions of older people who fall
   Age differences
   Gender differences
Appendix H: Supplementary Tables

Table H.1  A breakdown of actions undertaken by older men who have had falls

<table>
<thead>
<tr>
<th>Older Men (n=20)</th>
<th>Adaptive Actions</th>
<th>Avoidance Actions</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Environmental Modification</td>
<td>Enhancing Balance</td>
<td>'Taking care' actions</td>
</tr>
<tr>
<td>WeeksM</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>ThornM</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>JohnsM</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>ColsonM</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>SmartM</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>VokesM</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TibbsM</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>GiggsM</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>HudsonM</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>HallM</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>RushM</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>WallM</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>CantM</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>TuckM</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>HartM</td>
<td>1</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>ChardM</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>HullM</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>KeyM</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>GreenM</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>FinnM</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>No. of each type of actions</td>
<td>13</td>
<td>15</td>
<td>22</td>
</tr>
<tr>
<td>Average number of each type</td>
<td>0.65</td>
<td>0.75</td>
<td>1.1</td>
</tr>
</tbody>
</table>

This table provides a detailed breakdown of the actions undertaken by each of the older men in preventing future falls. The total and average numbers of actions undertaken by older men and women who have had falls can be seen in Table 8.2 in Chapter 8.
Table H.2  Subsequent actions undertaken by older women who have had falls

<table>
<thead>
<tr>
<th>Older Women (n=20)</th>
<th>Adaptive Actions</th>
<th>Avoidance Actions</th>
<th>Total number of actions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Environmental Modification</td>
<td>Enhancing Balance</td>
<td>‘Taking care’ actions</td>
</tr>
<tr>
<td>NicholsF</td>
<td></td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>HopkinF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MalkinF</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>PalmerF</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>CottonF</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>CrickF</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>BickleF</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>DayF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ScarrF</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>TylerF</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>ShirleyF</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>EdeF</td>
<td></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>BrookF</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>PayneF</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>ChildF</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>WoganF</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DaleF</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>DenchF</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>LongF</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>HareF</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>No. of each type of actions</td>
<td>2</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Average no. of each type of actions</td>
<td>0.1</td>
<td>0.45</td>
<td>0.8</td>
</tr>
</tbody>
</table>

This table provides a detailed breakdown of the actions undertaken by each of the older women in preventing future falls. The total and average numbers of actions undertaken by older men and women who have had falls can be seen in Table 8.2 in Chapter 8.
Table H.3  **Number of actions undertaken by older men and women to prevent future falls**

<table>
<thead>
<tr>
<th>Number of actions</th>
<th>Older Men (n=20)</th>
<th>Older Women (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>6</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>81</strong></td>
<td><strong>39</strong></td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>4.05</strong></td>
<td><strong>1.95</strong></td>
</tr>
</tbody>
</table>

This table indicates the number of actions taken by older men and women. It relates to Tables H.1 and H.2 which show in detail the number and types of actions undertaken by older men and women who have had falls. Discussion of these actions can be seen in Chapter 8.
This table provides a breakdown of the types of actions undertaken by sons who were key family members of older women who have had falls. Discussion on these actions can be found in Chapter 9 where Table 9.1 shows the types and numbers of actions undertaken by each of these sons.

<table>
<thead>
<tr>
<th>Sons of older women (n=10)</th>
<th>Protective Actions</th>
<th>Coercive Actions</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>S NicholsF</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>S MalkinF</td>
<td>2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>S PalmerF</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>S BickleF</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>S DayF</td>
<td>4</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>S BrookF</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>S DaleF</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>S DenchF</td>
<td>5</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>S LongF</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>S HareF</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td><strong>18</strong></td>
<td><strong>41</strong></td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>2.3</strong></td>
<td><strong>1.8</strong></td>
<td><strong>4.1</strong></td>
</tr>
</tbody>
</table>

**Table H.4 Types of Actions undertaken by Sons of Older Women who have had falls.**