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Older Homebound Women: Negotiating Reliance on a Cane or Walker

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Abstract

Canes and walkers are commonly characterized as assistive devices and as devices that serve the same purpose, as walking aides. These general views were reappraised and tempered in this descriptive phenomenological study with 40 older women (aged 85-98) who were unable to leave their homes without help. The purpose was to describe the phenomena of negotiating reliance on canes and walkers as walking devices and the lifeworld context underlying each phenomenon. Relative to lifeworld, there were differences between coming to terms with using a cane and coming to terms with using a walker. Data revealed similarities and distinctions between the basic intentions of relying on canes and on walkers and the associated purposes served by canes and walkers. Participants did not view either device as consistently assistive. Findings evoke opportunities for dialogue among older persons, scholars, practitioners, and designers of these devices about coming to terms with such devices and relying on them.

Keywords

lived experience; older people; rehabilitation; phenomenology; technology; assistive

As the aging population increases, the demand grows for technologies to enhance quality of life and ameliorate physical decline (Charness, 2005; Czaja, 2006). Yet few practitioners and researchers have asked older persons their opinions of technological devices (Zimmer & Chappell, 1999), including traditional technologies like canes and walkers. Thus, the issues we address in this article are important and timely. Our purpose was to elaborate what it was like for 40 older homebound women, residents of a mid-western state in the U.S., to negotiate reliance on a cane or a walker as a walking device and to set those descriptions in personal-social context. Recognizing that other terms are used for such devices in other nations, we refer to the “standard cane ... [that is] shaped like a candy cane and ... made of wood or adjustable aluminum” (Tideiksaar, 2002, p. 71) and “the standard walker [that] consists of four adjustable legs equipped with rubber tips ..., either folding or non-folding” (Tideiksaar, 2002, p. 71).

Compared to complex, high-technology devices, older adults tend to be much more familiar with low-technology devices (Mann, 2003; Rogers, 1985). Low-tech assistive devices (AD) are standard products with simple designs (Wolff, Agree, & Kasper, 2005), including

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“portable aids ... [such as] canes and walkers” (Freedman, Agree, Martin, & Cornman, 2006, p. 124). In the U.S. community-dwelling older adults have named canes and walkers as the ADs they use most frequently (Hartke, Prohaska, & Furner, 1998). Furthermore, they have ranked those devices as among the most important to them (Mann, Llanes, Justiss, & Tomita, 2004). In the U.S. in 2001, canes, walkers, and crutches accounted for about 53% of the mobility devices obtained by Medicare recipients through the Durable Medical Equipment (DME) benefit. Yet the cost of those items represented only 8% of DME expenditures (Wolff et al., 2005). Such cost-effective approaches to mobility problems should be explored by researchers and emphasized by policy-makers, because use of mobility devices is likely to burgeon as the population ages.

Indeed, Bateni and Maki (2005) observed that research could yield suggestions for improved design of canes and walkers. However, in contrast to “simple technology” (Wolff et al., 2005, p. 1142) like canes and walkers, researchers have focused on novel, high-tech devices (Gitlin, 2003). In a review of mobility aids for older persons, Mollenkopf (2003) did not mention either canes or walkers. The minimal scholarly interest in canes and walkers does not stimulate changes in Medicare policy that would support expanding coverage for mobility devices from conditions requiring restorative care to conditions requiring compensatory care (Wolff et al., 2005). Older persons face challenges with using mobility devices, but little is known about those experiences (Gitlin et al., 1998). Such challenges are especially critical for older women. They are more likely than older men to report the mobility problems that increase in prevalence with aging (Shumway-Cook, Ciol, Yorkston, Hoffman, & Chan, 2005).

Critical analysis of research traditions relevant to the experience of interest is a preliminary activity of Porter’s (1994a, 1998) descriptive phenomenological method, which we used in this study. We critique three trends in the literature. First, researchers tend to refer to canes and walkers concurrently (Mann et al., 2004; Kitchener, Ng, Lee, & Harrington, 2008). Whereas that approach might be necessary in epidemiological studies and large-scale surveys, it is an inference that the devices serve the same purposes. The concurrent reference to canes and walkers in research studies does not foster consideration of similarities and differences in intentions about using each device.

The notion of intention is at the heart of the second trend. Asserting that intention to use an AD for mobility or self-care is “the most direct determinant of the actual use of ADs” (Roelands, Van Oost, Depoorter, & Buysse, 2002, p. 40), Roelands et al. (2002) envisioned intention indirectly – as a measurable construct “determined by the proximal variables of attitude towards the use of ADs, the AD self-efficacy, and the subjective norm regarding ADs” (Roelands et al., 2002, p. 40). There are few phenomenological studies of intentions to use walking devices; from that stance, intention is viewed as what a person is trying to do relative to an experience (Porter, 1998).

The final trend of interest is the tendency to focus on helpful aspects of canes and walkers. Researchers have conceptualized them as assistive devices (Bynum & Rogers, 1987) or assistive technologies (Freedman et al., 2006). The word assistive highlights the potential positive impact on self-care ability, but it is also an inference that only benefits accrue from use. However, stigma associated with using a cane can lead to the choice to do without it in public (Allen, Foster, & Berg, 2001). Indeed, older persons who had suffered a stroke had more negative and mixed reactions to mobility devices than to other ADs (Gitlin, Luborsky, & Schemm, 1998).

In this article, we present findings that are counterviews to each of the prevailing trends in the literature. Phenomenological studies are focused on description of experience (Porter,

1994a) and its personal-social context (Porter, 1995a). From the standpoint of interpretive sociology, context can be viewed as *lifeworld* or “the unexamined ground of everything given in my experience” (Schutz & Luckmann, 1973, p. 4). Descriptive phenomenological studies should build knowledge that challenges extant research traditions (Porter, 1998). That standard is not always met; some of Porter’s early work is a case in point. In a study with older widows Porter (1994a) discerned four phenomena of the experience of living alone, including “reducing my risks” and its component “negotiating reliance ... on structural features of buildings, assistive devices, and other people” (Porter, 1994b, p. 57). With its embedded adoption of the phrase, assistive devices, that conclusion is a meager contribution to knowledge. Furthermore, although “facing vulnerability” (Porter, 1995a, p. 39) had been discerned as a feature of lifeworld, the contextual counterpart to negotiating reliance, Porter (1995a) had not fully explored it as a “reference schema” (Schutz & Luckmann, 1973, p. 7) for use of canes and walkers. This critique of work from a variety of traditions is an impetus for “further research [that] calls for new descriptions with manifold improvements” (Husserl, 1913/1962, p. 259). Accordingly, our aim in this article was to describe the phenomena of negotiating reliance on a cane and a walker and to illuminate the personal-social context of each phenomenon for older homebound women.

Methods

Data reported were obtained in a descriptive phenomenological study of the experience of reaching help quickly (RHQ); Porter was the lead researcher. Husserl (1913/1962), who originated phenomenological philosophy, emphasized the necessity of clarifying the empirical forerunners of scientific constructs through the descriptive study of experience. He characterized the work as “rendering intuitable” (Husserl, 1913/1962, p. 179) the essence of experience by “turning toward” (Husserl, 1913/1962, p. 178) the experience as it is lived, while setting aside what is held to be known about it. A description of an experience is to be set in personal-social context (Husserl, 1913/1962; Porter, 1998), which, as noted earlier, we understand in terms of lifeworld (Porter, 1995a). Lifeworld is that stratified stock of personal knowledge that serves as the “reference schema” (Schutz & Luckmann, 1973, p. 7) for one’s explanation of the world. Such explanations are understood to varying degrees by others; lifeworld is personal as well as social. Such explanations also are “taken for granted ‘until further notice’” (Schutz & Luckmann, 1973, p. 12); when one’s situation changes, one’s explanation of the world changes as well. In exploring experiences with walking devices, we expected to hear changing explanations of a particular facet of lifeworld: “habitual, functional unities of bodily movement” (Schutz & Luckmann, 1973, p. 106). That is, once one learns to walk, that problem has been solved, and there is no reason to question how it is to be done until that further notice when walking again becomes problematic.

Interacting with persons over time in the environment where they are living an experience enriches understanding of that experience and its lifeworld context (Porter, 1998). Hence, for the study of the experience of RHQ, an extended design was planned, with 4 in-home interviews per participant over 18 months. We explored experiences with walking devices in the RHQ study because perceptions about one’s mobility influence decisions about how one would reach help quickly; data about the experience of reaching help quickly are reported elsewhere.

Ethical Considerations, Sampling, and the Sample

The Health Sciences Institutional Review Board at the University of Missouri approved the protocol. The sampling frame was women aged 85 and older who were living alone and homebound (Smith & Longino, 1995); that is, they were unable to leave home without the help of a person, a device for walking, or both. We used those inclusion criteria because women aged 85 and older are part of a rapidly growing sector of the U.S. population (U.S.

Census Bureau, 2008b). Of community-dwelling women in that age group, 60% live alone (U.S. Census Bureau, 2008a) and 50% are homebound (Smith & Longino, 1995). Use of a cane or walker is associated with particular chronic health problems. Wolff et al. (2005) categorized problems reported by U.S. Medicare beneficiaries who had obtained a cane or a walker through Medicare's durable medical equipment provision. Of those persons, about 85% reported cardiovascular disease (including coronary heart disease and hypertension), about 81% reported musculoskeletal conditions (including arthritis), and about 22% reported a neurological condition (including stroke).

To recruit 40 women, we sampled by convenience through contacts with social service agencies and newspaper advertisements. Female volunteers living within 50 miles of the university were screened for age and homebound status when they telephoned to express interest. Eligible volunteers were informed of their rights, including confidentiality and freedom to withdraw from the study without penalty. In lieu of standardized screening for cognitive status, each volunteer was asked to listen to a short description of the study and then to respond to two simple questions about the purpose of the research and her role in it (Dubler, 1987). All 40 participants responded to those questions correctly prior to giving written consent to participate. At the outset of each ensuing interview, similar screening occurred; each participant could relate the reason that the interviewer had arrived at her home.

Participants ranged in age from 85 to 98 years. At Interview #1 we asked each woman if she had certain health problems. Of the 40 women, 38 (95%) had a musculoskeletal problem (arthritis, a broken hip or both); 37 (93%) had a cardiovascular problem (hypertension, coronary artery disease or both); and 17 (43%) had a neurological problem (stroke). Of the women 16 (40%) had all 3 problems, 18 women (45%) had 2 problems, and 6 women reported 1 problem. When we asked the women if they had help from someone else at home, all 40 women responded in the affirmative. Of the 40 women, 23 completed the 18-month study. Most of the others moved to an assisted living facility, nursing home, or relative's home. A few women lost interest or did not continue for health reasons, and one woman died. All 40 women offered data relevant to negotiating reliance on canes or walkers; we report data from each woman using a pseudonym that has no relationship to her surname.

Data Collection

The semi-structured, tape-recorded interviews, which averaged 70 minutes in length, were done at designated intervals over 18 months in the home. Porter and Matsuda co-facilitated interviews with 10 women; Porter facilitated interviews with the other 30 women. We did 137 interviews with the sample and an average of 3 interviews per woman. Monthly telephone calls were placed when interviews were not scheduled. Interviewers followed an interview guide, asking specific questions about the RHQ experience at each interview or telephone call. We bracketed the concept of assistive devices by omitting mention of that phrase. At each interview we asked about the use of a cane or walker in the house, because the need to use a walking device could have influenced the ability to reach help quickly. We sought to encourage women to elaborate, but we neglected to ask some key follow-up questions, as shown in this interview excerpt. "For a long time I did not want to become accustomed to it (using a walker in public), so I wouldn't use it very well. After talking with people and (her driver), and so on, I decided that I'd better come to terms with that thing." If we had asked the woman to explain what she meant by "and so on," we might have drilled closer to the core of her experience. Although most data reported here were responses about use of a cane or a walker in the house, other relevant data came from questions about using help to leave home or precautions to prevent the need to reach help quickly. That is, some women described reliance on a cane or walker to prevent a fall – a fall that might warrant the need to reach help quickly. After several interviews, some women anticipated our

interest in walking devices; they shared such experiences before we asked about cane or walker use.

Data Analysis

After each interview tape was professionally transcribed, Porter entered the file into QSR N6 qualitative software (QSR International Pty Ltd., 2002) designating each interview question and response or spontaneous remark as one or more text units. Porter had developed the descriptive phenomenological method (Porter, 1994a, 1998) chiefly from the philosophy of Husserl (1913/1962). Descriptive analysis involves “identifying similarities and differences in the factual details of experiences so that common patterns can be seen” (Porter, 2005, p. 298) through recursive cycling of deductive and inductive reasoning. Analysis involves repetitive engagement with textual data and dialogue with participants and colleagues (Porter, 1998). Porter and Matsuda initiated analysis during interviews, asking about reasons for intentions and exploring insights. During post-interview discussions, the research team compared data across each woman’s interviews and interviews of all women.

Some data pertained to intentions, or what women were trying to do (Porter, 1998), such as using the cane when I have to walk any distance. An intention is viewed as the basic level of the structure of an experience (Porter, 1998). Other data pertained to lifeworld elements that were forerunners of intentions; for instance, coming to terms with using a cane was basic to using the cane to walk any distance. Lifeworld elements and intentions were differentiated in this way, labeled in vernacular terms (Husserl, 1913/1962; Porter, 1998), and categorized separately in QSR N6, using systematic classification schemas (taxonomies) of three levels. The two taxonomies represent the structure of the experience and its personal-social context, lifeworld.

Data about the experience were analyzed by discerning and comparing similarities among intentions (level 1). Those similarities were labeled as broader categories or component phenomena (level 2), which were part of a broader previously identified phenomenon (level 3), negotiating reliance (Porter, 1994). With regard to lifeworld, basic elements were discerned (level 1); similarities among lifeworld elements were labeled as descriptors of lifeworld (level 2). Similarities among lifeworld descriptors were represented in the larger category, lifeworld feature (level 3). For example, the intention using a cane if I have to walk any distance was part of the component phenomenon relying on the cane for security in that situation in case I need it, which in turn was part of the larger phenomenon of negotiating reliance (Porter, 1994b) on a cane. Part of the context of that phenomenon is exemplified by a lifeworld element (knowing what the cane does for me even if I might prefer to do without it), which is part of a lifeworld descriptor (coming to terms with using a cane). In turn the lifeworld descriptors reported here are parts of the previously identified lifeworld feature, “facing vulnerability” (Porter, 1995a, p. 39).

Porter prepared a database for this article by extracting reports of relevant coded text units from QSR N6. Porter, Benson, and Matsuda developed the description reported here by reviewing text units, highlighting exemplars, and engaging in dialogue about data. We completed the activities of Porter’s (1998) phenomenological method by comparing findings to the bracketed literature and identifying scientific and practical uses for findings.

Findings

Before describing the phenomena of negotiating reliance on a cane and on a walker, we detail facets of lifeworld that we view as contextual to each phenomenon. Interviewer remarks are in brackets within data excerpts.

Negotiating Reliance on a Cane

For most of the women negotiating reliance on a cane was a common, longstanding intention. However, a few women were still in the early throes of that experience during the study; for them, especially, the facets of coming to terms with using a cane were in the foreground of lifeworld.

Coming to terms with using a cane—The lifeworld descriptor, coming to terms with using a cane, was understood as part of the previously identified feature of lifeworld, facing vulnerability (Porter, 1995). We discerned four lifeworld elements that reflected its complexity: (a) believing that they see the cane as a sign of my decline, (b) knowing what the cane does for me even if I might prefer to do without it, (c) finding that my cane can be a troublemaker, and (d) thinking of the cane as part of my body. The four lifeworld elements, singly and in combination, were emphasized in various ways by four women who were relying solely on a cane at the first interview. Ms. Ashe said, “A friend, one Valentine’s Day about 10 years ago, brought me a cane and a box of chocolates. So I just had it, and I just gradually used it more. I didn’t use it much at first. It definitely makes you look older. And who would want to look older?” For 2 years Ms. Behm had used a cane when she went out, because of back pain, fatigue, and balance problems. As to her thoughts about using it in public, she said, “It really didn’t bother me that much. A friend out at church said, ‘I see you’ve got a ‘friend’ there.’ I said, ‘Yup. I’d rather take the cane with me than fall flat on my face.’ If I had to use the cane, I had to use the cane.” Ms. Carzen simply said, “You just get used to it.” Some 10 years earlier, Ms. Doeher had experimented with holding the cane. The physician wanted her to hold it in her left hand; that was too painful. With the cane in her right hand, it “just became natural” to use it when she went out. Thus, each woman had a unique perspective about coming to terms with using the cane.

During the project Ms. Garst and Ms. Erlton reported ongoing efforts to come to terms with using a cane. After suffering a fall, Ms. Garst had given up driving and had stopped going to church. The family had offered to take her, but she had declined. “I don’t want people seeing me limping along with a cane.” Ms. Erlton, who had started to use a cane after a hip replacement surgery, had hoped to “get rid of it” and occasionally tried not to use it. “Both the doctor and the therapist told me I’d probably never even walk without a cane, because of my age. [How do you feel about being told that?] It makes you feel like you’re doomed, for that. So that makes me say, ‘Why should I try not to use it?’ See? It’s not encouraging. It’s not positive. It’s negative. They don’t tell me that (in so many words). They are trying to make me feel like it’s not abnormal.” When she got up to go to the kitchen, she said, “Maybe I should have my cane at this point.” Returning with it, she said, “I’ll bring my ‘buddy’.”

Like Ms. Erlton, other women attributed animate qualities to the cane, either when addressing problems associated with relying on it or characterizing their dependence on it. Ms. Steig fell twice while walking with her cane, explaining that “the cane tripped me” and that “the cane scooted when I walked through the door.” For Ms. Ashe the cane was a “nuisance” in part, because “Sometimes it’s not where you want it to be.” When Ms. Grune’s cane, which was propped against a table, fell and hit a wastebasket, her remark was inaudible. Then she said, “I don’t know if you heard, but I called it ‘my bastard’. It makes me mad when it does something like that, and I feel like throwing it away. But I know I’ve got to get around with something.”

Other women went beyond animating the cane to characterizing it as part of their bodies. At three interviews Ms. Palz referred to her cane as “a third leg.” She had come to rely on it in so many situations that it was “a necessity.” Ms. Steig, who also referred to her cane as “my third leg,” hinted at a friendly bond with the cane (the one that later “tripped” her and

“scooted” unexpectedly). “When I first get up in the day in the morning, me and my cane, to the bathroom, we go.” At Interview 1, Ms. Doeher had used the cane for 10 years. “It’s just part of me anymore.” A year later, her thoughts about the cane had not changed, although it had failed to prevent a fall (as we relate later). “My cane is just part of me anymore, because I have been using that cane for so many years.”

In contrast to the women who had come to terms with using a cane, Ms. Horak had become accustomed to taking a “lovely walking stick” whenever she left her apartment. She definitively stated, “It’s not a cane.” A gift from her husband, it was considerably taller than a cane; it had a knobby, straight top, rather than a curved handle.

I love that little stick. [What do you love about it?] I have a feeling that it’s sensible to have a stick at my age. A lot of people have canes. I don’t think I’d like a cane, but I do like this. It’s awful fancy. [What is it about a cane that you might not like?] I think they’re kind of awkward. I don’t like the idea. I would maybe not rule it out if I hadn’t had this, but this seemed to fit the bill, ‘cause I don’t have any disability as far as my body parts are concerned. I don’t have to wear special shoes. I can move perfectly without it, but I just feel like when you get my age, it’s a good idea to have a little something to steady you. [When you go out?] Yeah. I always have it if I’m in the car with the girls. I get in the car with my stick. It’s just part of me.

Although Ms. Horak had come to terms with using a walking stick, she revealed issues that one might face in coming to terms with using a cane, describing it as an awkward device and implying that it was really for persons with disabilities. Yet she had more in common with some women who had canes than she might have realized. Just as their canes had become part of them, her stick had become part of her.

Components of negotiating reliance on a cane—Against the backdrop of coming to terms with using a cane, women were negotiating reliance on canes. We discerned four component phenomena addressing various purposes for which women were relying on a cane. We present them in a sequence illustrating lesser to greater degrees of reliance on the cane, from affording security in case of need to engendering the perception of preventing a fall. The intentions basic to each component phenomenon are embedded in participants’ statements.

Relying on the cane for security in that situation in case I need it: Some women routinely walked with a cane for “security.” Ms. Erlton said, “I use my cane, which is for security as much as help, to walk.” Others considered their abilities relative to the uncertainty of walking unaided in a specific situation. Ms. Farris quoted her self-talk. “I’m a little hesitant. I mean, I don’t trust myself. You know, ‘Oh now, am I going to be able to do this?’ If I’d say, ‘I’m gonna walk over there without using my cane,’ (then she would ask herself), ‘Am I going to be able to do it?’ Rather than take the chance of falling, I’ll just go use the cane.” Ms. Trego implied that distance was a factor in the decision to use the cane. “I try to use the cane when I have to walk any distance.” Ms. Grune, who rarely walked without the cane, invoked the security afforded by taking the cane rather than “doing without it.” “I don’t take too big a chance that I can do something without anything. I decide if I can do it, and if I need to take it.” Ms. Hervey used a cane “more or less for protection” against a fall in the event her knee would “suddenly go out of place.” However, several women merely took the cane along “for security” in certain situations; they did not walk with it. Ms. Iltis took the cane when she went to the downstairs laundry or out on her balcony. “I keep it there until I do my little project. That’s security, just in case I need it.” Carrying the cane afforded security when Ms. Jofer walked outdoors to get her mail, “even though I’m not using it.”

Most women spoke of relying on the cane at home, but others reported relying on it in public situations. Ms. Iltis relied on it “to feel secure especially when I’m among people going to church and children moving, moving [who could] bump and knock me down.” Ms. Kacet mentioned a situation in which she sought more than physical security from the cane. “When I go out now to go to the doctor’s office, grocery store, I take my cane with me. You can tell if you’ve got to go down a step or something. (She held out her clenched fist and moved her wrist up and down, miming the maneuver of checking the location of a lower step.) It would be terrible if I had to fall up there (business district of her town). That’d be more embarrassing than it would hurt, I’m sure.” For Ms. Kacet, the cane afforded security in navigating unexpected physical demands and avoiding the spectacle of a public fall.

Relying on the cane to steady or stabilize myself: Some women (Ms. Behm, Ms. Lund, and Ms. Mezen) viewed the cane as an aid in balancing themselves. Other women described the cane as a counterfoil to “wobbling” (Ms. Erlton), “stuttering around” (Ms. Doebr), feeling “shaky and unstable” (Ms. Carzen), or feeling “dizzy” (Ms. Iltis and Ms. Nilte). Ms. Carzen explained why she walked with the cane. “Stability would be the main thing; it’s not speed, particularly.” Of the cane, Ms. Palz said, “It’s really a stabilizer, that’s all.” In a latter interview, she invoked the same idea. “I am relying on it to stabilize me more than anything else.”

Relying on the cane as a support or a brace: “At 95,” Ms. Querta said, “your legs began giving out on you. [So what does the cane do for you then?] It’s a support!” Ms. Palz explained, “I have learned that I need a support. I didn’t used to use a cane in the house, but I do now.” Women offered different reasons for viewing the cane as a brace. Ms. Orton said, “If you are kind of tottery and kind of falling to one side; you can brace yourself with it. If I get kind of overbalanced, the cane helps me to right myself.” Ms. Behm and Ms. Orton mentioned the need for a brace when out and about. Ms. Orton said, “When you’re in a crowd and when you have to stand wait for a period of time, it helps to kind of brace yourself.” With regard to bracing oneself, there were diverse views on the utility of the cane as an aide in getting up from a chair. At Interview 1, Ms. Ashe said, “It absolutely doesn’t help to get out of a chair at all.” She expressed a similar view at Interview 2. “It does not help you get up.” Ms. Mezen found the cane helpful to get out of her rocking chair but of no help with arising from other chairs. Ms. Palz was relying on the cane to push herself out of the chair and to get up when seated on her bed.

Relying on the cane to prevent a fall: Several women went beyond referring to the cane as a source of stability or support to asserting that they were relying on it to prevent a fall. “Sometimes I kind of stagger a little,” Ms. Royce noted, “and if I didn’t have my cane with me, I might fall.” In Interview 2, Ms. Erlton focused on the cane as security and denied that she had relied on it to prevent a fall. By Interview 3, about 6 months later, her experience had changed. “Once in a while, if I wouldn’t have the cane when I’m out in the yard, something would happen, and I would have gone down. But that ole cane, it’s really good.” Ms. Darva had fallen outdoors twice, so she no longer walked outside. At Interview 1 she was using the cane only when she walked “90 rounds” in her garage. “My cane is walking, too.” After a dizzy spell, her experience changed. In Interview 2, she said, “I’ve been hanging on to it more now. [For what reasons?] This feeling of weakness in my legs, and then, just for safety. I don’t want to fall again.” At Interview 2, Ms. Doebr said, “It has saved me from falling an awful lot of times.” At Interview 3, she reported a fall at home. “I had my cane in my hand when I fell, but it didn’t do me any good that day, that one time. I was just too much for it. I started to stumbling, and I couldn’t help myself at all.”

Negotiating Reliance on a Walker

Compared to negotiating reliance on a cane, negotiating reliance on a walker was a more recent phenomenon for most of the women. Whereas few women mentioned how long they had used a cane, most reported that they had used a walker since a specific occurrence (such as a hip fracture) or for a certain number of years. Ms. Hiltz remarked, “I got to the place, about three or four weeks ago when I had this bad spell, I’ve had to [use the walker] ever since then.” Ms. Unrue said, “I’ve been on a walker now for about 5 years.” A few women were in the throes of coming to terms with using a walker early in the project; over time, their data reflected the essence of negotiating reliance on it. At Interview 1, Ms. Torst said she sometimes used a walker when she went out with a helper. A few months later, she explained that after considerable consternation she had decided to “come to terms with that thing.” She continued: “So, I have! Until I came to that conclusion, it was a nuisance to me, and I didn’t want to have anything to do with it. I don’t feel that way now.” Indeed, in later interviews, she observed that she had come to rely on the walker when she needed to walk a certain distance, although a helper walked with her in those situations.

Before detailing the four components of negotiating reliance on a walker, we present the lifeworld descriptor, coming to terms with using a walker. Like coming to terms with using a cane, it was viewed as part of the previously discerned lifeworld feature, “facing vulnerability” (Porter, 1995a, p. 39).

Coming to terms with using a walker—We discerned seven elements of this lifeworld descriptor: (a) viewing the walker as a sign that I am crippled / handicapped, (b) hating the feeling that I am bound to the walker, (c) hoping to give up this walker, (d) realizing that I could benefit from using the walker, (e) resigning myself to using the walker all of the time, (f) convincing myself that it is alright to let the walker become part of me, and (g) making my peace with the walker. In a case study of Ms. Ashe’s experience, we present the first five elements in sequence as relevant data emerged over 18 months. Then we review data shared by other women.

Case study: Ms. Ashe was using a cane at Interview 1, but by Interview 2, she had started using a walker after a hospitalization because of weakness and a painful arthritic knee. At the start of Interview 2, she said, “I’m not doing as well as I was. I have to use this walker all the time now.” At Interview 3, she said, “I’m more bound to the walker, and I hate it. I just wish I could walk.” The walker was a “nuisance” and “the bane of my existence.” When we inquired, she said, “You don’t like to be so obvious that you’re handicapped. [This (walker) is a sign of that to you?] Right, definitely. Nobody likes to be crippled – nobody with my age and with my pride. Some day I’ll get rid of this (the walker), and I’ll feel better.” Hoping to get rid of the walker, Ms. Ashe asked her physician to order a physical therapy evaluation, which yielded “bad news. No amount of exercise would help. I could not walk with the cane safely. And that really bothered me. So I have to resign myself to use the walker.” During the next monthly follow-up call, she said, “I’m stuck with using a walker, and I’m not very happy about that, but it’s true.” At the last interview, Ms. Ashe greeted the interviewers by saying, “I have to use this walker all the time now.” When invited to say more, Ms. Ashe explained, “It just hurts. It’s so clumsy. And I feel like I’m a bother with this walker. It’s trouble.” We asked her to compare resigning myself to using the walker with making my peace with the walker, which we had recently explored with Ms. Torst. Ms. Ashe responded, “Well, I guess I should (make peace). I just fuss about it. [So, for you, making peace with the walker is not quite the same.] No. (She laughed.) I guess I should accept it. Of course, friends say, ‘Thank goodness you’re walking. You’re not in a wheelchair.’ But it’s awfully hard to even think about that. [So, would you say that making your peace with the walker is a step beyond resigning yourself to using it?] I guess.” Other

women shared data consistent with that of Ms. Ashe, but like Ms. Torst, they also provided evidence of two lifeworld elements (f and g) that Ms. Ashe did not report.

Other exemplars of coming to terms with using a walker: For Ms. Unrue, early experiences with taking the walker out were linked to distaste about being bound to it. “[It was] ... very obnoxious, just such a nuisance. It was in the way.” Ms. Vaxe was “on a walker” after a hospitalization and nursing home stay; it was “a real pain to take the walker out.” She said that the walker “causes you to be weaker. I’ve discovered that my own self.” Like Ms. Ashe, Ms. Vaxe was hoping to give it up and to go back to the cane.

At each of her interviews, Ms. Wald revealed conflicting perceptions about the walker as a problematic emblem in a social setting and as a potential benefit. “I have a walker. But I don’t use (it); it isn’t that I’m too proud to use (it). My friend says, ‘You’re just too proud. You’re just too proud,’ but I know sometime I will need it all the time. [Sometime, you will need it.] Sometime I think I will. [And at present?] Well, I could benefit from it if I would do it, if I would use it. I would probably make it fine (walking from a friend’s car to church), if I would use it.”

Ms. Xenia had used a walker after both of her hip fractures, but had returned to using a cane. “My knee got to bothering me, and my hip, so I thought maybe I better stay on the walker. I might fall and break another hip. I don’t have any more to break!” Her lifeworld was characterized by realizing that she could benefit from using the walker. Preventing a fall could be viewed as a potential benefit of walker use, but some situations were not that simple. Ms. Yost felt that her only fall had been a fluke and that she could prevent falls without using a walker, but her daughters worried that she would fall again. Ms. Yost “resented the walker a little bit,” but she was resigning herself to using it mainly to please her daughters. Ms. Zetco had walked without a mobility device, until she fell and broke a hip. For her, resigning herself to using a walker was linked to another major life-change. “I won’t be traveling, if I’m compelled to use a walker. I won’t get in my car and drive to (cities about 100 miles away) or (other states) as I used to.” For Ms. Unrue, resigning herself to using a walker was a matter of ongoing self-talk. “If I’m out in the yard, I’m awful tempted to let go of the walker, but I talk to myself. I say, ‘No, no, you can’t do that.’”

Before Ms. Torst spoke of making peace with the walker, her lifeworld was characterized by convincing herself that it was alright to let the walker become part of her. She explained the transition. “I use my walker more than I used to, and it’s because I made up my mind that it’s okay to use it, because until that time, I didn’t want to use it. I didn’t want it to become a part of me. But it’s alright with me now if it’s a part of me. If I have to take it where I’m going, it doesn’t bother me. So I think that’s good. You can’t use something and think that you don’t want to use it.” At the last interview, Ms. Torst, who was using her walker when she greeted the interviewers at the door, remarked, “I made my peace with this, so I use it all the time.” That statement is a fitting segue from coming to terms with using a walker to negotiating reliance on a walker for specific purposes.

Components of negotiating reliance on a walker—There were four component phenomena, and they appeared with about equal frequency in the dataset. We present them in an order depicting lesser to greater degrees of reliance, from relying on a walker to walk a long distance to relying on a walker to prevent a fall. The intentions basic to each component phenomenon are inherent within participants’ statements.

Relying on the walker when I have to walk that far: Several women referred to distance when explaining that they used the walker only on particular occasions. Ms. Torst noted, “If I go all the way across the patio outside, if I get close enough to the walls of the patio, I can

touch them, but it's a long ways out there sometimes, so I just take it." However, most of the other women who were negotiating reliance on a walker mentioned distances involved in locations away from home. Ms. Carver used the walker only when taking the OATS bus or walking several blocks to the bank. Ms. Grune relied on a cane to get around her small home and used a walker when she went to the physician's office. Her narrative, in which each phase of the journey is highlighted, clearly evokes the impact of distance and its impact on the phenomenon of negotiating reliance on a walker.

[When do you use the walker, then?] Getting out the door and getting in the car and to the doctor's office. I get out of the car in front of the doctor's office, and then I go in a hallway, and then I take the elevator, and I go upstairs, upstairs, to the doctor's office. And I do that with my walker. [That sounds like quite a walk.] Yeah, and I'm tired when I get there.

Distance played a role in decisions to use a walker when away from home. Ms. Nilte explained, "When I go as far as the church, I take my walker." After Ms. Ashe began using the walker at home, she took it with her when she left, relying on it to walk from the car to the beauty salon. "It's quite a little walk, and I thought it would be safer." Ms. Torst said, "When I know I'm going a long distance, and I'm not sure, that might be when I would use it."

Relying on the walker to get around on my own: When invited to explain why the walker was important to her, Ms. Ernst remarked, "So I can get around. I couldn't get around without it." Ms. Mezen characterized her reliance on the walker by pointing to it and saying, "I've got that. I get around with it." To affirm that "getting around" with the walker was an intention of women who relied solely on it rather than the cane, Porter asked Ms. Steig this question: "How are you getting around?" She pointed to her walker and said, "I'm using this here." Ms. Unrue shared an incident revealing her intention to rely on the walker to get around. "I sit and once in awhile I'll start up across the floor without my walker, and I'll back up and get it because I feel unsafe without having it." When we asked Ms. Rush her reasons for using the walker in the house, she said, "I just feel safer. I feel more secure if I use the walker. I'm not at all sure about walking without it. I don't know how it would feel." Some women were relying on the walker only in the morning, setting it aside as the day wore on. Ms. Kacet used the walker in her bedroom after she got up "and when I come out in here, but I don't have to use it for long."

Several women said that they could not have kept their social engagements unless they used a walker. Although they went out with a person, they relied on the walker to get around during the event. Ms. Ashe had gone out to dinner; she evoked the extent of her reliance on the walker when she said, "I could not have gone otherwise." Like Ms. Grune, Ms. Miller used her walker to get out for appointments, but unlike Ms. Grune, she was relying on the walker to get around on her own rather than to traverse a distance. "I take it when I go to the doctor, and I walk in with that pretty well." When we asked why she needed the help of the walker to leave her home, Ms. Couzi said:

To be able to walk and to go, actually. I couldn't get out that front door if I didn't have this walker. I couldn't walk into the mall or into the grocery store, because I can't walk without it. And at night when I get up to go to the bathroom, no way I could get there if I didn't have the walker, because getting out of bed that fast and getting to the bathroom, it's impossible to really get out and do it and walk. I've got to have that walker, so I'm dependent on it a great deal.

While relying on the walker to get around, women dealt in various ways with the challenge of manipulating it. Ms. Yost said, "You have to get the wheels [of the walker] going through right or they" As she trailed off, she flailed her arms to illustrate confusion of movement.

A few women described lessons learned by trial and error. Ms. Vander could not enter her utility room with her walker, so she asked her children to get anything she needed from that room when they stopped by. Ms. Yost, who was concerned that she might not “make it to the bathroom in time,” left the walker outside the bathroom door. Getting it into the bathroom required “juggling [that] takes time I haven’t got.” Some women transitioned between pulling and pushing walkers into position so they would be useful in getting around. Ms. Unrue was manipulating the walker in and out of her bathroom. “It’s close quarters to turn it and use the stool. I can do it, and I can turn it and come back out of there, at times when my balance seems worse.”

In addition to manipulating the walker, women often had to move or manipulate other objects while using a walker in the home. Of her walker, Ms. Ashe said, “It’s clumsy, and it’s heavy. And I had to move my chair this morning to have room to get through.” Ms. Steig had to have her kitchen table moved closer to the wall so she could get around with her walker. Ms. Nunn and Ms. Couzi struggled with their walkers while moving through a door. Ms. Nunn fell when she tried to hold her storm door open while moving her walker across the threshold. Ms. Couzi said: That’s where it’s hard, is getting in and out of the house with the walker.

That’s why I use a cane so much when I go outside on the porch. You can open the door, but when you go to open it, ... that door bangs shut before you can get down it [threshold] with the walker, so I got to ... Wham! ... that door out as fast and as hard as I can, put the walker down, and it hits every time.

Because of the awkwardness involved in handling the walker, some women expressed frustration or embarrassment about using it in public. Ms. Unrue described her discomfort with asking people at a restaurant to move chairs to make room for the walker so she could walk to the bathroom. Ms. Ashe shared, “When I go places, we immediately fold it up and hide it.” She wanted her walker out of sight so it would be out-of-mind to others.

Relying on the walker to steady / brace myself as I move into that position: Women who voiced this intention also emphasized that they were hanging on or holding on to the walker when changing positions. Each woman had fallen at least once, and there was a poignant intensity in their remarks. Ms. Ferker emphasized, “I hang on to my walker. I always have it in hand, and I always reach for it. I’ve always been able to depend on it.” She said, “It helps a little bit when I stand up. I lean forward into it if I feel a little unsteady.” Later, she reiterated, “I just always hang on to my walker. I don’t move, unless I can move with that.” When we asked what the walker did for her, Ms. Bosker said, “It steadies me, because I notice if I’m without the walker, I’m not steady, and I can’t keep my balance as well.” Ms. Unrue could put one hand on the counter when getting food out of the refrigerator, “but I don’t feel as secure as I do with one hand on the walker.” Ms. Sovon sought to steady herself with the walker. “I’m not dizzy, but I’ve got to hold. If my hand is on that, I’m alright.” Later, she elaborated. “I hold one of my walkers at all times. I know I can’t stand without holding my walker.” Then, as though she was speaking to herself, she emphasized her intention, “So, you’d better hold your walker.”

Relying on the walker to prevent a fall: Several women referred concurrently to relying on the walker to get around and to prevent a fall. Ms. Vaxe used it “mostly all the time so I don’t fall. If I’m out someplace and fall, somebody will know it, but nobody would know it here. So I use the walker around the house more than any other time.” Ms. Mezen used the walker when she got up “because I’m stiff and sore, and I can’t hardly walk. It gives me stability that I don’t fall.” Ms. Kacet explained her reliance on the walker.

Of a morning, when you first get up, you don't feel just right, and you use it so you don't fall or anything like that. Of course, whenever I go out, I take it, and for insurance that it's there. [You're trying to prevent falling outdoors?] Well, I could, yeah, but I don't, because I use that. I mean, I have it with me. I don't really roll it, but I can pick it up and put it down.

Other women spoke about using the walker to prevent a fall when we asked about precautions taken to prevent the need to reach help quickly. These women had fallen at least once at home. Ms. Xenia explained why she was using the walker when met the interviewer at the door of her apartment. "I don't take chances ... on falling, 'cause I did fall a couple of times." Ms. Vander said, "I don't go anyplace without it (the walker), around the house even. I use it all the time, so I won't fall." Similarly, Ms. Nunn said, "I don't feel safe without it." These women viewed the walker as affording considerable protection. As Ms. Torst remarked, "I've got a walker. I can't fall anymore."

Most women who were negotiating reliance on a walker revealed instances of multiple intentions, either during an interview or over the course of the project. For instance, at Interview #2, Ms. Bosker was using the walker when she greeted us at the door for Interview #2; this was unusual. When we asked if she was using it routinely in the house, she said, "I have to, because I'm unsteady on my feet. I'm afraid of falling." Later we explored this more.

I noticed the last year or two, mostly the last year, I am very unsteady on my feet. That is one reason why I cling to my walker {relying on walker to steady me}. Sometimes I feel like I might tip over or something {relying on walker to prevent a fall}, so I like to have my walker right there by me so it helps steady me {relying on walker to steady me}. [Is that the main thing it does for you, is to steady you?] Oh no, it helps me with my walking, too {relying on walker to get around}, because my knees can't bear weight.

In summary, these 40 older women shared an array of experiences with using canes and walkers, unique experiences with some key commonalities. Lifeworld was characterized by coming to terms with using a cane or walker, whereas the essence of the experience was that of negotiating reliance on a cane or a walker. Negotiating reliance presented particular challenges. Data revealed complex, dialectical facets characteristic of health-related experiences (Porter, 1998). Neither device was viewed as consistently assistive. Although the two devices had some common purposes, most women were relying on each device for different reasons and for a variety of reasons.

Discussion

Our findings present challenges to two key theses of the extant literature and pose companion suggestions for interventions. First, the tendency to refer to canes and walker as assistive devices (Bynum & Rogers, 1987; Porter, 1994b) or assistive technologies (Freedman et al., 2006) is asynchronous with lifeworld as described here. As the women came to terms with using canes or walkers, neither device was consistently perceived as assistive. Prior to or concurrent with recommending use of a walking device, practitioners might inform older persons that a device can be "a nuisance" on occasion; practitioners could also offer opportunities to clients to vent about such experiences over time. Second, our findings are in contrast to the tendency to refer to canes and walkers concurrently (Mann et al., 2004), as though they have the same purpose. Findings consisted of intentions associated with distinct purposes for relying on each walking device. Practitioners could use each set of intentions as a general assessment to ascertain the purpose or purposes for which an older person is using a specific device and to draw conclusions about safety implications

for relying on a given device for that purpose. That is, some persons who begin to use a cane for stability but eventually rely on it to prevent a fall might need to be counseled to transition to a walker. Furthermore, walker-users who have fallen but continue to use a walker to prevent a fall might need an assessment of fall risk and walker use in the home instead of at the clinic.

In addition to general implications for practice, this article extends prior phenomenological work (Porter, 1995a) by offering an expanded understanding of lifeworld as the “reference schema” (Schutz & Luckmann, 1973, p.7) basic to a negotiating reliance on a cane or a walker. That is, the women had received “notice” that they could no longer take a particular thing for granted – the “given” skill of walking. They realized that the formerly “definitive” solution to the problem of how to walk had been definitive only in relative terms (Schutz & Luckmann, 1973). Lifeworld was characterized by a modified stock of knowledge incorporating strategies to walk successfully with a device, driven by the goal to “repeat past successful acts” (Schutz & Luckmann, 1973, p. 7), again, until further notice.

Finally, this article contributes to the literature by offering a new phenomenological framework as an alternative to the theory that there are “dual outcomes” of using a walking device: “independence” and a collective of “social stigma, feelings of embarrassment, and issues of personal identity and self-definition” (Gitlin, 1998, p. 154). Rather than describing specific perceptions, feelings, and issues, we drew on data about those matters to discern elements of lifeworld, revealing a complex, multi-layered situation epitomized by descriptors such as knowing what the cane does for me even if I might prefer to do without it. Rather than highlighting “independence” (Gitlin et al., 1998, p. 154), a term that is seldom defined but has multiple connotations (Porter, 1995b), we elaborated the essence of negotiating reliance on a cane or walker, detailing intentions for relying on each walking device. Whereas the concept of independence is context-free, each intention refers to what a woman was trying to do in a situation, such as relying on the walker to move into a certain position. The lifeworld of negotiating reliance on a cane or walker is a world of time, space, and place. There was evidence of person-environment-device fit in reports about particular rooms, occasions, and times of day in which canes and walkers were viewed as more useful, such as getting to the bathroom at night. Practitioners should elicit such information from clients, and scholars should seek to reveal and compare situations in which older persons view canes and walkers as useful or not useful.

LifeWorld Basic to Negotiating Reliance on a Cane or a Walker

In the literature on use of walking devices, this article is unique in its emphasis on lifeworld as the inherent, shared knowledge underlying experience (Schutz & Luckmann, 1973). Although data came from individual interviews, the 40 women revealed a shared knowledge about coming to terms with using a walker or cane. Individuals raised similar issues, with uniquely personal twists. However, we did not explore several facets of lifeworld that could have influenced each woman. First, some women volunteered information about how they had obtained the cane or walker, we did not ask if they had purchased the device or inquire about the cost, although such factors can influence adoption of walking devices (Resnik, Allen, Isenstadt, Wasserman, & Iezzoni, 2009). Also, several women said they had talked with friends and family about using a walking device, implying that those conversations were factors in coming to terms, but we had no direct access to those data. Finally, some women spontaneously raised concerns about walking devices during interviews. Those conversations might have served a therapeutic purpose, but we did not inquire about that. Researchers should study how conversations with others influence the experiences of older persons who are coming to terms with using a cane or walker.

The two lifeworld elements, believing that they see the cane as a sign of my decline and viewing the walker as a sign that I am crippled / handicapped, are relevant to stigma (Rush & Ouellet, 1997), the concept typically used to explain a decision to hold off on using a walking device (Allen et al., 2001). However, these lifeworld elements evoke the personal nature of one's own perceived decline as well as the socio-cultural observations others might make about it. Accordingly, they are associated with two previously discerned, broader descriptors of the lifeworld of older women: "detecting my deterioration" and "watching others watch me grow older" (Porter, 1995a, p. 37). Those descriptors and another previously discerned lifeworld feature, "knowing what living is all about" (Porter, 1995a, p. 37), are also evidenced in the two lifeworld elements: knowing what the cane does for me even if I might prefer to do without it and realizing that I could benefit from using the walker. Such findings illuminate the intricacies of the lifeworld of older women, while extending knowledge about use of walking devices beyond the basic notions of accepting use and integrating use into one's life (Copolillo, 2001). However, the language of the women, captured in these lifeworld elements, evokes a self-adoption of negative stereotypes of aging (Levy, 2001), ranging from the explicit (the overt "sign of decline") to the implicit (a preference to do without a cane). These findings also have practical connotations; participants who were concerned about their personal appearance in public were quite concerned about facets of the device that they viewed as unattractive. Although we did not ask participants their views about improvements in device design, researchers have observed that "visually appealing devices would promote greater acceptance of mobility aids" (Resnik et al., 2009, p. 77).

For this sample, data about coming to terms with using a cane were more historical and more general than data relevant to coming to terms with using a walker. Just one woman shared current data about coming to terms with a cane, whereas several women were in the throes of coming to terms with walker use. These trends could reflect a cohort effect. All 40 women were at least 85 years of age, well within "the fourth age" (Baltes, 1997, p. 375) – that period after age 80 when physical decrements gradually become more apparent than in younger old age. In most cases, coming to terms with using a walker is likely to come on the heels of coming to terms with using a cane. We did not explore how coming to terms with using a cane influenced women who later had to use a walker. Researchers should explore similarities and differences between coming to terms with canes and walkers with other samples of older persons and investigate the experience of cane-to-walker transition prospectively over time.

Beyond emphasizing the "importance of the subjective fit between an older person's changing capabilities, environmental demands and technology use" (Gitlin, 1998, p. 155), this work exemplifies just how subjective that fit can be and how that subjectivity can vary with the person and the device. The women who relied on canes typically referred to "my" cane, unlike women who relied on walkers. It was women with canes, not women with walkers, who invoked language of embodiment, referring to body parts ("third leg") or invoking interpersonal terminology [friend ("buddy") / foe ("bastard")] to characterize the device. Canes, then, were typically assigned animate qualities that were not bestowed on walkers. Women did not report hating the cane, resigning themselves to using it, or making peace with it, as some did relative to the walker. This observation has clinical implications; women who rely on a walker might need more opportunities to vent concerns about perceived distinctions between their bodies and the device. Furthermore, if a cane is seen as "more like me" than a walker, this could be a consideration in walker design and marketing. This article extends knowledge about embodiment of a cane versus a walker for older homebound women. We recognized the dialectic spanning the observable "object body" (Sakalys, 2006, p. 17) of each woman who carried a cane and the "subject body ..., the phenomenological body, the lived body" (Sakalys, 2006, p. 17) of each woman for whom

the cane was a “third leg” or “part of me.” However, we did not consider potential influences of researcher embodiment on findings, such as the non-verbal communication of interviewers (Sharma, Reimer-Kirkham, & Cochrane, 2009) during dialogue with participants about “my cane” and “the walker.”

Insights and Implications

This study also yielded new ideas about what it is like to negotiate reliance on a cane as well as a walker and the reasons persons find it necessary to do so. Our approach differed from typical methods, such as that of Mann et al. (2004), who surveyed 1,016 older persons (aged 60-106, $M = 75$) about use of walking devices. After grouping four devices (cane, wheelchair, walker, and crutches) into a set, they consolidated participants' reasons for viewing any of those devices as important. They concluded that “cane, wheelchair, walker, and crutches ... [were important for] safety, balance, mobility (ambulation), stability, [and] fall prevention” (Mann et al., 2004, p. 8). Rather than merging findings about four devices, we elicited unique perspectives about two devices. Accordingly, components of the phenomena of negotiating reliance on a cane and on a walker extend knowledge beyond the work of Mann et al.

First, compared to cane-users, walker-users emphasized reliance on a device for walking any distance. Some women carried a cane “in case” they might need it while walking on a rough surface or traversing a distance; it offered insurance against a potential risk. In contrast, some women needed the assurance afforded by using a walker to “walk that far.” They did not take the walker along in case; they used it because they knew they could not walk that distance without it. Both cane-takers and walker-users recognized certain situations as potentially problematic, but for different reasons. Also, cane-users did not emphasize that they needed the cane to ambulate, whereas women who were relying on the walker to get around on their own were quite straightforward about their need for that kind of help.

In contrast to the basic notion that canes and walkers afford stability and balance (Mann et al., 2004), cane-users and walker-users in this sample afforded different degrees of importance to stability and balance. Cane-users spoke of a need for help with maintaining an upright position that walker-users did not mention, perhaps because to hold onto a walker is to have help keeping upright. We could group relevant data about walkers under the intention of steadying/bracing oneself, because those women were relying on the walker to carry out movements involving change of position. However, relying on the cane as a support or brace (because of fatigue or the possibility that a leg would “give out”) was different from relying on it to steady, balance, or stabilize oneself (because of dizziness). Both cane-users and walker-users referred to bracing themselves with the device while getting into a standing position, but in other situations women viewed the steadiness afforded by the walker as very important.

Just as Mann et al. (2004) reported, some women in this study were relying on a cane or a walker to prevent a fall. However, cane-users emphasized the utility of the cane as a fall-prevention device; either it had worked in a particular case, or it had been ineffective. In contrast, women who were relying on walkers as fall-prevention devices reported a great faith in the walker for that purpose. Perhaps those women, all of whom had fallen while not using a walker, were negotiating reliance on their last best hope to prevent additional falls of their own accord. Finally, although Mann et al. pointed to safety as the first of the important reasons why older persons use assistive devices for walking, our data did not yield a comparable pattern. Instead, five women briefly mentioned feeling safer or not feeling safe as a basic rationale for negotiating reliance on a cane to prevent a fall or on a walker (a) to walk that far, (b) to get around on my own, and (c) to prevent a fall. These very general

remarks were not helpful in understanding the experience, perhaps because we did not explore them in much detail during interviews.

Conclusions

As the capacity of technology to enhance independence in aging continues to increase (Czaja et al., 2006), findings evoke key planks for health-care providers to consider in dialogue with older persons. First, the wide variation in the degree of disability within the older population (Scialfa & Fernie, 2006) is an implication that no two older persons will rely on the same assistive device in the same way. Whereas low-tech devices have standard, simple designs (Wolff et al., 2005), the experiences of persons who use such devices should not be standardized and cannot be simplified. Each older homebound woman who uses a walking device is living a unique experience; practitioners must attend to that uniqueness to improve quality of life for that person. Second, despite widespread familiarity with canes and walkers, each person who starts to use such a device is likely to need individualized help to use it at home.

In contrast to Copolillo (2001), who identified discontinuation of use as the ultimate goal of persons who were using a cane, we found that the experience of women who had once hoped to get rid of a cane or a walker gradually changed over time. As part of coming to terms, they were thinking of the cane as a part of their bodies, deciding it was alright to let the walker become part of them, or making their peace with a walker. Nevertheless, the women were finding that a device that had become part of their bodies could be a nuisance or a trouble-maker, a difficult or impossible object to manipulate in the home, or an outright failure in achieving an intended purpose. Because of their implications for intervention, these paradoxical facets of coming to terms and negotiating reliance warrant continued elaboration in other qualitative studies with older persons.

Our findings illuminate the dialectical struggle older women can experience in their perceptions about mobility devices. Yet the impact of this work must be considered alongside limitations stemming from methodological decisions. We chose to present separate descriptions of lifeworld for canes and walkers. This decision enabled us to reveal new insights, but it belies the reality that some women were relying on both canes and walkers. To do justice to those data we will report them elsewhere, along with reasons the women gave for changing patterns of reliance on walking devices over time. Similarly, data about relying on canes and walkers as aides for tasks other than walking will appear elsewhere. Although this is not a limitation of the method, it is important to mention that the component phenomena are structures of experience discerned from data; they are not factual things. Furthermore, components are not necessarily discrete; although we perceived distinctions in this dataset between negotiating reliance on a cane for balance and for support, data reported by other women could yield other findings. Finally, although we present conclusions, the work itself is not conclusive; because an experience can never be fully understood (Husserl, 1913/1962), further descriptive exploration with other persons is always indicated.

Although health care providers and researchers tend to refer to canes and walkers as assistive devices, older homebound women do not necessarily view canes and walkers as assistive. These devices can prove inconsistent in achieving an individual's purpose or purposes for its use. In such situations, negotiating reliance on a walker or a cane can involve unexpected physical challenges that health-care providers need to consider in contemplating the decision to recommend such a device to an older person. Concurrently, additional qualitative studies are needed to challenge the research tradition in which canes and walkers are viewed as assistive devices. Such work could enrich knowledge of

experiences of older persons with more common technologies, while forging paths to explore experiences with new, more complex devices.

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