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Older Homebound Women: Sharing the Risk with Age-Peers of Being Unable to Reach Help Quickly

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Abstract

The purpose of this facet of a longitudinal descriptive phenomenological study of the experience of reaching help quickly for older homebound women was to explore the personal-social context (*life-world*) of situations when age-peers had needed to reach help quickly (RHQ). Twenty-five women aged 85–95 (13 subscribers to a personal emergency response system and 12 non-subscribers) reported 80 peer situations. Life-world was characterized by *sharing with peers the risk of being unable to RHQ*. Knowledge of peer situations had varying degrees of influence on participants' decisions to adopt and use RHQ devices. Findings support the need for healthcare professionals to explore the influences of age-peer RHQ situations upon adoption and use of devices to RHQ by older homebound women.

Keywords

Older persons; personal emergency response systems; peer influence

Influence of Situations Involving Age-Peers

Women aged 85 and older constitute the most rapidly growing sector of the U.S. population (U.S. Census Bureau, 2008a), and 60% of such women who live in the community live alone (U.S. Census Bureau, 2008b). Older women are at greater risk than older men for complications of chronic health problems (Wolff, Starfield, & Anderson, 2002) and falls (Mack, 2004). In a prospective study of situations in which 381 older persons were found down on the floor unable to get up, 72% survived, but only 38% of survivors were able to return home (Gurley, Lum, Sande, Lo, & Katz, 1996). Even for survivors, marked complications can ensue from being down for an extended time, including pressure sores, dehydration, hypothermia, and pneumonia (Tinetti, Liu, & Claus, 1993). On average, the older persons in the study by Gurley et al. (1996) had been down 4.5 hours before they were found. Because those who had prompt help were more likely to survive, Gurley et al. recommended “earlier intervention ... [including] the use of devices to summon help” (p. 1716).

Various devices are available to enable persons to reach help quickly (RHQ). One critical facet of any signaling or messaging device is ready access to it. Some persons carry a telephone or pager; others subscribe to a personal emergency response system (PERS; Dibner, 1982). The PERS subscriber wears a help-button equipped with a radio transmitter.

When the subscriber presses the button, a signal is sent to a control box in the home (Baldwin, Syverud, & Edlich, 1993) and on to a dispatcher at an emergency response center, who can contact emergency personnel or a first responder pre-specified by the subscriber (Dibner, 1992). Being a subscriber has been linked with hassles such as the unexpected arrival of first-responders when the help-button was pressed accidentally (Melander-Wikman, Fältholm, & Gard, 2008; Porter, 2003, 2005b). Although most subscribers have been satisfied with the PERS in emergencies (Fallis, Silverthorne, Franklin, & McClement, 2007), subscribing to a PERS does not guarantee that it will be used in an emergency. During a 1-year study of 110 persons aged 90 and older, participants with call-alarm devices reported 38 situations when they fell while alone and were down for at least an hour. In 37 of the 38 situations, they did not activate their alarms to seek help (Fleming, Brayne, & CC75C, 2008).

Before older persons can decide to use a PERS in a certain situation, they must subscribe to a PERS. Older people have reported reasons for electing not to adopt a PERS, such as being unaware of it, deciding that it was not necessary, viewing the cost as excessive, and seeing drawbacks to using it (Barrett, 2011; Johnston, Grimmer-Somers, & Sutherland, 2010; Mann, Belchior, Tomita, & Kemp, 2005; Porter, 1999; Porter & Ganong, 2002).

Although decisions to adopt a PERS and to activate it in an emergency are personal in nature, there are few data about personal and social influences on those decisions. In particular, few scholars have explored whether older persons are aware of emergencies faced by age-peers and if so, how that knowledge has influenced their intentions about adopting or using a device to RHQ.

Our interest in the potential relevance of peer influence upon a person's intentions is consistent with descriptive phenomenology, the philosophy underpinning Porter's (1995,1998) method, which was used in this study. According to Husserl (1962), "Only through the relation of a possible reciprocity of understanding can I identify the world of my experience with that of others, and at the same time enrich it through the overflows of their experience" (p.129). Indeed, Husserl's perspective was grounded in an interest in *life-world*, the "encompassing world of our immediate experience" (Spiegelberg, 1994, p. 747). The "everyday reality of the life-world includes not only the 'nature' experienced by me but also the social world in which I find myself" (Schutz & Luckmann, 1973, p. 5). In a series of phenomenological studies with older women living alone, Porter (1995, 2005a) has described the personal-social context of experience as life-world.

The purpose of this facet of the RHQ project, longitudinal descriptive phenomenological study of the experience of reaching help quickly for older homebound women (Porter, Ganong, & Matsuda, in press; Porter & Lasiter, 2008; Porter, Markham & Ganong, in press), was to explore *life-world* of situations when age-peers had needed to RHQ. We sought to explore (a) knowledge of situations when age-peers had needed to RHQ and (b) influences of this knowledge on participants' decisions to adopt and use devices to RHQ. We compared those facets of life-world for PERS subscribers and non-subscribers because we viewed being a PERS subscriber / non-subscriber as one of many "pragmatic ... stratifications" (Schutz & Luckmann, 1973, p. 35) of life-world shared by older homebound women. One of Husserl's (1962) key methodological maxims was that "All inquiries must be conducted with the completeness and comprehensiveness demanded by the nature of the case" (pp. 387–388). Thus, we discerned and categorized facets of life-world pertaining to situations when age-peers had needed to RHQ, comparing data from PERS subscribers and non-subscribers.

Method

Design and Sampling

We report data from the RHQ project, which was approved by the Health Sciences Institutional Review Board at the University of Missouri as involving minimal risk and requiring informed written consent. We planned a data-collection period of 18 months per participant, in part because 18 months was the average duration of a PERS subscription in the only available study reporting such data (Watzke & Kemp, 1992). We recruited volunteers by convenience from a five-county area of a Midwestern state, directly through newspaper advertisements and mailings to university retirees and indirectly through social service and health-related agencies. Women who were interested in participating telephoned us or returned self-addressed post-cards they obtained from cooperating agencies.

We screened volunteers for eligibility during a telephone call based on (a) being 85 years of age or older, (b) residing alone in a setting without services, and (c) being homebound or unable to leave home without assistance of a person, a walking device, or both (Smith & Longino, 1995). Decisions about sample size were influenced by three key factors. First, because there are fewer PERS subscribers than non-subscribers, we used quota sampling (Luborsky & Rubinstein, 1995) and planned to recruit 2 subscribers for every 3 non-subscribers. Second, we expected attrition due to changes in health status and living arrangements. Finally, recognizing that a sample of 6 to 10 persons is sufficient in phenomenological studies if each person has multiple interviews (Morse, 2000), we sought to retain at least 10 subscribers and 10 non-subscribers for 18 months. Accordingly, we planned to recruit a sample of 40 women (16 subscribers and 24 non-subscribers) for the RHQ project.

Sample

Of 73 women who volunteered for the RHQ project, 49 of the 57 eligible women were willing to be visited at their homes to discuss the study. Forty women, ranging from 85 to 98 years of age ($M=89.6$), gave informed written consent Rights to confidentiality, privacy, and withdrawal from the study without penalty were guaranteed. Of the 40 women, 25 women (aged 85 – 95 years, $M=89.1$) reported a situation when an age-peer had needed to RHQ. These 25 women (1 Black woman and 24 White women) constitute the sub-sample for this report. On enrollment, there were 13 PERS subscribers and 12 non-subscribers (including 2 ex-subscribers); during the project 1 non-subscriber and 1 ex-subscriber subscribed to a PERS. Of the 25 women, 17 (68.0%) were retained for the entire 18-month study. The others relocated ($n=5$); chose to stop participating ($n=1$); had new, grave health problems ($n=1$); or died ($n=1$).

Data Collection and Data Management

The research team developed an interview guide for each of four interviews. Per Porter's descriptive phenomenological method (1995, 1998), questions were designed to elicit perceptions, actions, and intentions potentially associated with the experience of interest (reaching help quickly) and its personal-social context. Of the various questions planned for each interview, certain questions yielded data relevant to this report. At Interview 1 we asked each woman if she carried a telephone in the house and if she had subscribed to a PERS; we asked non-subscribers if they had heard of a PERS. A month later, during Interview 2, we asked subscribers how it came about that they had a PERS and how they first heard about it. Six months later we did Interview 3, when (among other questions) we asked all women this direct question to elicit reports of age-peer RHQ situations (*peer situations*): "Are you aware of situations when a friend, relative, or neighbor had to get help quickly? Please don't mention names, but tell us what happened and your thoughts about the

situation.” We also asked all women if they had talked with other older women about ways to RHQ and what they had discussed. Eight months after Interview 3, we did Interview 4. At Interviews 2 – 4, we asked each woman if she thought of herself as a person who might need to RHQ, and if so, how she would do that. In Interview 4, we raised this issue with non-subscribers: “I am not suggesting that you need [a PERS], but I wonder if you have thought about getting one.” Most women responded to questions in detail; we used probes as needed to explore responses.

Although we solicited peer situations through a direct question in Interview 3, that question was not the sole stimulus of such reports. We noted with interest that participants spontaneously shared some peer situations, while reflecting on their interest in the RHQ project or its relevance to their lives. Accordingly, we identified three distinct patterns in which participants reported peer situations. First, all 15 women (9 PERS subscribers, 6 non-subscribers) who answered “yes” to the Interview 3 question had already spontaneously related at least one such situation in Interview 1 or 2. Some of those women mentioned new incidents in Interview 3; others repeated prior narratives. Second, 7 women (2 PERS subscribers, 5 non-subscribers) responded “no” to the Interview 3 question but spontaneously mentioned a peer situation in Interview 1 or 2, later in Interview 3, or in Interview 4. Finally, 3 women (2 PERS subscribers, 1 non-subscriber) did not have Interview 3 (due to non-retention as explained earlier), but they had already reported peer situations in a prior interview.

We did 94 tape-recorded in-home interviews with the 25 women. Most women had 4 interviews about 70 minutes in length; the sample range was 1 to 5 interviews. Project staff telephoned each woman every month when an interview was not scheduled, following a protocol to explore changes in life circumstances and health status. Porter facilitated or co-facilitated all interviews but one; Lasiter co-facilitated multiple interviews and many telephone calls. Transcribed interviews were checked for accuracy and uploaded into *QSR N6* software (QSR International, 2002) for data management.

Data Analysis

Descriptive phenomenology is the method of choice to describe an experience and its personal-social context (Spiegelberg, 1994). We used Porter’s method (1995, 1998) to describe context in terms of “life-world, [that] “taken-for-granted frame in which all the problems I must overcome are placed” (Schutz & Luckmann, 1973, p. 4). From the perspective of phenomenological sociology, everyday life is lived “within a reality that is fundamentally and typically familiar” (Schutz & Luckmann, 1973, p. 7). That is, one can assume that prior solutions to typical problems will work in the future. However, when atypical situations arise, one can no longer take matters for granted (Schutz & Luckmann, 1973).

In keeping with the life-world perspective, data of interest were these atypical situations: (a) participants’ awareness of situations when age-peers had sought to RHQ and (b) conversations with peers about reaching help quickly and devices to RHQ. Analysis begins as the researcher spends time with participants where they are living the experience of interest (Porter, 1995). During data-gathering, the researcher sets aside or brackets usual scientific and professional perspectives about the experience of interest. In this case, we set aside the research reviewed earlier about health-related outcomes of PERS use, so that we might better grasp participants’ perspectives about events associated with peers’ attempts to RHQ.

Because life-world is to be delineated in “objectivated categories” (Schutz & Luckmann, 1973, p. 180), the method is designed to yield a three-level taxonomy: “element, descriptor,

and feature” (Porter, 1995, p. 35). An element is unique to each person; that is, its “nuances [are] defined by the uniqueness of each life history” (Porter, 1995, p. 35). Each life-world element is discerned and labeled in common language arising directly from data. We compared those data, first within each interview, then for interviews of each woman, and finally, for interviews of all participants.. Similar elements are grouped into a larger category, a “life-world descriptor” (Porter, 1995, p. 35). Similar descriptors are grouped into a general category, the “life-world feature” (Porter, 1995, p. 35). Analysis proceeded primarily by inductive reasoning (Porter, 1995, 1998).

In life-world data analyzed for this project, some of the storied peers had been able to RHQ, while others had not. Within each of those groups, some peers had been PERS subscribers, and others had not. We devised labels to capture that cross-classification, such as *knowing of situations when peers needed quick help and could not get it* and one of its subsidiaries, *knowing of a peer who had a PERS but failed to RHQ*. Each unique peer story was listed under the relevant life-world element. The iterative analysis yielded serial versions of elements, but we concluded that all were similar enough to be grouped under one life-world descriptor. We viewed that descriptor as part of one life-world feature of the experience of reaching help quickly. By devising that three-level taxonomy to reveal peer influences about devices to RHQ, we completed the activity of “filling out the life-world features” (Porter, 1998, p. 21),

We compared frequencies of certain types of peer situations reported by participants who were PERS subscribers and non-subscribers. Descriptive analysis of pertinent numerical data is consistent with the view of Husserl (1913/1962) that “numbers themselves are essences ... from which “number-presentations [can be] constructed” (p. 81) during phenomenological analyses.

To enhance rigor of analysis through recursive dialogue (Porter, 1998), we solicited each woman’s views about certain findings.. Emergent findings were discussed with two groups of co-investigators at two intervals during data collection with each woman. Finally, we related the emergent taxonomy to a previously discerned life-world feature (Porter, 1995) and compared findings to the bracketed literature.

Findings

Referring to each participant by an initial not associated with her surname, we report findings that are subsidiary parts of a life-world feature of the experience of reaching help quickly: *recognizing my risk of being unable to RHQ*. One of its parts, a life-world descriptor, was *sharing with peers the risk of being unable to RHQ*. An exemplar was shared by Ms. A, who subscribed to a PERS during the project and believed she had done so at the right time. “I know that anything can happen to anybody that is my age. That’s the reason I thought I would need it.” We discerned three facets of sharing with peers the risk of being unable to RHQ, these life-world elements: (a) *knowing of a situation when a peer needed quick help and could / could not get it*, (b) *holding beliefs about whether certain peers need a certain device for reaching help quickly*, and (c) *being influenced by a peer / peer’s situation about adopting or using a device for reaching help quickly*. Life world-element (a) was an influence upon life-world elements (b) and (c). That is, after relating reports about peers’ situations of needing quick help, women typically took the conversation in one of two directions. They expressed opinions about whether persons with certain characteristics should have certain devices for reaching help quickly or linked their personal interest in adopting a device to situations akin to those the peer had faced.

Before reporting details about each of the three life-world elements, we illustrate the links among them in this exemplar from Ms. B, a PERS subscriber, who was in the position of

being even more convinced by her situation that everyone like us could end up in her situation.

When I had back surgery and had to recuperate at the nursing home, the lady in the room with me had fallen at home. And she didn't have any (PERS). She lived alone.... She fell in the garage. Nobody came to see about her all that day, and all night, and all the next day. Finally a friend had tried to get her on the telephone and decided she'd go see about her. There she had laid with a broken hip in the garage all that time. So, I think everybody ought to have one. [Everybody in what situation?] In her situation and in mine. [How are your situations alike?] Not being able to take care of yourself or to walk or to get up if you fall down, things like that. [Some people think that they are not in that situation.] Everybody's in that situation. They may not have to use it, but they have the potential to be. [So, the people who have the potential should ...] Should have one (a PERS), I think.

Knowing of a situation when a peer needed quick help and could / could not get it

The 25 participants reported 80 situations in which an age-peer had needed quick help, including 35 situations involving PERS subscribers and 45 situations involving non-subscribers. In 43 situations (54%), the peer did not RHQ "in time" and suffered major consequences. We viewed 37 situations (46%) as *RHQ success stories*; the peer had been able to RHQ "in time." We discuss both types of situations as reported by subscriber and non-subscriber participants, comparing frequencies of types of situations reported by both sub-samples.

Subscriber and non-subscriber participants reported similar numbers of stories about non-subscriber peers who did not RHQ (17:13). In 2 of those cases the peer had telephoned for help, but the helpers did not arrive "in time." In the other 28 cases, there was no known attempt to RHQ; the non-subscriber peer was down for hours or days; some incidents resulted in injuries or death. Subscribers and non-subscribers also reported comparable stories of PERS subscribers who did not RHQ (7:6). Their failure to RHQ was attributed variously to inability to press the help-button or failure (a) to wear it, (b) to remember that one was wearing it, (c) to press it in a timely manner, or (d) to enable helpers to enter. However, the non-subscriber who related two such stories insisted that the peer had pressed her PERS help-button and waited in vain for assistance.

Of the 37 RHQ success stories, 22 (59%) involved activation of a PERS. Non-subscriber participants related 5 RHQ success stories due to PERS, akin to the 6 stories that subscriber participants knew about before they became subscribers. After they became subscribers, participants knew of 11 such incidents, most of which were stories about their own friends. They had viewed those friends as at risk of being unable to RHQ, had urged them to adopt a PERS, and had been gratified when the friends later had used the PERS to RHQ "in time." The other 15 success stories involved peers who contacted help after getting to a telephone with difficulty, banging on the floor or ceiling, shouting for help, or pulling an apartment alarm cord.

Of the 15 participants who were PERS subscribers by the end of the study, 14 had known of at least one peer situation before they subscribed. Three women (Ms. G, Ms. L, and Ms. M) knew of peers who did not RHQ and peers who did RHQ. During Interview #1, before Ms. G subscribed to a PERS about 8 months later, she said, "There's been a lot of people that fell that doesn't have them [PERS], people I know," including a man she found on the floor "some years back while delivering meals on wheels." She also related that her sister, a polio survivor who was wheelchair-bound, had used a PERS several times. "She'd fall off the bed or miss the chair. Then after she fell, why, she used it. They were real nice to come out."

Before subscriber participants subscribed to a PERS, they knew of only 3 peer situations when non-subscribers had managed to RHQ. In contrast, the non-subscriber participants knew of 7 such situations and occasionally repeated those stories. Ms. H, a non-subscriber, shared this example. “A lady fell, laid in the floor for awhile, but she managed, even though it did hurt, to get up and get to a wall phone. It was imperative. She had to do it.” As they related stories of peers who had been unable to RHQ, non-subscribers incorporated comparisons of their own risk of being unable to RHQ in similar situations. They did not see themselves as vulnerable to the incidents others had experienced, and they explained why they would not find themselves in the same situation. Ms. C was a non-subscriber but carried a pager connected to her nephew’s phone. Her aunt had fallen down the stairs, broken a hip, and had to crawl back up the stairs to get to the telephone. “But I don’t have stairs, so that wouldn’t happen to me.” She also related stories about PERS subscribers who did not activate the PERS when they needed to RHQ, including someone who had failed to wear the PERS button. She used this as rationale for relying on the pager in lieu of subscribing to a PERS and emphasized that she always kept her pager with her. Ms. D often mentioned a close friend, a non-subscriber who fell, was unable to get to the telephone, and died soon afterwards. Ms. D said that the incident increased her perception of the risk of being unable to RHQ. However, like other non-subscribers with similar stories, Ms. D did not carry a telephone and did not want to subscribe to a PERS.

Several non-subscribers related stories of peers who had died “in the chair” or “while sleeping.” In such cases they did not see an opportunity to RHQ. Ms. E, an ex-subscriber, believed that the PERS would not have helped her two neighbors who were found dead – “not the way they died.” Although two non-subscribers reported three incidents in which they thought a peer could have used a PERS, they compared their own situations favorably to those peers. They thought that peers who failed to RHQ lacked specific resources – resources that they themselves possessed. Ms. F said that her rural neighbor had been found dead on the road. “I think if she had it [a PERS], she might still be alive. But she had no children, and no one that lived close to her that was real close.” Ms. F emphasized that her situation was different. Unlike her neighbor, she had “plenty of people,” that is, three children living within a mile, including a daughter to whom she referred as “my living lifeline.”

Holding beliefs about whether certain peers need a certain device for reaching help quickly

The sub-elements of this life-world element included: (a) *believing that when people get older they are likely to need a PERS*, (b) *believing that women who have trouble walking or cannot get up if they are down should have a PERS* (c) *believing that women who have people checking on them might not need a PERS*, and (d) *believing that women with poor memories are not good candidates for a PERS*. Another example, *believing that she does not need a PERS any more than I do*, emerged in remarks of Ms. E, a non-subscriber who had been at home alone. Before she lost consciousness, she had unlocked her door but had not been able to call for help; her daughter-in-law found her “in time.” After a long hospitalization for a massive kidney infection, her physician sent her home with a PERS. However, Ms. E used the phone to RHQ and ceased the PERS subscription after 6 months, affirming her decision to do so as she related a story about a “lady I know [who] just got hers (PERS) about 2 weeks ago. I just said, ‘If you don’t get any more help from it than I did, you won’t be wearing it long.’”

Being influenced by a peer / peer's situation about adopting or using a device for reaching help quickly

This life-world element encompassed circumstances in which women were *being advised/encouraged by peers to consider a PERS*. Dialectical circumstances are characteristic of life-world, and dialectics emerged related to peer influence. On the one hand, some women were *linking a peer's situation to my decision to get/accept/rely on a certain device to RHQ*. Ms. J, a PERS subscriber, said: "My friend Cleo had gotten one (a PERS) after she fell and laid for 4 hours before someone either heard her yelling or wondered why they hadn't heard from her and went and got in and found her. She was the one that suggested that I get it after I fell. She said she liked it, and it was good. That was one thing that helped me decide I wanted one." Other women reported peer incidents that influenced their decisions to subscribe to a PERS. Ms. K's neighbor, a non-subscriber, fell in her house. The next morning the neighbor's nephew failed to gain entrance to the locked house. He knocked on Ms. K's door; she urged him to call the fire department. "She had been laying there all night." The neighbor was hospitalized with fractures and later died in a nursing home. Ms. K subscribed to a PERS the next day.

In contrast, Ms. H, a non-subscriber, was *linking a peer's situation to my decision not to get that RHQ device right now*. Several years before the project, she had had "sudden trouble breathing." Her sister called the ambulance; a heart attack was diagnosed. In Interview 1, she said she knew two PERS subscribers: "a friend who is blind" and a sister-in-law, who had "deteriorated mentally and physically from a condition, a name about a mile long."

I don't know the particulars of how they [PERS] work, but I could call the clinic and find out. [So, you've thought about this some. For what reasons?] Well, being alone. Things can happen. Some things happen that you are not mobile [mobile]. If you're down, and you can't get up, then you have to have help. And those are solutions. I've never made any effort to get one, but I know it's available. [Have you thought of yourself as a person who might need such a thing?] Well, I might need something like that down the road, but right now, no. I'm not in a bad shape.

Ms. H viewed herself as in better "shape" than her sister-in-law and her friend. At Interview 3, she denied knowing anyone who had needed to RHQ, but she told this story early in Interview 4.

Now a man here [in her rural town] was just buried. He told one of the church ladies that had he had one of those push-button things, he could have probably helped himself. He had a stroke. He laid from Friday until Sunday afternoon in the floor. [Does that make any impact on you in thinking about yourself and your situation?] No. [Tell me the reason.] I know that push-button gizmo that you're supposed to wear all the time is the safest thing. You have to come to, to push it. But it would help, because from beginning to end, until somebody found you, the situation could be shortened. [Do you think the church folks are considering a PERS because of what he said?] (She shook her head emphatically). No. [You said you don't feel that you're a candidate for one.] That's right. Let's just say it this way: 'Don't fix it, if it ain't broke.' And right now, I ain't broke.

Recently, Ms. H had fallen, lost consciousness briefly, and crawled to the phone to call 9-1-1. Yet she did not feel vulnerable to the risk of being unable to RHQ. She did not feel broken.

Conclusions

The older homebound women in this study were recognizing that they shared a risk of being unable to RHQ with age-peers. They knew of atypical situations that had arisen – situations

when peers had needed to RHQ. They were aware that those peers had either obtained or failed to obtain help, with or without a device. There is evidence that the women viewed such situations as atypical and as problematic for the peers who had endured them. That is, the women shared such scenarios before we asked about such incidents and repeated scenarios that they found especially compelling.

Personal knowledge of attempts by peers to RHQ in specific scenarios influenced (a) personal interest in obtaining or using a device to RHQ and (b) beliefs about whether older persons with certain characteristics should have specific RHQ devices. Compared to non-subscribers, more PERS subscribers reported scenarios in which older persons had used a PERS to RHQ. For some participants, awareness of those scenarios increased their own uncertainties about whether or not they would be able to RHQ if such situations occurred in their lives.

Ms. D, a non-subscriber, voiced a belief echoed by 5 other women (2 non-subscribers and 3 subscribers). “Some old people don’t think of the importance (of the risk of being unable to RHQ) until something happens to them.” In such remarks, the women offered empirical affirmation of the phenomenological perspective that persons tend to “take the structure of the world for granted ‘until further notice’ (Schutz & Luckmann, 1973, p. 8). In this study, older women related stories of other older persons who were at-risk for being unable to RHQ, but failed to recognize that risk and took the status quo for granted.

Discussion

Findings support the need for healthcare professionals to explore the influences of age-peer situations upon adoption and use of devices to RHQ. Findings pertaining to each life-world descriptor have particular relevance for research and practice. Prior to addressing those points, we consider several limitations of the work.

The scope of this report is limited because we did not fully document or explore the myriad of other potential influences upon participants’ decisions to adopt or use a device to RHQ. We sought to highlight the unexplored influence of the peer scenarios that participants themselves emphasized in their conversations with us. With regard to intentions to adopt or use a RHQ device, participants were also influenced by family members and occasionally by healthcare providers (Porter, Ganong, & Matsuda, in press). Furthermore, we did not analyze the particular conversational channels through which the women learned about the peer scenarios they reported. Although conversation with friends was apparently the primary vehicle, that issue should be pursued in further work pertaining to adoption and use of devices to RHQ.

That thrust would dovetail with efforts to differentiate the influences of social support networks and health discussion networks. Perry and Pescosolido (2010) emphasized the potential influence of health discussion networks upon morbidity and mortality “through social regulation, or the normative influence applied by social networks to shape a member’s decisions, behaviors, or attitudes toward health ... as well as patterns of health care utilization” (p. 356). Our findings are consistent with that perspective and with the recommendation of Perry and Pescosolido that researchers explore how social regulation occurs in the context of health discussion networks. Furthermore, scholars should document how health discussion networks actually influence morbidity through conversations with members that result in decisions to adopt or use a device to RHQ.

Findings of descriptive phenomenological studies should suggest implications for quantitative studies pertaining to the experience of interest (Porter, 1998). Accordingly, findings of this work have implications for refining and testing models of health behavior

change. In the transtheoretical model, “consciousness raising” (Prochaska, Velicer, DiClemente, & Fava, 1988, p. 520) has been understood in terms of direct information received from “experiential and environmental sources” (p. 526) about changing the behavior in question.

Our findings suggest that indirect forms of consciousness-raising, such as hearing about peers who have tried and failed to RHQ, could be influential as well. Indeed, knowledge of age-peer RHQ scenarios influenced some women to change behaviors with regard to adopting and using a device to RHQ. Yet, some women who told and re-told stories of peer situations did not adopt a RHQ device that they could carry with them, at least while they were enrolled in the study. The spontaneity with which they offered these stories signifies that reaching help quickly was salient to them. We draw a possible explanation for this finding from the criminology literature. In the context of crime where victims feel violated, Hale (1996) pointed out that “hearing of it from a relative, neighbor or friend, allows one’s imagination full scope without perhaps the same urgency to find some coping strategy” (p. 105). However, Hale also argued that “if one can make comparisons between oneself and the victim, this will reinforce one’s sense of vulnerability” (p. 105). In contrast, we found that knowledge of situations when peers had failed to RHQ did not necessarily influence a woman to adopt a PERS if she did not see herself as vulnerable to the same type of incident. Similarly, awareness of success stories with PERS activation did not necessarily interest some non-subscribers in becoming subscribers. However, other women had been influenced by peer situations to adopt a RHQ device or to plan to use one more effectively. That is, they prepared for an atypical situation, even if they could not prevent its occurrence. They did not take the structure of their worlds for granted.

Healthcare providers should be aware that influences upon decisions to obtain and use RHQ devices extend beyond availability, accessibility, and affordability of such devices and include awareness of peers with whom they share the risk of being unable to RHQ. Providers should ensure that older homebound women begin to recognize that shared risk and that they consider adopting and using a device to RHQ, especially given the low rate of PERS adoption and its potential effects on health-related outcomes. When assessing potential need for RHQ devices, providers should assess knowledge of peers’ attempts to RHQ and ascertain the influence of that knowledge on perceived vulnerability to various RHQ incidents.

To paraphrase Husserl (1962), the extent to which a woman identifies the personal world of her experience with that of others is a critical consideration for providers. Although participants were influenced by peers’ RHQ situations in similar ways, each woman experienced those influences in a unique personal-social context. Accordingly, practitioners must individualize the thrust of conversations about reaching help quickly and any interventions designed to enable older homebound women to RHQ. Practitioners must explore each woman’s beliefs about characteristics of persons who need to adopt or use RHQ devices. Nonetheless, for some women, readiness to adopt a device to RHQ might hinge on whether they view themselves as different from age-peers who failed to RHQ. Practitioners must be ready to acknowledge and explore those perceived differences and initiate discussion about potential RHQ scenarios that the woman could face, relative to her health-related situation and in her particular environment.

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References

- Baldwin AS, Syverud SD, Edlich RF. Technical considerations in the selection of a personal emergency response system. *Journal of Emergency Medicine*. 1993; 11:451–455. [PubMed: 8228109]
- Barrett, LL. Healthy@home 2.0: Full report. Washington, DC: American Association of Retired Persons; 2011. Retrieved from:
- Dibner, AS., editor. Personal response systems: An international report of a new home care service. Binghamton, NY: Haworth Press; 1982.
- Fallis WM, Silverthorne D, Franklin J, McClement S. Client and responder perceptions of a personal emergency response system: Lifeline. *Home Health Care Services Quarterly*. 2007; 26(3):1–21. [PubMed: 17804350]
- Fleming J, Brayne C, CC75C. Inability to get up after falling, subsequent time on floor, and summoning help: Prospective cohort study in people over 90. *BMJ*. 2008; 337:a2227. [PubMed: 19015185]
- Gurley RJ, Lum N, Sande M, Lo B, Katz MH. Persons found in their homes helpless or dead. *The New England Journal of Medicine*. 1996; 334:1710–1716. [PubMed: 8637517]
- Hale C. Fear of crime: A review of literature. *International Review of Victimology*. 1996; 4:79–150.
- Husserl, E. Ideas: General introduction to pure phenomenology. Gibson, WRB., translator. New York, NY: Macmillan; 1962. (Original work published 1913)
- Johnston K, Grimmer-Sommers K, Sutherland M. Perspectives on use of personal alarms by older fallers. *International Journal of General Medicine*. 2010; 3:231–237. [PubMed: 20830199]
- Luborsky MR, Rubinstein RL. Sampling in qualitative research: Rationale, issues, and methods. *Research on Aging*. 1995; 17:89–113. [PubMed: 22058580]
- Mack KA. Report from the CDC: Fatal and nonfatal unintentional injuries in adult women, United States. *Journal of Women's Health*. 2004; 13:754–763.
- Mann WC, Belchior P, Tomita MR, Kemp BJ. Use of personal emergency response systems by older persons with disabilities. *Assistive Technology*. 2005; 17:82–88. [PubMed: 16121648]
- Melander-Wikman A, Färltholm Y, Gard G. Safety vs. privacy: Elderly persons' experiences of a mobile safety alarm. *Health and Social Care in the Community*. 2008; 16:337–346. [PubMed: 18613909]
- Morse JM. Determining sample size. *Qualitative Health Research*. 2000; 10:3–5.
- Perry BL, Pescosolido BA. Functional specificity in discussion networks: The influence of general and problem-specific networks on health outcomes. *Social Networks*. 2010; 32:345–357.
- Porter EJ. The life-world of older widows: The context of lived experience. *Journal of Women & Aging*. 1995; 7(4):31–46.
- Porter EJ. On “being inspired” by Husserl’s phenomenology: Reflections on Omery’s exposition of phenomenology as a method for nursing research. *Advances in Nursing Science*. 1998; 21(1):16–28. [PubMed: 9730404]
- Porter EJ. “Getting up from here”: Frail older women’s experiences after falling. *Rehabilitation Nursing*. 1999; 24:201–206. 211. [PubMed: 10754911]
- Porter EJ. Moments of apprehension in the midst of a certainty: Some frail older widows’ lives with a personal emergency response system. *Qualitative Health Research*. 2003; 13:1311–1323. [PubMed: 14606415]
- Porter EJ. A phenomenological perspective on older widows’ satisfactions with their lives. *Research on Aging*. 2005a; 27:80–115.
- Porter EJ. Wearing and using personal emergency response system buttons: Older frail widows’ intentions. *Journal of Gerontological Nursing*. 2005b; 31(10):26–33. [PubMed: 16262088]
- Porter EJ, Ganong LH. Considering the use of a personal emergency response system: An experience of frail, older women. *Care Management Journals*. 2002; 3:192–198. [PubMed: 12847936]
- Porter EJ, Ganong LH, Matsuda S. Intentions of older homebound women with regard to reaching help quickly. *Western Journal of Nursing Research*. (in press).

- Porter EJ, Lasiter S. Reducing my risk of intrusion: An intention of old homebound women who live alone. *Nursing Research*. 2008; 57(5):351–359. [PubMed: 18794719]
- Porter EJ, Markham MS, Ganong LH. Incidents when older homebound women tried to reach help quickly. *Research in Gerontological Nursing*. (in press).
- Prochaska JO, Velicer WF, DiClemente CC, Fava J. Measuring processes of change: Applications to the cessation of smoking. *Journal of Consulting and Clinical Psychology*. 1988; 56:520–528. [PubMed: 3198809]
- Qualitative Solutions and Research (QSR) International Pty Ltd. QSR N6. Melbourne, Australia: Author; 2002.
- Schutz, A.; Luckmann, T. The structures of the life-world. Zaner, RM.; Engelhardt, HT., Jr, translators. Evanston, IL: Northwestern University Press; 1973.
- Smith, MH.; Longino, CF. People using long-term care services. In: Harel, Z.; Dunkle, RE., editors. Matching people with services in long-term care. New York, Y: Springer; 1995. p. 25-48.
- Spiegelberg, H.; Schuhmann, K. The phenomenological movement: A historical introduction. 3rd revised and enlarged ed. Dordrecht, The Netherlands: Kluwer Academic Press; 1994.
- Tinetti ME, Liu WL, Claus EB. Predictors and prognosis of inability to get up after falls among elderly persons. *JAMA*. 1993; 269:65–70. [PubMed: 8416408]
- U.S. Census Bureau. Projections of the Population by Age and Sex for the United States: 2010 to 2050 (NP2008-T12). 2008a. Retrieved December 3, 2008, from <http://www.census.gov/population/www/projections/index.html>
- U.S. Census Bureau. Family status and household relationship of people 15 years and over, by marital status, age, and sex: 2007. 2008b. Retrieved December 16, 2008, from <http://www.census.gov/population/www/socdemo/hh-fam/cps2007.html>
- Watzke JR, Kemp B. Safety for older adults: The role of technology and the home environment. *Topics in Geriatric Rehabilitation*. 1992; 7(4):9–21.
- Wolff JL, Starfield BS, Anderson G. Prevalence, expenditures, and complications of multiple chronic conditions in the elderly. *Archives of Internal Medicine*. 2002; 162:2269–2276. [PubMed: 12418941]