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**Exploring the Use of Assistive Aids in Later Life:
A Narrative Analysis with Older People and Occupational Therapists**

A thesis presented in partial fulfilment of the requirements for the degree of

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Abstract

Assistive aids (AA) are increasingly used by older people to support autonomy and improve quality of life. Despite their functional benefits, adoption is often accompanied by complex psychosocial challenges, including experiences of stigma and ageism, which can fuel resistance to adopting AA. This study explores how older people make sense of and negotiate the use of these devices in daily life, and how occupational therapists (OTs) involved in AA prescription understand the process older people go through when adopting AA.

Qualitative data was collected from two sources: in-depth semi-structured narrative interviews with seven older people considering or beginning to use AA and interviews with five OTs involved in the prescription of AA. Narrative analysis was used to understand the experiences of older people and OTs separately, and to examine similarities and differences between user and professional perspectives. Analysing these data sources enabled a contextualised understanding of the social narratives that underpin AA adoption.

Four overarching narratives were identified. Older people used two narratives to describe how ageing is shaped by the use of AA: ‘The More You Give up, The Older You Get’, in which older people navigated ageing as something within individual control; and ‘It Makes me Feel Like I’m on the Downward Spiral’ to describe how AA are implicated in the process of decline. Two narratives were used by OTs to make sense of AA use for older people: ‘AA Represents the Ugliness of Ageing’ in which OTs interpreted their clients resistance to AA as loss of independence; and ‘I Hear From Almost Every Client I See, I Just Want to Stay in My Own Home’ in which OTs

described the shared goal they had with their clients: for older people to remain in their homes. The analysis explored points of tension and adaptation, such as the emotional and social implications of using AA at home and in community settings, and differences in perspectives between users and professionals. Findings highlighted the barriers and facilitators to acceptance, as well as the complex psychosocial processes involved in integrating AA into daily life. These narratives demonstrate how the adoption of AA in later life is a nuanced process shaped by psychosocial factors beyond physical need. Although older people and OTs describe the process of adopting and adapting to AA in similar ways, this analysis revealed tensions and disjuncture in how AA are experienced in the context of ageing.

Understanding and addressing the social and psychological dimensions of AA use is critical for challenging ageist stereotypes and reducing stigma for older people, enabling them to access the mobility and social benefits of AA as they age.

*“You’ll often hear the phrase
“I’m not old enough for that yet”,
but they’ll be like 85,
and I’m like, well, how old do you
have to be to use a walker”?*

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Dad, thank you for inspiring this important work. I miss you every day, but I can hear you saying, “*go Nina go*” every step of the way.

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I honour all First Nations cultures and pay respect to elders past, present and emerging. I recognise that the Kaurana land I am writing from was never ceded or surrendered by the Traditional Owners, and I acknowledge the continuing connection to land, waters, and community since the first sunrise.

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Chapter 1: Introduction and Background

The phenomenon of a globally ageing population has been widely recognised, with the United Nations estimating that by 2080, the number of persons aged 65 years or older will outnumber those aged 18 years or younger (Department of Economic and Social Affairs Population Division, 2022). Over the past century, the age structure of the population has undergone significant shifts, with older people now comprising one of the largest segments of the population (Bengtsson & Scott, 2010). The definition of what constitutes an older person varies, with some countries setting the threshold at 65 and others at 60 years of age (Tinker, 2002). An ageing population refers to a growing number and proportion of older people, which is driven by reduced fertility rates and increasing lifespan due to declining mortality at older ages (Ermisch, 1990; Grundy, 1998; Scott & Canudas-Romo, 2024; Tinker, 2002). In some contexts, ageing is associated with poorer physical, mental and social health, and particular concern is directed toward the increasing proportion of very old people in the population due to the association between advanced age, higher rates of long-term illness, disability and dementia (Tinker, 2002; Veitch et al., 2020). While average lifespans are considerably longer than 30 years ago, the proportion of years spent in poor health has not changed. This indicates that while older people are living longer, the total years lived with disability attributed to functional decline, fall injuries, hearing loss, and pain have not markedly reduced, resulting in more years lived with some degree of disability (BMJ, 2022). The shift towards an older population structure often raises questions about the provision of care, including who will provide it and who will pay for it (Dieleman et al., 2017; Reeves et al., 2018).

Societal Framing of Ageing as a Problem

Population ageing is said to pose economic and social challenges, including labour force shortages, creating pressure on pension funding policies, shifting disease burden and increased expenditure on health and long-term care (Chand & Tung, 2014; Grinin et al., 2023; Higo & Khan, 2015; Jakovljevic et al., 2023; Sudharsanan & Bloom, 2018). This framing of population ageing as negative is not inevitable; while older people make up approximately 24% of the global population, they also contribute significantly to the world's GDP, accounting for 34% (All Older Americans (AARP), 2024). Older people play a significant role in economic activity through consumer spending, workforce participation, caregiving, volunteering and other vital community functions (All Older Americans (AARP), 2024). Perceptions of older people as a societal burden often overlook the significant contributions they make to the broader population. Further, population ageing is only possible due to public health initiatives, advancements in medical treatments, and improved living conditions, leading to longer lifespans (Stoodley & Conroy, 2024).

Within Western neoliberal societies, ageing is problematised in several ways, including the commodification of age-related products, and narratives of ageing as irrelevance, ageing as rigidity and ageing as dependency. Framing ageing as a problem fuels the marketing of age-defying cosmetics, supplements, medicines, and treatments designed to slow the signs of ageing (Neilson, 2006). This approach not only positions ageing as a condition to be managed, but it also creates lucrative markets for industries targeting older people. The relentless focus on youthfulness

drives consumer demand for products that promise rejuvenation, while reinforcing the narrative that ageing is undesirable.

Older people are often portrayed as invisible or irrelevant in Western societies, particularly in the workplace and social settings. Evidence suggests that older people's views and experiences may be dismissed or considered outdated, and that they are often viewed by younger people as more rigid and resistant to change (Sargeant, 2011; Shore & Goldberg, 2005). Further, von Humboldt et al (2024) find in their study that 71% of participants mentioned they felt their opinions were less regarded as they got older, which had an adverse effect on their mental health. As well as mental health implications, feelings of irrelevance can inhibit older people's willingness to participate in the community (von Humboldt et al., 2024). These social attitudes shape how older people interpret their experiences of ageing, independence and perceived decline.

Furthermore, narratives that position ageing as problematic perpetuate discrimination and ageism, reinforcing negative stereotypes of dependency and burden (Lodge et al., 2016b; Tinker, 2002). Prejudiced attitudes toward older people are socially acceptable in a way that prejudices against other groups are not; compared to sexism, racism, or transphobia, ageism is the least criticised and the most acceptable and most normalised form of prejudice (Gullette, 2017; Lodge et al., 2016b). Alongside prejudiced attitudes, the use of language, such as terms like "*elderly*" or "*pensioners*," implies that ageing happens to others rather than to ourselves, reinforcing separation between the "young" and the "old". Such language contributes to the othering of older people as a homogenous group, despite significant

differences in needs, ambitions, gender, class, income, ethnicity, and many other life variations that shape diversity (Lodge et al., 2016b). This categorical thinking helps sustain the invisibility and acceptability of ageism. While much of the discussion continues to construct ageing as an issue requiring intervention, there is a need for a more nuanced understanding of older people that looks beyond problematisation.

As populations continue to age, these demographic shifts could be understood not as indicators of crisis but as evidence of public health success and extended physiological resilience. Yet the bodily changes that accompany ageing are often socially interpreted through a stigmatising lens that equates ageing with decline. This conflation of ageing processes with dependency sustains the perception of older people as burdensome, shaping both policy and interpersonal attitudes. These ideas highlight how the biological realities of ageing intersect with social narratives of worth and capability (Lodge et al., 2016b, 2016a). Developing this understanding enables equitable and enabling environments that recognise ageing as a shared dimension of human experience rather than a social or economic threat.

Assistive Aids in the Context of Ageing

Ageing has been defined as a chronological, biological, psychosocial, and socio-cultural process characterised by a declining ability to respond to stress and an increased risk of ageing-associated diseases (Rattan, 2014). As part of the normative ageing process, people experience a range of physical and cognitive changes across various domains, including strength, mobility, vision, hearing and memory (Astell et al., 2020). To mitigate some of these changes, many older people use Assistive Technology (AT) or Assistive Aids (AA) to maintain their autonomy and quality of

life. The International Organization for Standardisation (ISO, 2022) defines AT as products designed to optimise functioning and reduce disability. These include a wide range of devices, from technologies supporting cognitive impairment to mobility aids such as walking sticks, canes, walkers, scooters, and wheelchairs, as well as home adaptations like toilet lifters, rails, reachers, grabbers, and tipping kettles (Abri & Boll, 2020; Astell et al., 2020). Although AT encompasses a broad spectrum of devices, the term Assistive Aids (AA) will be used hereafter for clarity and alignment with the study's focus.

Assistive Aid Support in the Australian Context

In Australia, access to government-funded aged care support is structured through a multi-step process. Older people first register for an assessment with My Aged Care (MAC), where they undergo an eligibility screening. Following this, they are assessed by an OT, who typically determines the need for AA. Eligibility is available to people aged 65 years and over, and to Aboriginal or Torres Strait Islander people aged 50 years and over.

These different age-based eligibility criteria reflect and respond to significant inequities in health and mobility across ethnic groups in Australia. For example, older Aboriginal and Torres Strait Islander people are almost three times more likely than non-Indigenous older people to require help with self-care and mobility (Australian Institute of Health and Welfare, 2011). These disparities are shaped by a range of factors, including a higher rate of chronic disease, social and economic disadvantage,

language and cultural barriers within a Eurocentric system and limited access to culturally safe health services (Georgeou et al., 2021; Johnstone & Kanitsaki, 2008).

Following eligibility screening, an in-home assessment is conducted to determine the appropriate level of support. The Commonwealth Home Support (CHSP) provides entry-level care for people who are largely independent but require support with a limited number of tasks. CHSP is typically recommended for those requiring one or two services, such as transport or housework, to maintain independent living (Department of Health, Disability and Ageing, 2025). For people with more complex needs, the Support at Home Program offers four levels of care, each tailored to address requirements that extend beyond the scope of CHSP. This program encompasses clinical care (including nursing care, occupational therapy, and continence care), support for independence (including assistance with personal care, medication management, transportation, or respite care), and help with everyday living (including tasks such as cleaning, gardening, shopping, or meal preparation). The Support at Home Program also provides access to AA and home modifications, with funding available for products, equipment, and/or home modifications up to a maximum of \$15,000 AUD, subject to assessment outcomes (Department of Health, Disability and Ageing, 2024b). People who do not wish to pursue government-funded support may purchase equipment privately or seek independent OT advice.

Ageing in place is a social policy model for successful ageing that encourages older people to avoid institutional care for as long as possible and remain in their own homes as they age (de Silva et al., 2023; Normie, 2011; Rose et al., 2023). Ageing in place is widely recognised as the preferred option for older people, who express a

strong desire to remain in their own homes and communities rather than move into institutional care (Gitlin et al., 2013). This preferred model aligns with government and policy agendas that promote ageing in place as a cost-effective strategy to reduce demand on residential aged care and health services (Department of Health, Disability and Ageing, 2024a). Further, ageing in place is associated with significantly reduced levels of depression (Marek et al., 2005). Consequently, ageing in place has become a driver of technological and environmental innovation, fuelling demand for AA and supporting independence, safety and social participation in later life. However, despite evidence of positive outcomes for older people and government agendas, there is limited empirical evidence on older people's experiences of and attitudes toward ageing in place. Furthermore, the available literature largely excludes Indigenous populations and groups at the margins (Hillcoat-Nallétamby & Ogg, 2014). Recognising diverse ageing-in-place experiences is essential, as inadequate support heightens older people's risks of loneliness, social isolation, and vulnerability (Hillcoat-Nallétamby & Ogg, 2014; Rose et al., 2023), outcomes AA aim to mitigate.

The development of AA has significantly benefited people with diverse abilities for many decades. One of the earliest applications was to increase, maintain, or improve the functional capabilities of people with disabilities; AA has since evolved toward enabling technologies that facilitate tasks for people with diverse needs and abilities, thereby enabling broader use and acceptance. One such benefit of this evolution is that AA enables older people to age in place (Zallio & Ohashi, 2022). AA play a role in the improvement of older people's lives by providing enhanced mobility inside and outside the home, community participation, improved safety, and overall well-being. For example, home modifications such as ramps and adapted

bathrooms are associated with reduced falls and pain among older people, while mobility devices such as walkers or motorised scooters enable access to the community (Chandola & Rouxel, 2022; Schorderet et al., 2022; Sweeting et al., 2024).

The suitability of the home environment is central to reducing risk and supporting people to adapt well to ageing in place. AA and home modifications are therefore pivotal, but only to the extent that older people can access them. Further, older renters may face barriers to installing home modifications, including a lack of autonomy to make decisions about modifications without suitable landlord support, potentially shouldering the cost of modification removal, uncertainty around rent increases, and the risk of needing to move in high-pressure housing markets (Rose et al., 2023). This presents a challenge for older people, where ageing in place may not be a viable option for everyone.

Despite being designed to enhance mobility, safety and social participation, AA are frequently rejected by older people (Astell et al., 2020; D. Yang & Moody, 2022). Rejection of AA can arise for a number of reasons, including their medicalised aesthetic design and the social meanings attached to their use, which often symbolise dependency or decline (Astell et al., 2020). Despite their practical benefits, AA can inadvertently reinforce ageist stereotypes and perpetuate the framing of ageing as a deficit, thereby reproducing narratives of vulnerability (Astell et al., 2020). This rejection of these devices reflects a more complex negotiation between functionality, identity and self-image.

Ageism

Ageism is a concept that spans various domains, including cognitive (how people think about ageing, such as believing stereotypes), affective (feelings of prejudice toward others) and behavioural (acts of discrimination toward others). Ageism can manifest at both a conscious, deliberate level and an unconscious level, shaping attitudes and behaviours in subtle ways (Marques et al., 2020). Ageism is also evident across various layers of society, including the interpersonal level, within social groups and networks, and broader institutional and cultural frameworks such as policies and health practices.

Importantly, ageism can be directed both outwardly toward others - referred to as other-directed ageism, or internalised, leading to self-directed ageism (Marques et al., 2020). Other-directed ageism occurs when people make assumptions or behave in ways that stereotype or marginalise older people. For example, at an interpersonal level, a healthcare provider might speak to another family member rather than directly addressing the older patient, assuming the older person is less capable of understanding or making decisions (Minichiello et al., 2000). Within social groups, ageist jokes at birthday parties, such as those that denigrate ageing, and workplace practices, such as overlooking older candidates for jobs, are common forms of other-directed ageism (Minichiello et al., 2000; Nelson, 2016).

An example of how ageism manifests in society, as well as in institutional and cultural frameworks, is evident in the media. Amundsen (2022) discusses how online media frames the term *elderly* as powerless, which matters for how ageist messages are internalised and influence perceptions across all age groups. Media depictions of

older people illustrate how cultural frameworks shape and reinforce exposure to age-related biases, ultimately leading to their internalisation (Amundsen, 2022; Camacho-Markina & Santos-Diez, 2025; Luborsky & Sankar, 1993).

Ageism is a highly prevalent phenomenon that spans many cultures; however, the experience of ageism varies across different societies. Ageism is often built on biomedical understandings of ageing as decline. However, some cultures may display more positive perceptions of ageing (such as admiration or respect) (Marques et al., 2020). For example, in Aotearoa New Zealand, Māori perspectives on ageing are generally positive, viewing older age as the culmination of lifelong achievements and recognising Kaumātuas' significant support roles within Māori society (Butcher & Breheny, 2016). Further, many Indigenous communities see ageing as a process of maintaining strong connections to culture, land and community, which fosters a positive outlook on ageing and emphasises resilience (Quigley et al., 2022). While this does not mean ageism is absent in cultures outside of Western contexts, it highlights that conceptions of old age are complex and that the form, intensity, and social meanings of ageism are shaped by cultural, historical, and institutional contexts (Ng & Lim-Soh, 2021; Vauclair et al., 2017). Scholars in critical gerontology caution against making universal claims about ageism, arguing that researchers should consider ageism within the context of shared cultural narratives and representations that vary across societies (Higgs & Gilleard, 2020). This important perspective demonstrates that ageism is not a single, universal phenomenon, but rather is shaped by many factors that vary across societies.

Furthermore, social constructions of ageing are increasingly recognised as a socially constructed category that intersects with gender, class, race, and ethnicity, underscoring age's power to shape social relations and produce inequalities (Krekula et al., 2018). Intersectionality is important here because it reveals how ageism compounds with other forms of oppression. Gendered ageism demonstrates one example of how two interacting power systems lead to an increased vulnerability, where patriarchal norms combined with a preoccupation with youth contribute to a more rapid diminishment of the social status of older women compared to men (Krekula et al., 2018). This perspective is important for capturing the subjectivity of age and has implications for how AA might be accepted or rejected. For instance, AA might be rejected both because it is viewed as a symbol of undesirable ageing, and because it disrupts dominant ideals of femininity that value youthfulness and autonomous bodies. This example demonstrates how age is one of many dimensions of social differentiation.

Ageism by Younger People and Toward Future Selves

Internalised stigma or stereotypes are crucial for understanding how people perceive themselves and their role in society. Research on age-related stereotypes typically examines the perspectives of younger people, rather than focusing on older people as the recipients of these stereotypes. For example, younger people often perceive older people as being high in interpersonal warmth but low in cognitive and

functional competence. The enactment of these stereotypes can result in paternalistic behaviours, such as patronising speech (Bohlmeijer et al., 2011).

However, knowing how older people experience these stereotypes is important for understanding how they are expressed toward themselves and others. Gemma Carney has developed the Acquisition, Internalisation and Reinforcement (AIR) model of ageism, which suggests that from a young age, people acquire attitudes towards older people through interactions with parents or other significant social models, including television, movies, and celebrities. Throughout life, ageist attitudes gradually begin to be expressed, often through seemingly trivial remarks. For instance, the phrase ‘you look great for your age’ may appear harmless but subtly reinforces stereotypes about ageing, reflecting how ageist attitudes become embodied in everyday language (Carney & Nash, 2020a, 2020b). These findings are significant because they demonstrate that through this process of stereotype embodiment, people develop prejudices against their future selves, and this has implications for how ageism circulates and is reinforced.

Ageism by Older People Toward Other Older People

While much ageism originates from younger people, research also suggests that older people themselves may reproduce and direct ageist stereotypes toward their peers. However, research in this area remains limited. One systematic review identified very few studies that examined older participants’ attitudes toward their peers (Marques et al., 2020), and more recent work has highlighted the ongoing

scarcity of knowledge about ageism expressed by older people toward other older people (Ayalon, 2025).

Within the limited existing research, Breheny et al. (2020) found that older people internalise societal stereotypes and prejudices about ageing, which can influence their perceptions and interactions with others. Older community volunteers categorised other older people experiencing decline or expressing negative attitudes as examples of what to avoid. In their study, volunteers described difficult, isolated, or complaining older people as providing an object lesson of what to avoid as they age (Breheny et al., 2020). These interactions reflect internalised prejudice, where certain traits associated with older age, such as irritability, isolation or dependence, are viewed negatively, with the volunteers striving to avoid these undesirable ageing identities. This process demonstrates how societal stereotypes about ageing are reproduced and reinforced within the volunteers' perceptions of both others and their future selves (Breheny et al., 2020). This study demonstrates how older people contribute to the reinforcement of negative stereotypes about their own age group. This matters for the present research as it suggests that the rejection of AA may not only come from negative stereotypes held by others in general but also from other older people themselves.

Self-directed Ageism and its Forms

In contrast to other-directed ageism that exists within social interactions, institutions, and cultural norms, self-directed ageism refers to situations in which people internalise negative beliefs or emotions about their own ageing process. For instance, older people might feel unimportant or irrelevant and avoid social

interactions, adopting a view of ageing as unwelcome (Minichiello et al., 2000). Self-directed ageism can also manifest as self-doubt about one's abilities or concern about being judged by age-based stereotypes, such as being perceived as forgetful due to older age. These internalised beliefs can undermine confidence and negatively affect well-being (Marques et al., 2020). Self-directed ageism has important implications for the use of AA and how people participate within society. For example, ageist stereotypes may lead older people to avoid environments in which using AA could draw attention to age-related changes in their physical abilities, whether in public or private settings. They may also resist the use of AA when they are perceived as a symbol of ageing, thereby reinforcing ageist stereotypes (Marques et al., 2020; Minichiello et al., 2000).

While self-directed ageism is often an implicit belief, self-stigma is distinct and is characterised by a person's explicit application of any negative societal stereotypes and prejudice; however, it is often used interchangeably with self-directed ageism (Hausknecht et al., 2020). Levy (2009) theorises self-stigma as the embodiment of stereotypes, where stereotypes from the surrounding culture become internalised and ultimately influence functioning and health. Levy (2009) cites studies that find older people who embody ageist stereotypes walk more slowly, have poorer hearing, perform worse on cognitive tests, and live, on average, 7.5 years less than those with a positive attitude toward their ageing (Levy et al., 2002, 2006). Stereotype embodiment suggests that people begin by expressing ageist stereotypes toward others, before these become internalised.

Taken together, these dimensions of ageism by younger people, by older people and toward the self, reveal how societal stereotypes are circulated, reinforced and embodied across the lifespan. Understanding these interconnections is essential to examining attitudes toward AA and ageing identities.

My story

The topic of AA and how they are intertwined with the experience of ageing is both personal and academic for me. My interest in this intersection began after my father's diagnosis of Parkinson's disease. I witnessed my dad shift from a strong Kiwi bloke to a frail Parkinson's patient. This shift in identity is what piqued my interest in how AA can have a profound impact on people's lives. While the presence of disease exacerbated my dad's experience of ageing, it drew attention to how physical decline and frailty are so often linked with ideas of older age. This concept is gaining wider recognition as the intersection of ageism and ableism. Horst and Vickerstaff (2022) advocate for a more precise separation that recognises ageist attitudes may operate independently of ableist assumptions. In contrast, other attitudes are inherently linked due to societal norms about disability and ageing. As my Dad's Parkinson's progressed, AA were introduced to support his everyday tasks. I noticed how decisions about his mobility gradually became assumed by others, with little consideration of how this transition affected his sense of control and autonomy. I bore witness to his rejection of these devices, actively rebuffing the idea that he was incapable. I noticed how, from others' perspective, AA were a clear solution and at the same time not always accepted as helpful or useful by my Dad. There was a medicalised practicality and a deficit focus where these devices were prescribed in

response to his impairments, positioning AA as solutions to problems rather than as tools that supported his preferred way of living. These items now stood out, obtrusively, among the carefully curated living spaces of the home. Quite frankly, they made him sad. Motivated by how this experience affected him, I wanted to know whether others shared similar experiences. This lived experience inspired my research, driving me to explore these issues beyond a single story.

Chapter 2: Literature Review

Ageing with Assistive Aids

While AA are utilised for a variety of reasons, including disability, illness, or injury recovery, this research focuses on the use of AA to support the normative process of ageing. The normative process of ageing refers to typical, age-related physical and cognitive changes, such as changes in strength, mobility, and vision, that occur independently of disability or mobility impairments acquired earlier in life (Astell et al., 2020). In some cases, the ageing process coincides with age-related disease, and while they are not mutually exclusive, ageing increases susceptibility and vulnerability to the onset and progression of disease (Luo et al., 2020). Age-related diseases include cancer, type 2 diabetes, cardiovascular and neurodegenerative diseases, including Parkinson's disease (Luo et al., 2020). Although age-related disease can coincide with these age-related changes, and the experience of illness or injury may overlap with ageing, this study does not focus on people whose primary experience of disability or impairment began before older age. This chapter provides an overview of existing research on AA use, drawing on perspectives from both older people and healthcare professionals.

Much of the existing literature on AA adoption is shaped by dominant perspectives that prioritise observable outcomes that can be directly seen or measured, with less attention to broader social or cultural influences. Many studies in this area concentrate on reasons for rejection, such as the appropriateness of the aid for the home environment (Steel & Gray, 2009), limited support or education from health providers (C. McGrath et al., 2017) and users' capacity and willingness to adapt to AA use (Remillard et al., 2019). While much of the literature emphasises reasons for rejection, other studies draw attention to the ways AA

use can maintain activities of daily living (Remillard et al., 2019), support functional limitations (Latham-Mintus & Clarke, 2019), mediate the impact of poor physical health (R. Tang et al., 2024), and promote participation in social activities (McDonough & Ryan, 2023). Use of AA can also enhance older people's independence and safety, allowing them to live at home for longer while reducing reliance on family and formal caregivers (Jaschinski et al., 2021). Further, AA has been found to boost confidence, improve quality of life and foster a sense of autonomy, contributing to wellbeing and social connectedness (Sweeting et al., 2024; World Health Organisation, 2022).

Several seminal studies in the field have found that factors such as symbolic value, self-perception, and social processes can significantly influence AA acceptance. Stigma surrounding AA adoption is deeply influenced by the symbolic meanings assigned to technologies marketed for older people. Yusif et al. (2016) considered barriers to adoption by systematically reviewing a body of empirical studies. They found that stigma associated with AA arises not from feelings of embarrassment, but from the symbolic meaning associated with technologies specifically targeted at older people. For example, AA are often marketed exclusively to older people, which suggests their use can signal frailty or dependence. This stigmatising symbolism may lead older people to avoid adopting such technologies, not because they are embarrassed by the device itself, but because its use publicly identifies them as old, reinforcing negative stereotypes about ageing (Yusif et al., 2016). This finding is particularly relevant, as it suggests that the meanings assigned to AA in both private and public contexts may shape not only initial adoption but also ongoing use and negotiation of these devices in everyday life.

Accepting AA is not only about incorporating them into everyday activities; these devices also have implications for identity. Jensen (2014) highlights how, during the process of applying for an AA, older people prioritise self-image, dignity and quality of life. Participants sought assistive devices not just to enhance and manage day-to-day living but also to support their life objectives. For example, a chair should support the person in sitting comfortably but also provide a sense of rest, comfort, and dignity. When these were in conflict due to poor design, cultural stigma, or poor service delivery, participants had negative perspectives of AA. This finding underscores the importance of understanding how people make sense of AA not just as tools for performing activities but also the ability to independently fulfil their priorities in later life.

While physical functionality often dominates discussions of AA adoption, social contexts also shape the acceptance of AA. Peek et al. (2015) argue that the adoption of AA is as much a social process as it is a technical one, emphasising the role of family, peers, and professionals in shaping decisions. Family members and professionals often act as advisors, directly influencing the decision to adopt AA. For example, a family member or OT might help with understanding how to operate a new device. Their support can facilitate adoption by providing reassurance and guidance, but can also introduce conflicting perceptions about the necessity of AA (Peek et al., 2015). These findings align with a focus on the negotiation of AA use, highlighting the influence of social relationships and expectations in both private and public domains.

Decisions regarding the adoption and use of AA are shaped by an interplay of perceived needs and product characteristics, which are further influenced by concerns about autonomy, visibility and social context. In a widely cited study, McCreadie and Tinker

(2005) emphasise the role of perceived need and product quality, noting that older people often prioritise independence even if it means enduring increased pain or a reduced quality of life. Their findings highlight complex trade-offs, which older people may negotiate differently depending on whether AA use is visible to others or confined to the privacy of the home.

Collectively, these foundational studies suggest that AA use is embedded within personal, social, and physical contexts. This suggests a dynamic interplay between social meaning, personal identity, and functional needs that shapes adoption. However, while these studies acknowledge the complexity of AA adoption, they tend to overlook how people actively negotiate the use of AA across different settings. In particular, there is limited exploration of how older people and healthcare professionals co-construct meaning and practices around AA in the shifting boundaries of private and public space. This gap is important, as it underscores the need to better understand how social meanings and personal identity influence how older people negotiate the use of AA in various settings. Ageing is increasingly recognised as a socially constructed category derived not only from innate biological processes but also strongly shaped by social determinants (Gilleard, 2025). By focusing on how AA is adopted and used in both private and public life, the present study aims to add to this research and provide a more nuanced understanding of the social and personal factors that shape engagement with AA.

Deficit Focus

The dominant scientific literature, media discourse, and policy framing of older people reproduces a deficit narrative, characterising them primarily as elderly, frail, burdensome and submissive (De Coninck et al., 2021; Sawadogo et al., 2022; Shin et al.,

2023). These constructions of older people reflect and reinforce ageing itself as a social and economic problem, where dependency and vulnerability become defining features. Within such a framework, not only are older people positioned as in need of intervention, but their use (or non-use) of AA is interpreted as impacting society, specifically through resource expenditure and perceived burdens on family and state. For example, authors have written about the economic burden the ageing population places on caregivers and broader society (Roelands et al., 2002; Yu et al., 2022). Interventions such as AA are often introduced with the explicit aim of reducing costs associated with state or familial care (Chen et al., 2023; B. Tang et al., 2022). Roelands et al. (2002) argue that when older people do not utilise assistive devices such as walking frames, wheelchairs and lifts, it represents a misallocation of valuable public resources, foregrounding the deficit perspective and overlooking the broader context in which decisions to use (or not use) AA are made.

Within this deficit-focused framework, decisions and motivations for the use of AA are often explored from a shortfall perspective, with non-use framed as problematic. The focus tends to be on the risks associated with non-use, such as the increased likelihood of injury (Luz et al., 2015), and an intense focus on physical impairment (Thielke et al., 2012). In addition, older people's passivity in the AA adoption process is considered problematic (Hägglom-Kronlöf & Sonn, 2007). Such accounts emphasise physical deficits associated with ageing, operating from the assumption that interventions should mitigate decline rather than enhance agency and wellbeing.

These concerns overlook how the deficit framing itself may discourage AA use; older people may reject AA precisely because they are perceived as markers of frailty or dependence. Luz et al. (2015) found that, at the time of a fall, participants often were not

using their AA device, citing reasons including the belief that the device was unnecessary, forgetfulness, the device making them feel old, and the device being inaccessible.

Furthermore, the authors find that a perceived risk of falling was insufficient to motivate the use of AA, despite their view that these devices prevent fall risk (Luz et al., 2015). These reasons suggest that practitioners' and researchers' perceptions of non-use may not align with participants' perceptions of using these devices.

These studies show the ways perceptions of AA rejection can contribute to ageist attitudes toward older people. While many AA devices aim to address issues of physical impairment, they also offer older people broader solutions, including support for independent living and enhanced social participation. However, when AA is primarily framed in terms of physical deficiency, this broader potential is obscured, reinforcing deficit-based narratives that can further marginalise older people.

The Role of Identity and AA Acceptance

Within social constructionism, terms such as personality, attitude and temperament are not viewed as concrete or inherently meaningful ways of understanding people. Instead, these *qualities* can be seen as cultural ideas produced through the ways we talk and think, with language itself bringing them into view (Burr, 2003). Instead, a term that is frequently used by social constructionists in place of these terms is that of identity. The term identity avoids the fixed connotations of personality while being an implicitly social concept (Burr, 2003). For example, when an older person is described as “a walker user” or “dependent on a walker,” the device becomes part of how their identity is framed, foregrounding frailty and dependence. Social psychologists describe identity as created through the process of managing opposing forces of change and continuity and stability and growth (Gergen &

Gergen, 1988; Smith, 1994). This can be understood as the process of attempting to maintain a consistent identity over time while striving for change and progress (J. Elliott, 2005).

The desire to preserve an identity of competence and independence in later life can lead older people to resist assistive devices that are perceived as stigmatising. This tendency is supported by Astelle et al. (2020), who found that older people often reject devices because they reinforce notions of dependency and negative stereotypes of ageing. Kylberg et al. (2013) underscore the significance of identity in AA acceptance. For example, the authors link participants' expressions of sadness when acquiring AA to a reluctance to appear different due to their declining ability to perform daily tasks. Similarly, Copolillio A et al. (2001) found that older people expressed a strong desire to maintain control over their lives, often viewing assistive devices as a last resort due to their impact on self-image. In contrast, Kabacińska et al. (2023) found that some participants viewed AA positively, as tools to maintain social inclusion and enhance quality of life. These studies underscore the centrality of identity, participation and autonomy in shaping older people's acceptance or rejection of AA.

Professional Prescription of AA

Occupational health professionals offer not only insight into the physical and functional needs of their clients but also into how their clients react to and perceive AA, particularly in the early stages of adoption. Typically, the AA prescription process begins with an assessment by health professionals, who identify risks, match AA options to perceived needs and then recommend or prescribe specific devices. This process can vary across settings, with health professionals often exercising most of the decision-making authority. For example, McGrath et al. (2017) found that solutions to cope with age-related

disabilities with AA were initiated by home nursing staff around 40% of the time, highlighting the influence of professionals in driving the process. Hedberg-Kristensson et al. (2006) similarly observed that older people are often passive participants in the prescription process in a community setting, with few actively involved in decisions about AA adoption.

This passivity does not necessarily indicate exclusion, as many older people trust health professionals to select appropriate devices and are content not to participate directly (Hedberg-Kristensson et al., 2006). Yet such professionally dominated decision-making can both streamline adoption and risk hindering it, particularly when prescriptions prioritise deficit-based needs over users' aesthetic preferences and sense of self. This raises important questions about why some older people prefer not to be involved in decision making and how meanings attached to AA and their connection to self-identity may influence preferences.

Trust in health professionals plays a pivotal role in shaping people's willingness to adopt AA, influencing how users perceive and engage with healthcare solutions. However, the degree of autonomy experienced by older people is not uniform, as some people actively negotiate their involvement while others prefer to defer to professional expertise. Skymne et al. (2012) considered AA adoption from the user's perspective and found that the experience of adoption was closely linked to the level of trust in the AA provider. This finding suggests that the dynamics of decision-making are complex and shaped not only by institutional structures but also by interpersonal relationships and perceptions of expertise.

The uneven power relations between health professionals, older people, and their younger family members further illustrate the complexity of AA decision-making. The literature reveals the various ways decision-making power is distributed through institutional hierarchies (e.g. privileging clinical expertise over lived experience), and ageist assumptions

about age-related decline. Bechtold et al. (2021) highlight how various stakeholders, including policymakers, researchers and scientists, shape the outcomes of built environments and ageing support tools by making decisions on behalf of older people. These groups often implement age-based policies that suggest people adopt preventive measures and integrate AA into their lives at predetermined stages, rather than allowing for personalised, autonomous decision-making. Gooberman-Hill and Ebrahim (2007) demonstrate that older people often associate walking limitations and the use of AA with the ageing process, a connection further reinforced by doctors who frequently attributed pain and mobility difficulties to older age. McDonough and Ryan (2023) highlight how the communication styles of those interacting with older people (often adult children) can either reinforce or mitigate age-related stigma, ultimately influencing whether AA are accepted or rejected.

Decision-making processes in adopting AA raise important questions about autonomy and authority in determining the needs of older people. Häggblom-Kronlöf and Sonn (2007) find that many users of AA do not actively participate in the prescription process, with participants reporting that other people had made decisions about the need for an AA on their behalf. The authors highlight related ethical concerns by emphasising the importance of being aware of the client's perspective alongside their own professional perspective (Häggblom-Kronlöf & Sonn, 2007). Abri and Boll (2020) support this point, highlighting that many reports of AA use or non-use assume the user decided to adopt the device, and do not consider that, in some cases, family members have made the decision on their behalf.

These studies highlight that government structures, professional authority, and family members all contribute to influencing decision-making regarding AA adoption. The degree of user involvement varies not only according to healthcare system structures but also according

to personal attitudes and relationships with health professionals and family members.

Understanding these nuances is essential for developing more person-centred approaches to AA prescription and adoption.

How Ageism Affects AA Design

Ageism influences both how older people are treated in society and can also shape the design of products for older people; ageing as a deficit influences the medicalisation and functional design focus of AA. Implicit bias may lead to the design of products that fail to address the needs and preferences of older people. AA product design tends to prioritise function over aesthetic factors (look, feel, design), and the ways older people navigate private and public spaces, with these latter elements often being largely overlooked.

Implicit bias in AA design is evident in the lack of consideration of user suitability, the influence of decision-makers on design outcomes, and user satisfaction. Başibüyük et al. (2024) showed that companies designing assistive equipment fail to consider comfort, safety, usability and the unique requirements of older people. For example, ergonomic factors and measurements, such as range of motion and reach, were not considered in the design of bathroom assistive devices, which the authors suggest may contribute to falls among older people. Further, Morris et al. (2022) found that participants frequently used multiple walking aids for different environments. The necessity for multiple aids indicates a limited understanding of the diverse spaces that older people use, reflecting an implicit assumption that older people with mobility impairments are more likely to be confined to their homes. Design outcomes are also influenced by who drives the decision-making process for adopting AA, whether family members, caregivers, or healthcare professionals. Abri and Boll (2020) highlight that when others are involved in the decision-making process, they often advocate

for features they believe will benefit older users, thereby shaping the development priorities of AA. This external influence may lead to designs that emphasise safety or ease of use, reflecting the perceptions and biases of the decision-makers rather than the needs and preferences of the older person.

While these factors are important considerations, they may overlook the older person's preferences, autonomy and individualised needs. For example, a family member might recommend an ergonomic walking frame with large handles to an older person who experiences balance issues. The family member's perspective is that a sturdier walking frame will improve safety, while the older person may prefer a more subtle walking frame because they value simplicity. If the particular type of device is uncomfortable or stigmatising for the older person, they may be less inclined to use it. Ravenberg (2012) discuss how cultural norms, values, and societal attitudes regarding disability and age are inscribed into the design of AA. The author highlights that standardised design and the neglect of individual needs can lead to dissatisfaction and abandonment. For example, user dissatisfaction with one-size-fits-all devices that do not align with personal preferences suggests that design often reflects societal stereotypes or assumptions that do not fully accommodate older people's specific needs.

While limited studies advocate for and address consumer-focused outcomes, some indicate a link between aesthetic-focused design and ageism concerns (Astell et al., 2020; Kabacińska et al., 2023). For example, Astell et al. (2020) discuss how older people advocated for discrete and unobtrusive designs, signalling a desire to reduce stigma-based ageism. Participants in this study also prioritised fashion over function. These preferences were related to fear of stigmatisation with ageist stereotypes and judgement cited as key

reasons older people reject the use of AA (Astell et al., 2020). Kabacińska et al. (2023) further illustrate this point, noting that older people rate aesthetics as a preference to counter the stigma associated with AA use. Yang and Moody (2022) discuss how a lack of user-centred and context-appropriate product design can lead to poor adoption and acceptance. The authors recognise how stigma is perpetuated when ideas of frailty are intrinsically linked with functional solutions (i.e., how a device performs to improve balance, reduce falls, and enable sleep and mobility) that lack consideration of aesthetic design. For example, while older participants saw functionality as imperative, aesthetics and style were seen as important dimensions not to be ignored: “I am still looking for nice, colourful and modern things that I like”. (D. Yang & Moody, 2022, p. 256). Together, these findings suggest that older age does not preclude people from prioritising aesthetics. A preference for aesthetic function suggests AA design is not immune to social processes of meaning-making, despite being largely ignored by product designers and researchers alike.

However, how the end user interprets functionality may differ; for example, functionality could mean the ability to store assistive items in ways that make them less obtrusive in the home, or it could refer to adaptability for use outside the home. While functionality is an important component of any assistive device, its interpretation has implications for design outcomes. How AA are used is an important consideration, as underlying assumptions about what older people *should* be able to do, rather than what they want to be able to do, may reflect ageist stereotypes (D. Yang & Moody, 2022).

Additionally, significant power disparities exist between designers of AA and older people, who are positioned primarily as passive consumers rather than co-designers. This manifests in older people’s limited involvement in product evaluation, where they report

being inadequately invited to evaluate assistive devices against their own priorities, such as autonomy and social acceptability (Kabacińska et al., 2023). These disparities are compounded by welfare policies and insurance companies that hold significant influence over the types of AA support people can access, prioritising cost-effective or compliant products over user-centred design (H. R. Lee et al., 2016). In Australia, where most AA for older people is accessed through publicly funded aged care services, rather than direct-to-consumer purchasing, older people have limited scope to exercise traditional consumer power. Consumer power is usually enacted by shopping around, rejecting poorly designed products, or signalling demand for alternatives. Instead, access to AA is mediated by policy design, which can narrow the range of options available and privilege devices that meet funding criteria over those that best fit users' preferences.

These studies reveal the power disparities between designers and older people and highlight the significance of appearance and aesthetics in maintaining social identities. However, it is important to consider what else is of concern to older people: the environments in which they live that may make using AA challenging, and the social activities they participate in that may make using AA desirable. For example, the types of spaces older people are assumed to navigate with a standard walking aid may not reflect the diversity of environments that are navigated regularly. The use of an AA is an active process in which an older person engages in specific activities within a particular environment; at its core, this involves the imagined environments and needs of older people that stem from implicit biases about what they are perceived to require.

Private vs Public Spaces

Social visibility and the potential for stigma in public environments have an impact on the acceptance and utilisation of AA in these spaces. Astell et al. (2020) found that participants across multiple studies described the use of AA in public spaces as embarrassing, and this perception was described as deterring their use. Visibility of AA in private spaces was also a consideration, as participants avoided devices that were visible or obtrusive to visitors.

While the use of AA can differ between public and private settings, fear of dependency stereotyping can also lead to older people withdrawing from public life. A preference to remain homebound rather than risk outward signs of disability is cited across multiple studies (Astell et al., 2020; D. Lee & Tak, 2023; C. McGrath et al., 2017; Peterson & Adams-Price, 2022). For example, Peterson and Adams-Price (2022) find that older people's reluctance to use AA often stems from fears of appearing dependent and embodying negative stereotypes can lead them to limit their outdoor activities. Specifically, resistance to using AA out of concern for stigma may lead to older people avoiding leaving their homes.

Similarly, D. Lee and Tak (2023) found that older participants avoided outward signs of disability, such as using mobility devices, and discussed how avoidance behaviours driven by fear of social judgment diminished outdoor mobility and participation in community life, leading to home confinement. Further, McGrath et al. (2017) found that participants in their study refused outside grab rails or other devices because they felt these made them look "too medicalised" or vulnerable, and they preferred to maintain an image of independence (C. McGrath et al., 2017, p. 673). These findings are important for the present study, as paying attention to how older people construct meaning from different settings allows a critical

stance toward mainstream knowledge assumptions that stigma is experienced similarly across settings.

Personal and social factors may shape the stigma around the use of AA and influence decisions to avoid using them in public. Stigma is not static; it can shift over time as both societal and individual values change (Galvin, 2005; L. H. Yang et al., 2007). For example, while someone may initially feel embarrassed about using a walking device, these feelings can subside as perceptions of ageing or AA become more positive within their social circles and personal outlook. Gooberman-Hill and Ebrahim (2007) found that participants developed positive feelings about using walking aids over time. This change was linked to viewing walking limitations as part of getting older, which depended more on people's feelings about ageing than chronological age (Gooberman-Hill & Ebrahim, 2007). Peek et al. (2015) find that older people experience stigma about using a walking aid in public, describing a shift in acceptance over time, where AA is viewed as a tool that supports involvement in public outings, social participation, and exercise. Importantly, this shift in acceptance demonstrates how people's experiences of stigma evolve as individual values shift in response to the emergence of positive sentiments related to social interaction and physical well-being.

Summary

Three key threads run through the literature. Firstly, AA are framed ambivalently: they can support independence, safety and participation in later life, yet they are also saturated with ageist meanings that mark ageing as a deficit. Within the literature, AA are often treated as signs of frailty and burden, leading to older people refusing them as a way to protect their valued identity of competence and autonomy. Secondly, the literature demonstrates how power differentials shape both the prescription and design of AA. Health

professionals, family members, and policymakers often shape decisions on behalf of older people, from assessing needs and prescribing devices to determining which products are fundable and therefore available. Designers and manufacturers similarly hold power over what kinds of bodies and environments are imagined in the design process, often privileging functional and cost-containment priorities over aesthetics, comfort and the diverse contexts in which AA are used. These dynamics can limit older people's consumer power and constrain opportunities to articulate and act on their own preferences.

Finally, ageing itself emerges as a denigrated social identity that interacts with these power relations. AA are tied to stereotypes of decline, dependency and risk, so that taking up a device may feel like "becoming old" in a negative, socially devalued sense. The literature on identity, stigma and private/public spaces shows older people working to negotiate these tensions: some resist devices that threaten a desired self-image, others adopt them but seek more discrete or aesthetically pleasing options, and many recalibrate their views over time as they balance stigma against participation and wellbeing. Together these threads suggest that older people's apparent lack of autonomy around AA is not simply individual reluctance, but the product of ageist narratives, unequal power in health and design systems, and the limited space given to older people's own meanings and priorities.

What Stories are Missing?

While considerable research on AA use exists, there is a gap in our understanding of how older people negotiate their adoption and use in private and public spaces. While identifying barriers hindering AA adoption is useful, understanding how psychological acceptance is constructed may provide a more illuminating pathway to AA development and integration, as well as a deeper understanding of the consequences of societal influence.

These findings suggest that any framework for understanding AA adoption should consider the complex interplay between social meaning and personal identity concepts that will be central to further research.

Focus of the Present Study

The available literature highlights how AA rejection and adoption can vary across public and private spaces, even when reasons are not explicitly articulated. This raises the question of whether reasons for AA rejection and adoption are implicit in the social identities constructed through social interaction and cultural narratives. The present study, therefore, explores how people make sense of adapting to AA use within the context of ageing, focusing on how the adoption is negotiated in both private and public spaces. In particular, it explores how experiences of using AA are constructed by older people and, in contrast, by OTs, and how these constructions, shaped by power relations and ageist assumptions, may have implications for the acceptance, modification, or rejection of AA.

Chapter 3: Methodology

This study explores older people's experiences with AA within a qualitative framework that emphasises the analysis of contextual and subjective data. Qualitative methods are particularly suited to psychological questions that involve the exploration and analysis of constructed meaning because they analyse rich, in-depth data about people's subjective experiences, perspectives, and interpretations (Camic et al., 2003).

This chapter provides the theoretical foundation for the present study by introducing the key concepts of social constructionism, discussing critical gerontology as an important perspective on ageing, and describing how narrative theory informs both the research methodology and analysis.

Informed by Previous Research

My previous Honours research considered the lived experiences of older people who use AA, resulting in themes and ideas that warranted further exploration. One notable theme was that older people adapt to using AA by utilising other everyday items. Participants used umbrellas and shopping trolleys as a means to blend into society, avoiding the stigmatising stereotypes of old age that they associated with AA. These strategies provide an opening for further understanding and exploration, for example: in what contexts do older people opt not to use AA, and are these decisions place-based or used in certain social situations? How are these decisions made, and why are these strategies used? What items count as non-stigmatising? Other themes included withdrawing from social life and emotional adjustment as part of navigating changes to physical ability. These themes also invite consideration of how AA impedes engagement in social life and how AA use might be anticipated prior to adoption.

The previous Honours research considered older people's experiences after they had adapted to using AA. While this perspective is valuable, after adapting and integrating AA into their daily lives, older people may rationalise their experiences differently (Abri & Boll, 2020). Focusing instead on older people who are new to AA created an opportunity to hear how they view its role in signalling ageing, which reveals potential barriers and challenges to adopting AA that may not be apparent later in the journey. Similarly, including OTs provides insights from the perspective of those prescribing AA, revealing distinct understandings of how AA signals ageing.

Theoretical Framework: Social Constructionism

This study employs a theoretical framework of social constructionism, which proposes that reality is created and maintained through social interactions (Burr, 2003; Gergen, 1992). Social constructionism suggests that knowledge, categories, social norms, and their meanings are actively constructed, emphasising the role of social interactions, shared cultural contexts, and individual experiences in shaping our understanding of reality (Gergen, 2009).

Burr (2003) outlines four key assumptions that form the foundation of social constructionism. Central to this perspective is a critical stance towards knowledge, whereby taken-for-granted knowledge is subject to scepticism. This means being critical about what is typically accepted as truth, and remembering that conventional understandings of the world are shaped by bias; therefore, true objectivity cannot be achieved (Burr, 2003). In the context of the present study, this means questioning prevailing narratives about AA use functioning as a sign of ageing. For example, social constructionism would challenge this notion by examining how signals of ageing are a construction that emerges through interactions

between older people, medical professionals, and family members. Social constructionism, therefore, locates problems away from the pathologised domain of physical gerontology and toward an analysis of how problems are socially located (Burr, 2003).

Furthermore, social constructionism highlights the historical and cultural specificity of knowledge. Social constructionism posits that what is regarded as truth can be viewed as a currently accepted way of understanding the world, which varies across history and culture (Burr, 2003). What it means to age changes over time and varies across cultures. What is currently thought of as a typical life-course transition to retirement is a relatively recent phenomenon of industrial work organisations and labour unions (Atchley, 1982; Minkler & Estes, 2020). Historically, the social ideology of 1800s America did not support mandatory retirement. Labour force participation remained high among older people, and attributes such as wisdom, virtue, and experience were culturally constructed and valued as positive traits during this period (Atchley, 1982). As a result, signs of ageing, such as grey hair and retirement, were often embraced as indicators of accumulated status and respected roles within society, rather than as symbols of decline. In contrast, contemporary contexts that valorise youth tend to associate these signs with negative stereotypes, leading to less acceptance and increased efforts to conceal signs of ageing. In Australia and Aotearoa New Zealand, despite differences in social philosophies, compulsory retirement welfare measures were introduced in the 19th century (Nolan, 2016), making the idea of a set retirement age largely accepted. This policy created the expectation that older age would mean withdrawal from paid employment, with implications for older people's role in public life. These examples demonstrate how the conceptualisation of ageing (both negative and positive) is shaped by the social and economic arrangements of a particular time. In this way, knowledge

is both maintained and changed through language and social interaction in which people are constantly engaged (Burr, 2003).

Moreover, social constructionism asserts that knowledge is not discovered, but created and maintained through social interactions and processes (Burr, 2003). For example, what is understood as *old*, *elderly* or *aged* is not an objective description based on a person's chronological age. Instead, these terms have emerged through the exchanges between older people themselves, their families, healthcare professionals, policymakers, the media, and society. In essence, the meanings attached to being *old*, *elderly* or *aged* are shaped by cultural values, expectations and stereotypes, such as assumptions about frailty, wisdom, or retirement. For example, Amundsen (2022) suggests that how the term *elderly* is framed in online media matters for how messages of ageism are internalised and influence how people of all ages perceive themselves. Social processes play a role in exposing people to and maintaining age-related biases, which are further reinforced by applying these biases to ourselves and others (Amundsen, 2022; Luborsky & Sankar, 1993). Importantly, these framings can change their meaning over time through challenge, discussion and debate.

The assumption that knowledge influences social action is pivotal. Social constructionism suggests that the world is understood through social actions, where different constructions of the world can lead to distinct forms of social action (Burr, 2003).

Accordingly, the ideas and understandings that people hold are closely linked to the way people behave in society. When ageing is predominantly viewed as a process of inevitable functional decline, AA, such as walking aids, or home modifications, are often developed, marketed and funded with the goal of compensating for loss and dependency. This framing may result in products that prioritise safety and functionality rather than supporting autonomy

and self-esteem. The allocation of public funding reflects these underlying assumptions, with resources directed toward remedial interventions. In contrast, where ageing is conceptualised as a period of potential growth and participation in society, there is a shift in providing AA that fosters independence and inclusion. This example illustrates that the way society understands knowledge shapes how it responds through social action, which in turn reinforces or reshapes that understanding. In the context of this research, the use of AA may be interpreted as evidence of lost independence, potentially leading to stigma against people who utilise such aids. What society *knows* about ageing can influence everyday behaviours (e.g., stigma), further solidifying what is *known* or valued in society.

Social constructionism enables the examination of social processes to critique taken-for-granted knowledge. This approach aligns well within the context of the present study, as it considers what might be taken for granted about older age and the use of AA (Burr, 2003). For example, it may seem obvious that functional decline necessitates AA. However, it takes for granted categories of ‘*elderly*’ operating as fixed or natural, rather than as social constructs shaped by cultural expectations and social norms. Some researchers suggest reasons for AA adoption are linked to attitudes, acceptance of functional limitations and beliefs about need (Jaschinski et al., 2021; Latham-Mintus & Clarke, 2019; Luz et al., 2015). While these are important, they lack consideration of the social context in which AA are embedded and their implications for identity. Accordingly, social constructionism is an ideal epistemological stance for the present research, which assumes that the way people make sense of their personal experiences, such as adapting to AA, is inseparable from the social world in which they live.

Critical Gerontology

Critical Gerontology is a multidisciplinary field that critically examines how social, cultural, political and economic forces shape the experience and meaning of ageing in contemporary society. Firstly, critical gerontology encompasses a broad range of theoretical interests, including how issues of power and control shape the experience of ageing in modern society (Estes, 2018; Moody & Sasser, 2018). Critical gerontology is concerned with the construction and deconstruction of ageing (Katz, 2003, 2015). Critique from this perspective has been applied to biology, clinical medicine, and behavioural and social sciences on ageing (Estes et al., 2001). What unites these perspectives is a focus on how later life is organised through social, economic and political arrangements, and on exposing the power relations and ageist assumptions that shape what it means to age.

Critical gerontology challenges the dominance of the positivist research paradigm on ageing, which asserts that objective truths on ageing can be established through systematic observation and measurement (Moody & Sasser, 2018). While researchers generally agree that ageing is a distinct part of the life course, critical gerontologists dispute the definition and perception of what constitutes ageing. Some even challenge the notion of the term 'life course', arguing that it implies a predictable evolutionary course to ageing, overlooking the interpretive meaning-making of events throughout people's lives.

Consequently, a growing recognition of social, behavioural and environmental factors influencing the processes of ageing is largely due to critical gerontology. For instance, *problems* such as dependency in older age often reflect the influence of socially constructed ideas and attitudes about older people and reflect political and economic structures that create dependency in later life. What is *known* about older people through research and subsequent

programs and services is often influenced by these social ideas and structures (Estes et al., 2001).

Recognition of social, behavioural and environmental influences is another key aspect of critical gerontology. For example, critical gerontology posits that health behaviours, such as smoking or physical activity, and environmental factors, like the quality of housing and access to resources, are equally likely to influence how older age is experienced (Chong & Gu, 2021). Therefore, questioning who decides what constitutes a problem, who shapes addressing such problems, and how they compare with the experiences of older people are critical to the present research. Understanding AA use requires attention to the interactions, cultural meanings and societal rules that shape how ageing is experienced – factors that extend beyond what can be captured through language alone.

Critical gerontology aligns with social constructionism and emphasises the view that experiences of ageing are constructed through social processes that can produce an imbalance of power between social groups (Chong & Gu, 2021). As Baars et al. (2006) discuss, age is used as a tool for political power and control, citing the example of disengagement theory by Cumming and Henry (1961), which conceptualises ageing as an inevitable process of social withdrawal, often linked to the retirement age of 65. However, from a critical gerontology perspective, this account largely overlooked the political context of the time, namely the standardisation of retirement at age 65. In the United States, for example, mid-20th-century social security and pension schemes were designed around mandatory retirement at age 65, so that retirement age was not simply a marker of chronological ageing but a product of political decisions, signalling society's expectation that older people would step back from the labour market (Baars et al., 2006, 2016). By presenting withdrawal from social and

economic roles as both natural and beneficial, disengagement theory can be seen as deflecting attention away from these underlying social and political forces and towards individual ageing itself.

The epistemological alignment of critical gerontology is well-suited to the current study, as it focuses not only on older people but also on how political and socioeconomic forces shape their experiences. In contemporary society, increasing economic inequalities, shifting welfare policies, and the impact of globalisation have compounded the challenges of ageing, especially regarding living standards, life expectancy, and expectations for daily living. Recognition of these forces underscores that age-related outcomes are more than a naturalistic process of ageing (Baars et al., 2006, 2016).

Methodology: Narrative Inquiry

Given the exploratory nature of the research questions and the aim of understanding older people's experiences as socially mediated, a qualitative research design is appropriate. Informed by critical gerontology and social constructionism, this research challenges traditional assumptions about ageing and examines how societal norms, cultural values, and institutional structures shape experiences. Given this epistemological and theoretical background, a methodology that critically examines how social processes shape the stories people tell was appropriate. As Hydén (2014, p. 798) describes, "human beings are constructed by stories and are storytellers by nature". Accordingly, narrative inquiry emphasises the experiences people embody and express within cultural, social and political narratives (Clandinin et al., 2018). Valuing the temporal dimension of lived experiences and meaning-making processes, narrative inquiry privileges stories as legitimate in their uniqueness (Bradbury, 2017). These stories are not merely personal; they also reveal social

processes, exposing how broader social understandings, institutional practices and power relations mediate individual experiences of ageing, therefore offering critical insights into the interplay between personal narratives and the societal structures that shape them.

Narrative inquiry was chosen for its ability to consider stories in context. For example, using talk, narrative inquiry orders events into a sequence in which characters and locations are positioned within a series of unfolding events (Bamberg, 2021). Narrative inquiry is well suited to the present research for its ability to examine the ways older people use narratives to account for their experiences, position themselves in relation to others, and reconstruct their sense of self as they integrate AA into their lives.

Exploring Narratives

Narratives are central to how people make sense of the world. While the term *narrative* can refer to various levels of text and talk, within psychology, narratives are considered long sections of talk of a life in context that develop over the course of either one or more interviews (Riessman, 2008). Within ageing research, these are also referred to as *big stories* or biographical narrative content, which help to explore the content and structure of important life episodes and how these stories contribute to the construction of a person's sense of self over time. Big stories are instrumental in understanding how older people interpret their past experiences, which shape their current identity and worldview (Phoenix & Sparkes, 2009). These are distinct from *small stories*, which are every day, mundane occurrences. Paying attention to the different kinds of stories people tell reveals complex processes of identity construction and ageing.

Narratives offer a way to organise events and their meaning by shaping them into a structured plot. By connecting the beginning of a story to the end, narratives bring a sense of

order to otherwise expansive concepts and details (Murray, 2003, 2017). The order and meaning of narratives provide context for how the social world is experienced; they express how people interpret and enact social identities, values, and power within a specific context, revealing both the overt and hidden rules that shape social life. The sequencing and structure of a story can reflect people's assumptions about the social world. For example, an older person may describe their experience of having to use a walking aid as a result of falling by first acknowledging embarrassment (reflecting society's stigma about decline and dependence), followed by support from an OT and seeing others use AA, and finally, beginning to view the walking aid as a tool for staying mobile. This narrative structure conveys not only what happened but also how cultural values shape how events are understood and recounted. While prototypical, this story illustrates how cultural attitudes and narrative order can shape personal experiences of ageing and AA.

Narratives include distinct features: they are chronological, in that they recount events that occur over time; are made meaningful by the narrator, who provides structure; and are social, in that they are shared by and with others (Murray, 2003, 2017). For example, an older person might recount their journey of adapting to life with reduced mobility by describing the initial challenges, the decision to use AA, and how this change was supported or discussed with family and friends. Through their telling, the narrator organises these events in time, makes sense of what happened, and shares their evolving identity with others, turning personal experience into a meaningful, social story. Narratives provide a window into how individuals perceive themselves, as well as the cultural meanings and social forces that shape how people story their worlds (Stephens & Breheny, 2013). For example, the storyteller must decide what is deemed relevant to the story, choosing to leave out parts that are unable to be expressed via language. Conscious decision and intentionality are present in how stories are

constructed in time and place, and there is an interplay between the form and content of the constructed story (Bamberg, 2021).

Scholars largely agree that the way stories are told are typically ordered temporally and spatially, by looking back at a single topic and recounting it within a particular time and place. However, Riessman (2008) notes that plots can be ordered temporally or episodically. For example, Riessman (2008) describes how school-aged children of colour constructed stories comprising several linked episodes, each connected by themes that shifted across time and place. This demonstrates the diverse forms of storytelling and highlights the importance of paying attention to the different narrative styles people use, as well as hearing narrative forms that differ from our own in the process of interview conduct and interpretation. Attention to the structure and presentation of narratives provides insight beyond what can be learned from referential meanings alone. For example, factual details across two different stories could be identical, but this does not mean their experience will be the same. How stories are presented and organised gives insight into unique experiences and perspectives.

Finally, narratives are useful for hearing how people construct meaning about life events, particularly when those events are in breach of a person's ideals and reality, or their sense of self and society (Riessman, 2008), making them a particularly relevant approach when considering adaptation to an AA. Through stories, people tell us who they were and who they are becoming and how AA plays a role in that becoming.

Narrative Interviews

The primary way to collect people's narrative accounts is by utilising an interview setting. While other interview techniques might present an idea or theme with carefully crafted questions to guide the participant, narrative interviews make narrative accounts

central to the interview process. Narrative interviews are largely unstructured, allowing participants to describe their experiences in their own time and with as little or as much detail as they are comfortable with. The goal of narrative interviews is to generate a detailed account rather than concise answers. Hydén (2014) advocates for this approach using the term *teller-focused interview*, which fosters processes of co-construction, supporting and expanding narratives. This approach incorporates the use of open-ended questions that encourage participants to explore topics, rather than those that elicit concise answers, allowing them to construct answers in ways that are meaningful to them. For example, the present study asked, “*What is it like to begin the process of accessing assistive aids*”? This question encouraged participants to begin at the beginning and describe their experience over time.

While the researcher may take a less central role in the narrative interview than in other interview approaches, it is important to note that personal stories are co-created in the interview context. In this way, narrative interviews can be considered a form of potential social action (Murray, 2017). The interviewer and interviewee are both active participants who together construct narrative and meaning (Riessman, 2008). This approach requires an awareness of how the researcher may shape the narrative. For example, following up specific components of a story or asking for something to be explained in more depth allows participants and the interviewer to develop narratives collaboratively. Equally, the imagined audience of the analysis may also shape how questions are asked and how the narratives are interpreted. Importantly, the interviewer’s personal characteristics shape the interaction, as participants craft their stories for the particular listener. Stories are recipient-designed, meaning an account shared with a young, white researcher will differ from one told to a close friend (Riessman, 2008). In this way, age difference may influence the relationship between

the participant and the researcher (Wong & Breheny, 2018). For example, during an interview, an older participant remarked: *“Even at my age, and it’s very hard, you’re young and beautiful. There are pictures around here of me in bikinis and all that, and I got a lot of attention. You get to an age. The only interesting part about me, for men, is my house”*. This participant draws attention to the age difference between herself and the researcher, highlighting that the researcher may not fully grasp what it feels like to grow older.

Although the present research has a focused question, narrative interviews follow participants along their story pathways, which involves creating a space where participants can direct the flow of the interview and tell stories that reflect their experiences (Riessman, 2008). In this way, participants are encouraged to be the storyteller while the researcher refrains from interrupting or suppressing expressions of participants’ stories (Murray, 2003, 2017). Given the often deeply personal nature of stories about ageing and AA, narrative interviewing requires empathy and support during the interview process (Murray, 2003). Riessman (2008) further illustrates this point by suggesting that the wording of a question is less important than the emotional attentiveness, engagement, and degree of reciprocity the interviewer provides during the conversation. Bamberg (2021) highlights empathy as a condition for narrative inquiry, enabling participants to feel comfortable speaking about their experiences. This is particularly salient in the context of ageing and acquiring an AA as participants come to terms with this personal adjustment to their lives.

Consideration of how interviews are conducted is another important component of narrative analysis. This includes arranging interviews at a time and place that are convenient for the participant, paying attention to how the interview setting may influence the content and structure of the narration, and forming relationships with the interviewee (Ruthellen &

Hammack, 2021). Convenience for the interviewee encourages personal responses. For example, positioning both the interviewer and interviewee in a setting where they are most comfortable allows for a relaxed narrative discussion, whereas an interviewer behind a desk in an office building might signal a desire for more formal responses (Ruthellen & Hammack, 2021). In addition, Hydén (2014) suggests a focus on the relationship between the interviewer and the interviewee by taking responsibility for ways to support the storytellers. For example, the two parties are considered partners with distinct tasks and responsibilities, while remaining aware of the power dynamic between the researcher and the participant. These characteristics of narrative interviewing mean it is well-suited for the present study, as it enables in-depth exploration of people's personal experiences with ageing and AA, capturing both the context and the social context that shape people's everyday lives.

Narrative Analysis

Narrative analysis enables the examination of the stories people tell and what they reveal about cultural rules, human meaning-making and the structures of their social world. Narrative analysis is an inductive method that contextualises understandings in relation to the narrative as a whole. This involves examining people's stories and the patterns that naturally emerge from the data, and attempting to understand them within the context of the entire narrative, including characters, events, and structure, as well as the social and cultural contexts of the participants (Ruthellen & Hammack, 2021).

It is generally acknowledged within the human sciences that the researcher does not discover narratives but instead participates in their creation through a complex interplay of interview, transcription and interpretation (Mishler, 1991; Riessman, 2008). Furthermore, the interviewer does not have access to the speaker's emotions or motivations, but only to the

story as the participant tells it. In this way, narratives are both event-centred and experience-centred; for example, narratives do not just describe an event happening in the world, but what the world does to that person. This facilitates understanding of the subjective experience of that story world. Narratives do not just refer to past experiences; they also create experiences for their audience (Riessman, 2008). During the process of transcription and interpretation, it is important to acknowledge that access to knowledge about the participants' experiences is mediated. The researcher does not have access to the original, real-life events or experiences, but rather a version tailored for a specific purpose or audience. Researchers have access to narratives that are constructed by socially situated people from a particular perspective and for an audience. Analysis, therefore, requires critical examination of how the narrative is structured and interpreted (Riessman, 2008). For example, the researcher's decisions shape how the data are produced from particular perspectives and influence the focus and direction of the inquiry.

To illustrate how narrative analysis works, Riessman (2008) uses the analogy of music: a piece of music is composed of component parts, such as individual instruments or musical phrases. Each has a function in the overall composition, ultimately forming a cohesive song. Narrative analysis requires a similar level of scrutiny in that researchers pay attention to the component parts of a narrative account to notice form and language. According to structural approaches to narrative analysis, six elements form a narrative structure including: a summary or "point" of the story; orientation to time, place, characters and situation; complicating action (the sequence of events or plot); evaluation (where the narrator steps back from the action to communicate emotion or make meaning from what they are saying); resolution or outcome of the plot; and a coda which is the ending of the story and bringing action back to the present time (Labov & Waletzky, 1997; Riessman,

2008; Ruthellen & Hammack, 2021). Importantly, not all stories will include all of these elements, and they can occur in varying sequences (Riessman, 2008). Keeping these elements in mind helps to recognise how narrative is structured with the complicating action and the evaluation being the focus of interpretation. Focusing on the structure rather than specific parts of the narrative orients the analysis to the form of the narrative (Ruthellen & Hammack, 2021). For example, acquiring an assistive aid may be a narrative of regression away from appearing and feeling young or a narrative of progression toward acceptance. Further, it is important to analyse how the speaker composes their stories, not just what they say. This step involves paying attention to sequence and narrative structure to avoid missing important differences in the meaning of similar events for different participants (Riessman, 2008). This approach to analysis ensures that both thematic similarities and broad patterns are captured, as well as the variation in meaning across participants. For example, there might be a broad theme around the acceptance of ageing when using an AA, but this may be experienced differently across participants. Another key component of analysis is the way the researcher can analyse narratives. Narratives can be analysed across a group of stories or common thematic patterns across participants or as an overarching narrative of each participant.

Narrative and Identity

Narrative can be used to organise long sequences of events that include our own experiences and activities as well as the actions of those around us. The ability to form narratives enables people to construct experiences in a way that is meaningful, intentional, and continuous over time (J. Elliott, 2005). Narratives are also used to build a sense of self by

creating and evolving a personal life story (McAdams & McLean, 2013). It is through narrativity that we constitute our social identities (Somers, 1994).

As people move through later life, many accounts describe efforts to maintain a sense of continuity in who they are, while simultaneously navigating change, making narrative and identity particularly suited to the present study (J. Elliott, 2005; Gergen & Gergen, 1988). Narrative identity is particularly useful in ageing research because it provides a framework for understanding how people make sense of their life experiences over time, especially as they encounter age-related changes and challenges (J. Elliott, 2005; Gergen & Gergen, 1988). For example, a narrative of a life experience, such as acquiring an AA, involves restructuring and reconfiguring past events in light of the present, as age and physical ability change and evolve. For example, upon leaving an interview, one participant drew attention to photographs on the wall of her past, in which she was wearing a bikini in one and dating a Formula One driver in another. In this way, she was drawing attention to her past as youthful and desirable. A continuity of self through time makes us accountable for past actions, yet it is also what is expected of others (J. Elliott, 2005; Gergen & Gergen, 1988). In this way, narratives can be used to hear how people make sense of AA, and how changes in health or ability disrupt their sense of self.

Quality and Validity

Criteria for quality research that is valid, objective, reliable and generalisable are often situated within an empiricist positivist paradigm predicated on assumptions such as the existence of universal cause-and-effect relationships, the potential for research to be conducted in a bias-free and context-free manner, and statistical power in quantitative inquiry (Bamberg, 2003; J. E. McGrath & Johnson, 2003). These quality criteria for quantitative

research do not translate to qualitative constructionist research, which foregrounds knowledge as situated, contextual and changing. However, good qualitative research relies on several guiding principles such as subjectivity, reflexivity, contextual validity, and generality (Marecek, 2003).

Firstly, subjectivity is recognised as an inescapable component of qualitative research, in which personal perspectives inevitably influence the research and its outcomes. Rather than attempting to eliminate them, subjectivity should be explicitly acknowledged, which enhances the richness and authenticity of the research findings. Further, empathy has been proposed as an important precondition for narrative inquiry and for the induction of quality data so that participants' subjectivities are able to "speak" and can become heard (Bamberg, 2021). Adhering to these principles involves taking a reflective stance that recognises that the conduct of research is shaped by the researchers' personal histories and social locations.

Another crucial aspect of quality in qualitative research is contextual validity. Unlike traditional notions of validity, which often focus on internal consistency or statistical criteria, contextual validity is about the extent to which the research captures the richness and specificity of the social environment in which the phenomena occur (Marecek, 2003). According to this principle, researchers should consider relevant contextual factors such as cultural norms, political influence and economic conditions. For example, in the context of AA use, cultural attitudes toward ageing should be considered a real-world context that may affect how older people perceive, discuss, and use these types of devices.

Furthermore, narratives are not simply reports of experiences but make sense of and subsequently alter those experiences, which some scholars view as an advantage of a qualitative approach, as it focuses on an individual's subjective interpretations and the

meanings they make of their lives. Accordingly, validity is improved because participants are empowered to provide details about the topics discussed within a context in which they feel comfortable describing their experiences (J. Elliott, 2005). In this way, narrative interviews give meaning to experiences rather than merely reflecting them. The focus is on the meanings attached to older people's experiences and the way they are communicated, which provides understanding of their lives in a social context (J. Elliott, 2005).

Finally, generality refers to the broad applicability of insights derived from specific cases; unlike generalisability, it does not imply that results can be applied to a larger population. Instead, generality involves the ways in which detailed, context-rich findings can inform the community in which they are situated. For example, the present research may be beneficial for OTs, designers of AA equipment and older people as a way to provide specific and detailed knowledge about how older people construct meaning about ageing and AA use.

Reflexivity

Using a constructionist lens, people's worlds are the focus of the research, and the researcher interprets how these worlds produce particular realities within the culture of the stories told and heard (Willig & Stainton Rogers, 2017). This approach posits that language does not mirror a world *out there*; rather, it is used to construct realities. Therefore, any knowledge produced in social constructionist research reflects the researcher's positionality, and this should be critically questioned (Willig & Stainton Rogers, 2017).

Reflexivity involves actively acknowledging one's own subjectivity, including personal biases, and considering how these factors shape research decisions, data collection, and interpretation (Marecek, 2003). This principle enhances the integrity of the analysis by ensuring that a range of possible interpretations are considered and by acknowledging how

the researchers' position has influenced the interpretive process (Ruthellen & Hammack, 2021). For example, the present research was inspired by the personal lived experience of a father who actively rejected AA. This experience has the potential to shape biases about how AA might be experienced for older people, including views of AA as negative. Reflexivity includes reflecting on the developing interpretations of data and being mindful of seeking out patterns that confirm these biases. However, while reflexive awareness is important in becoming open to what might influence the research, it is of equal importance not to divert attention away from the subject matter onto the researcher. Rather than providing details about the researcher's experiences and the research itself, it is about producing an analytical discussion of how theoretical and biographical perspectives might impact the relationship with participants, the interpretation of their stories, and the form in which the research is presented (Riessman, 2008).

Furthermore, qualitative data do not exist independently of the researcher's perspective. This is because the interest in the research and its associated questions are formulated within a historical and societal context, which brings perspective to the analysis (Bamberg, 2021). Consequently, reflexivity is an important consideration in social constructionism and narrative research. Being reflexive requires a self-critical dimension to the subjective conditions of conducting research and prioritises the inevitable impact the researcher has on data collection and analysis, including how the researcher may shape the narrative (Shaw, 2010). In the context of the present study, my personal interests in ageing are situated within my experience of my Dad's rapid ageing and need for AA. The co-constructed nature of narrative analysis means that the interview is a performance in which two social actors engage in dialogue, whereby the analysed text is not considered *truth* but

rather speech, produced spontaneously in response to the interviewer (Ruthellen & Hammack, 2021).

Journals or memo writing are one way to practice reflexivity. This practice involves a clearly identified context in which the researcher records their meaning-making process as the research unfolds. Writings can include feelings, insights and nonverbal and nonrecorded comments. For example, an interview filled with laughter or one that includes emotional expression may not be captured in a transcript, but these are valuable features of the interview that are crucial to analysis (Ruthellen & Hammack, 2021).

These practices enable the knowledge produced during narrative analysis to be situated in a contextual encounter that aligns with the tenets of social constructionism, which views knowledge as historical, contextual, and produced within the boundaries of language and power (Ruthellen & Hammack, 2021). Reflexivity, viewed through a social constructionist lens, highlights the inseparable influence of the researcher on qualitative research, in which historical, societal, and personal contexts shape both research questions and analyses. Researchers interpret the diverse worlds constructed by participants' stories, recognising that language itself actively creates reality. Ultimately, reflexivity situates knowledge as contextually produced.

Summary

This chapter has outlined how social constructionism and critical gerontology together provide the epistemological and theoretical grounding for the present study, positioning ageing and AA use as socially produced rather than natural or self-evident phenomena. Social constructionism foregrounds how meanings of “old age”, “decline”, and “dependence” are historically and culturally situated, sustained through language and

interaction, and linked to particular forms of social action, including the framing, prescription and design of AA. Critical gerontology extends this lens by highlighting how political, economic and institutional arrangements, such as retirement policies, welfare structures and biomedical narratives, embed power relations and ageist assumptions in everyday experiences of later life.

Within this framework, narrative analysis offers a methodological approach to examining how older people and OTs narrate ageing and AA use over time, revealing how identities, relationships, and power are negotiated. Narrative interviews and narrative analysis make visible the co-constructed nature of people's accounts, providing important context and revealing the multiple narrative forms through which people organise change and disruption in their lives. Attention to quality, validity and reflexivity ensures that the knowledge produced is understood as situated and partial, shaped by my positionality and the interview encounter, rather than as a neutral reflection of an underlying reality. Taken together, these approaches position the present study to explore how meanings of ageing and AA are constructed, contested and lived.

Chapter 4: Method

The present research examines the beginning of the adoption journey from two important perspectives: older people approaching eligibility for AA support (aged 65+) and OTs who are instrumental in prescribing and implementing AA for older people. The present study utilised semi-structured narrative interviews and narrative analysis, in which participants were encouraged to describe their specific experiences of ageing and AA use in both private and public spaces. Including these two distinct groups aimed to provide a nuanced perspective on the social meanings of AA in the context of ageing.

Older People

Participants

The inclusion criteria for older people were adults 65 years or older living in South Australia, who were considering or in the process of acquiring one or more AA, including equipment that supports daily living, such as walking frames, adaptive utensils for tasks like eating, writing, gripping, rails, and adaptive equipment for using the bathroom or showering. Concentrating on the lead-up to adoption for older people provided an opportunity to look at how people construct meanings about AA early in the adoption process or before they have experienced them. This means older people have had less time to adjust to and adapt to their use, providing a greater opportunity to hear stories about their views of how AA contributes to signals of ageing. This also provides access to potential adoption barriers and challenges that might be less obvious later in the process. While the age restriction was designed to capture older people at the beginning of the AA journey, chronological age is a rudimentary approach to meeting study eligibility requirements. From a social constructionist standpoint, taking a critical stance on knowledge requires acknowledgement that an age restriction can be

susceptible to the exclusion of some minority groups. For example, in Indigenous cultures such as Māori, Aboriginal and Torres Strait Islanders, life expectancy is estimated to differ by up to 12.5 years and 7.3 years compared to non-Indigenous populations, respectively (Phillips et al., 2017). This results in Māori, Aboriginal and Torres Strait Islander people being less likely to reach old age than the general population. Indigenous Australians experience significantly higher rates of chronic disease and functional decline from earlier ages. For instance, multimorbidity (defined as two or more chronic conditions) is over ten percentage points higher for Indigenous Australians than non-Aboriginal Australians from as early as age 25, and this difference exceeds 20 percentage points by age 40 to 79, with chronic conditions such as diabetes and kidney disease not only more prevalent but also occurring at younger ages. This earlier onset of morbidity means Indigenous people often experience disability and health problems commonly associated with ageing, some 5 to 10 years before their non-Indigenous counterparts. Similarly, Māori experience mortality rates nearly twice those of non-Māori across both rural and urban environments, and higher rates of earlier-onset chronic disease and functional decline (Cotter et al., 2012; Randall et al., 2018; Yon & Crimmins, 2014).

While the age limit was set at 65 years old to include people at the beginning of the AA journey, it is also lower than the typical age at which people in Australia access MAC support. The largest group of new MAC users is aged between 80 and 84 years (23%), with a median age of 81 years in 2024 (Australian Institute of Health and Welfare, 2024). While this study does not explicitly target minority groups, using a broad eligibility criterion not only captured people considering an AA, but it also increased accessibility to a broader population base.

Participants were not asked to report their ethnic identity as this was not a focus of the study, nor was the data intended to be analysed by ethnicity. Participants were encouraged to describe any aspect of their personal, cultural, or social context that was relevant to their experiences of acquiring AA.

Recruitment

Older people were recruited through a targeted Meta advertising campaign using Facebook (Appendix G). The campaign included a series of advertising sets (Reels and Facebook Feed) with a *send message* call to action. People who clicked the ad received an automated Facebook Messenger prompt containing the inclusion criteria, which served as a vetting process. If potential participants met the criteria, they were sent the information sheet (Appendix A). After confirming eligibility for the study and answering any questions, the interviews were scheduled. The participants are presented in Table 1 below alongside their age and type of AA used.

Table 1

Participants: Older People

Participant	Gender	Age	Assistive aid/aids
Participant 1	Woman	65	In the process of considering a walking aid, self-installed rails in bathroom
Participant 2	Woman	66	In the process of acquiring rails in the bathroom
Participant 3	Man	67	In the process of acquiring an adjustable chair

Participant 4	Woman	70	Walking frame, in the process of acquiring an adjustable bed
Participant 5	Woman	68	Walking frame, walking stick, kitchen aids
Participant 6	Man	69	Ramp, in the process of installing rails.
Participant 7 (<i>wife of Participant 6</i>)	Woman	69	Ramp, in the process of installing rails.

Interview Procedure

Interviews were conducted from June to August 2025 and ranged from 30 to 190 minutes. Interviews were conducted using a semi-structured conversational approach. Before the start of the interview, participants were reminded of the nature of the study, informed that the interview would be audio recorded, and offered the opportunity to ask further questions before completing the consent form (Appendix C). After providing written consent, demographic (age, gender) and AA details were collected. Interviews were conducted face-to-face in participants' homes or in preferred public spaces, such as a café, thereby allowing older people to discuss their experiences with AA in familiar contexts. Participants were asked to share stories of their experiences of acquiring AA to understand how they construct their experience of AA use, including what *truths* about these experiences are constructed, what are their consequences in a public setting, and how do these constructions affect what they say, feel or do. The opening question intended to encourage a narrative account and description of experiences of acquiring AA, for example: "Can you tell me what prompted you to think about getting an assistive aid?" An interview question guide was utilised and included follow-up questions and phrases to prompt responses (see Appendix D). Occasionally, participants were encouraged to provide more detail to their stories, for example: "Could you tell me more about what you mean by that?".

Participants received a \$30 AUD voucher to recognise the time and effort invested in participating.

Occupational Therapists

Participants

The inclusion criteria for OTs included those living and working in Australia who specialised in working with older people (aged care clients) and had experience supporting older people in acquiring AA devices or home modifications. OTs were invited to contribute to the research through professional organisations and social media occupational therapy interest groups. In Australia, OTs providing community-based support to older people must be registered to provide services through MAC. Once older people have undergone eligibility screening and assessments to determine the appropriate level of support, an OT will then carry out the implementation process of AA.

As was the case with older participants, OT participants were not asked to report their ethnic identity but were encouraged to describe any aspect of their personal, cultural, or social context that was relevant to their experiences working with older people in the context of AA and home modifications.

Recruitment

OTs were recruited through LinkedIn, personal networks within South Australia and a targeted Meta advertising campaign using Facebook. Emails were sent with a brief description of the study, a copy of the recruitment poster (Appendix B), and the information sheet (Appendix F). The participants are presented in Table 2 below, along with their roles.

Table 2

Participants: Occupational Therapists

Participant	Gender	Role
OT 1	Woman	Private Occupational Therapist - Home Care Package Provider, Department of Veterans' Affairs Provider
OT 2	Woman	Hospital setting Provider
OT 3	Woman	Private Occupational Therapist
OT 4	Woman	Registered Occupational Therapist Working in Retirement Village
OT 5	Women	Registered Occupational Therapist Working in Aged Care Strategy

Interview Procedure

Interviews took place from July to October 2025 and ranged from 45 to 60 minutes each. OTs were interviewed over Zoom to provide flexibility within existing work commitments. Prior to the interview commencing, OTs signed a consent form (Appendix C). After providing written consent, demographic (professional role, gender) was collected, OTs were invited to share stories of their experiences of prescribing AA to older people and included questions such as “what it is like to support older people to access assistive aids?” and “can you tell me how you approach working with older people when it comes to prescribing assistive aids?”. An interview question guide was utilised and included follow-up questions and phrases to prompt responses (see Appendix D). OTs received a \$30 AUD digital voucher to recognise the time and effort invested in participating.

Transcription

For both participant groups, audio-recorded interviews were individually transcribed in full verbatim using Otter.ai on an iPhone 14 Pro Max and analysed using NVivo 15 for Mac. The audio was listened to several times for familiarisation purposes, and each transcript was checked for accuracy. Transcripts were edited to remove repeated words and utterances such as “I I” and “so and so I”. Omitted words were added using square brackets to provide context, for example: “if I go out with these on which, depending on how my hands are, people can treat you differently” was transcribed as: “if I go out with these on [hand braces] which, depending on how my hands are, people can treat you differently”. Non-linguistic features such as emotion, facial features, and gestures were added using brackets, for example: “Oh,

you look at some things other people do and you go (rolls eyes)”. Including these non-linguistic features is important for providing context and significance, which is otherwise obfuscated in the transition from spoken talk to audio recorded and therefore reliant on the author to ensure they are captured (Riessman, 2008). The data comprised audio recordings, written transcripts and reflexivity memos from semi-structured narrative interviews with seven older people (six interviews) and five OTs.

Ethical Considerations

This research involved several ethical considerations, including risk level assessment, informed participant consent, potential for distress, participant confidentiality, and data storage protocols. Each ethical consideration is discussed in turn.

A risk assessment was conducted in accordance with the Massey University Research Human Ethics Committee guidelines, which included a set of screening questions to determine whether the research was low or high risk. After answering the screening questions, the project was categorised as low risk. Prior to interviews, each participant was fully informed about the research and their rights. Those who expressed interest in participating were provided with an information sheet that explained in detail the nature of the research and outlined confidentiality, data storage, and participant rights (Appendices A and B). The information sheet clearly outlined participant expectations, including the option to seek further information without expectation of participation. A potential risk associated with the research was the associated emotional distress when talking about the use of AA, which are not always *assistive* and can result in ageism, disempowerment and stigmatisation. In the unlikely

event of participants experiencing discomfort or distress when talking about their experiences, they had the option to withdraw from the study and be provided with local mental health support. Participants were advised at the beginning of the interview that they were free to decline answering any questions they did not wish to answer and could ask for the recording to be stopped at any time during the interview. If participants withdrew from the study for any reason, they would still receive the \$30 AUD voucher. Participants were reminded that their names would not be used to maintain privacy and confidentiality.

Participant data has been stored in keeping with Massey University's Code of Responsible Research Conduct. Consent forms, digital audio recording files and transcripts have been stored securely and separately on a password-protected computer using Massey OneDrive, only accessible by the named researchers. These people were the researcher and research supervisor, Mary Breheny. The hard-copy consent forms were scanned, and the physical copies were subsequently securely destroyed by a professional shredding service. The data will be retained for five years as required by section 13 of the General Disposal Authority and subsequently destroyed once the retention period has elapsed.

Narrative Analysis

Narrative analysis was conducted following the methodology outlined by Murray (2021), Riessman (2008), Ruthellen and Hammack (2021) and Stephens and Breheny (2013). Data was coded according to both how stories were told and the sequence of events. Analysis was conducted across multiple levels of meaning,

including personal stories (particularly those related to identity and ageism) and broader cultural narratives (Stephens & Breheny, 2013).

Transcription and coding provided an opportunity for immersion into participants' stories, while the NVivo software allowed for transcript highlighting and organising of transcript sections. Familiarisation with the transcripts over time allowed for commonalities and differences to emerge. During the coding process, notes were taken of any ideas that stood out. For example, OTs frequently emphasised objective, practical benefits of adopting AA, such as improved safety, while largely overlooking emotional and social considerations that may also influence adoption decisions. Coding of each dataset (older people and OTs) was conducted independently to allow each dataset to reveal its own unique narratives without being influenced by the other. The data from older people were coded before the data from OTs. After coding, stories that shared thematic similarities were identified and grouped; themes that closely aligned with the research question were then used to inform the final analysis.

Analytic Reflexivity

Reflexivity was conducted as a process of self-reflection. A reflective journal formed part of the analysis to keep track of impressions as the research progressed. Reflexivity memos provide fidelity to the analytic process by making explicit how the interviewer experiences the participants' narratives throughout the research (Ruthellen & Hammack, 2021). Reflexivity memos were written following each interview, providing context of meaning-making throughout the research process. This method allowed for a way to take note of non-verbal cues and components that were not

recorded, such as body language or the encounter prior to the recording device being switched on. This was also important for considering how the researcher was positioned in relation to the research question and the participants. For example, how I, as a younger person, experienced views of ageing through a different lens than participants who are living through the process of becoming *old* through the acquisition of AA.

Mauthner and Doucet (1998) argue for a methodologically explicit approach to reflexivity and data analysis. A set of strategies taken on for the present research included: reading for the plot and one's own response to the narratives; reaching for the active *I*, referring to who is telling the story; reading for the participant's relationship with family, friends and healthcare professionals (namely OTs) and reading for the broader social and cultural context of the participant. The first reading comprised sense for the overall story, e.g. how AA became part of an older person's life or how an OT helped someone acquire an AA. Further, explicit attention was given to my response to the narrative, which consisted of placing myself within the narrative with my own history and experiences in relation to the participant. I paid particular attention to my emotional response to the narrative by keeping notes. This included certain elements and phrases that stood out, allowing for an examination of how and where my own assumptions and views might affect the interpretation of the participant's story, as well as how the participant is written about.

In the analysis phase, I became aware of the co-construction process and the ways in which participants tailored their stories for me as the listener, for example, the participants developed their accounts and their *self* specifically for me as the listener,

a white Western woman who was young in comparison with the older participant cohort, and untrained in the field, as was the case with the OTs. Different audiences would have different assumed shared knowledge, which would shape how they develop their accounts.

Another component of reflexivity was the active process of providing pseudonyms to participants. Typically, the researcher assigns a false name, or participants choose a pseudonym, to protect their privacy and confidentiality. In engaging in self-critique, there was an uneasiness with assigning names, as they have the potential to locate participants' sociohistorical concepts in terms of culture, identity, and age, potentially reinforcing ageist stereotypes. For example, the act of conducting a Google search for 'old person's name' commonly returns names such as Beatrice or Albert, which in a Western context are widely associated with older generations. This reinforces ageist assumptions by automatically linking certain names to older age, contributing to the stereotyping of older people as distinct from other groups. To mitigate this, numbers were used, as they help remove some of the meaning that names carry within a particular analytical context while allowing the identification of recurring stories within a participant's narratives.

Additionally, the way in which the analysis was ordered was an active process of consideration. The older people cohort is presented first, to prioritise the voices of those who experience AA first-hand. Furthermore, older people spoke of their experiences of ageing and ageism as a way of providing context for the adoption of AA. In the process of writing up the analysis, AA could not be understood without first understanding older people's experiences of ageing and ageism. Within the data,

AA represented a signal of ageing and, therefore, these devices were often resisted or avoided. AA became increasingly respected by older people as an essential tool for remaining independent as their bodies declined with age. The analysis is organised in this way because understanding how AA are experienced cannot be adequately explored without first understanding how people make sense of ageing and ageism. For example, older people used the narrative “the more you give up, the older you get”, which shaped how they understood and gave meaning to the use of AA. Participants saw ageing as something they could control through lifestyle choices and health behaviours in order to avoid outward signals of physical decline, such as AA. Yet over time, AA was also understood as a tool to help them manage physical decline and preserve their autonomy.

Finally, the OT data set required a more tailored analytic strategy. A dual layer of interpretation became apparent in the way OTs talked about older people: OTs make sense of their clients and their own professional lives through narrative, and the researcher then interprets these constructions. The analysis, therefore, drew on a double hermeneutic orientation, attending to how OTs make sense of their practice with older people and how that sense-making is itself shaped by broader narratives of ageing. Like all stories, these accounts are selective and perspectival, reflecting the power of memory to remember, forget, neglect, and amplify moments in the stream of experience (Reissmann et al., 2021).

Taken together, these reflective practices shaped both how the data were generated and how the analysis was organised. Ongoing memo taking and attention to my positionality made visible the co-constructed nature of the narratives, including

the ways participants tailored their stories to a younger, Western researcher and how my own assumptions might influence interpretation. Choosing numeric identifiers and foregrounding older people's accounts before OT narratives reflected a commitment to minimising ageist stereotyping and prioritising the voices of those living with ageing and AA first-hand. Finally, adopting a double-hermeneutic stance toward the OT analysis acknowledged that their stories, like those of older participants, are partial, perspectival constructions, and that the analysis involves making sense of how different actors make sense of ageing, ageism and AA use.

Chapter 6: Results

Chapter six explores four core narratives along with their sub-narratives. These include two narratives from the older people dataset and two from the OT dataset. “The more you give up, the older you get” describes the experience of getting old and how taking an active role through health behaviours gives older people a sense of control over their own ageing process. “It makes me feel like I’m old, it makes me feel like I’m on the downward spiral” captures ageing as a gradual, one-directional process intertwined with decline and loss, where adopting AA is narrated as signalling the beginning of a more visible transition into old age. “The ugliness of AA represents the ugliness of ageing” explores how OTs describe the underlying reasons they believe older people resist AA. Finally, “I hear from almost every client I see, I just want to stay in my own home” examines the shared goal that OTs describe between themselves and older people.

Older People

Narrative One: “The More You Give up, the Older You Get”

The narrative “The more you give up, the older you get” frames ageing as under individual control. Participants used this narrative in various ways to construct ageing not as a passive process that happens to them, or an inevitable consequence of time passing, but as a process they can influence both in how it unfolds and how quickly. Ageing is considered a dynamic process that can speed up or slow down, depending on lifestyle choices. They describe ageing as being able to be delayed by making the *right* decisions about their physical and mental health. For some

participants, taking control of the ageing process was viewed as a priority, while others framed it as a necessity; failing to take control was linked to rapid decline and, in some cases, a fast-tracked pathway into institutionalised care. This narrative of taking control produced tensions in their acceptance of or resistance to AA. Not needing AA was a sign of successfully resisting decline; however, maintaining functionality often included the need to accept and get used to using an AA, serving as a subtle indicator of decline. Two narratives demonstrated the experience of the more you give up, the older you get, including “I Brought it Upon Myself” and “No, I’ve Got to Get Used to it”.

“I Brought it Upon Myself”

Participants conceptualised illness, ageing, and becoming old as factors that can be influenced by health behaviours. Participants used this narrative to explain that their health behaviours could either contribute to ageing or contribute to avoiding functional decline that was understood to represent ageing, including avoiding AA and institutionalised care. Participant 1 characterised her husband as someone who has been able to avoid AA due to his active lifestyle. In the extract below, in response to being asked if her husband is also thinking about AA, she strongly rejects his need for any mobility support by detailing his schedule of physical activities:

Participant 1: *[Shakes head furiously] No, no, he’ll be 77 next birthday. He’s utterly and completely mobile. He goes swimming. He does 50 laps once a*

week in the local pool. He's in a walking group. He plays tennis twice a week. He's 1000 times better than me. No dramas at all.

Participant 1's response suggests that her husband has a high level of physical functioning due to his active lifestyle. She characterised her husband as someone who is doing a good job at ageing by listing his sporting activities. This is juxtaposed against his chronological age of nearly 77 years. She concluded with “*no dramas at all*”, positioning decline as drama that can be forestalled through an active lifestyle. This narrative characterises people who are willing to commit time and effort to engaging in health-promoting behaviours as being able to control the ageing process. Participant 1 goes on to describe brain health as an essential component in avoiding age-related and genetic decline:

Participant 1: *Oh, it's my Wordle group.*

Int.: *Do you do it every day?*

Participant 1: *Every day, sad but true. So, we don't, we just share, it's good. Oh, she's done it in five. Sometimes I forget, Tony and I sit there and look at each other about nine o'clock at night and think, oh I haven't done it yet! Yep, every day. Gotta do it. I do 4 of them, strands, connections, the mini crossword and Spelling Bee, but don't share that one. I like the way that puzzles. I'm a firm believer in the importance of exercise, as Alzheimer's runs*

on both sides of my family, and I'm a firm believer in exercise, keeping your brain active. I don't have the markers for it, luckily.

Participant 1 explains how she and her friend group do daily online puzzles, which she suggests is important for brain health and is about management rather than pleasure, “*sad but true.*” Her phrase “*Gotta do it*” reinforces that daily puzzles are a brain exercise that should be maintained; this daily, consistent routine is explained as health-promoting. In this way, Participant 1 has reworked interview questions about AA within her relationship to discuss what she thought was important in managing age-related decline. Physical decline was only part of the self she believed she needed to manage; the mind is described as just as important as physical exercise in avoiding age-related decline.

Health behaviours were understood as capable of counteracting even genetic predispositions. Genetic predispositions for illness were not seen as mitigating responsibility for managing their health. Participant 3 describes how a failed medical examination prevented a career as a commercial pilot. The sequence of events is used to explain how he developed a genetically predisposed illness; however, the story is used to reinforce the illness as a failure of weight management and therefore something he is responsible for:

Participant 3: So I failed. I was really depressed. I started eating, eating, eating, eating. The eating disorder started putting on weight, became obese, and by the time I turned 40, the doctors found out that I had type two diabetes. I brought it upon myself. My father was diabetic, mother was diabetic, grandfather was diabetic, so I should have been more careful, but I was

careless. 40th age, I got my diabetes. Now it's 27 years of diabetes, type two diabetes. It's given me more problems, more problems, more problems (...). And since December last year, I found it extremely painful to walk. Just couldn't walk, and it took me almost eight months now, for my GP to refer me for a CT scan and X-ray, and found out there's some damage in my spine, because of which I'm not able to walk. So only this morning, went to Aida care to see the recliners, the first time I've tried out a recliner, found it very comfortable. So, I'll have to now make a choice. Got two models and decide which one is better, diabetes and hypertension, these two things have caused me several other problems, (...) That's where I am today. I do go out a lot. Unfortunately, I had requests for a wheelchair everywhere where there is a lot of walking required. I can't get it everywhere, so I missed a lot of meetings. Diabetes has done me more damage as well, because I just can't be sitting in one place for more than two hours. I have to go out, and it has nearly wrecked my life.

Participant 3 describes how he has come to need an AA. He describes his early life as one full of promise, but a medical examination for his pilot's license changed the course of his life to one characterised by health problems. The failed medical examination becomes a turning point that shifts from a life of active sports to overeating, which he frames as self-made, describing his later health decline as something he caused: *"I brought it upon myself"*, despite recognising that the loss of his bright future originated from that external event. He suggests that because there is a genetic predisposition in his family, he should have known better: *"My father was diabetic, mother was diabetic, Grandfather was diabetic, so I should have been more*

careful, but I was careless.” Counterintuitively, knowing that particular illnesses were common in their family increased his sense of responsibility for prevention. He argues that because this condition runs in his family, it is something he should have and could have controlled. In spite of the characterisations that *“has nearly wrecked my life”*, Participant 3 continues to describe the strategies he uses to control his health:

Participant 3: *The physiotherapist comes regularly. And then I also get a massage twice a week, which has helped me get rid of the pain. And the food, of course, exercise is important. Equally important is the food.*

Participant 3 discusses the various ways he is controlling his pain, weight and health condition. His proactive approach to his health demonstrates his responsibility to self-manage further decline. Narrating a sense of control over outcomes was used by participants to teach themselves to act in certain ways. These included explaining what *“you’ve got to do”* to achieve continued function in older age. Participant 5 used the analogy of taking control of weight by going to the gym to describe how she needs to get used to using a walker to stay in her home: *“It’s a bit like, you want to lose weight, so you’ve got to go on a diet, and you’ve got to go to the gym.”* This is later reinforced by dismissing her reluctance to use the walker with, *“No, I’ve got to get used to it.”* The way she works through taking control of her perceived ability to stay in her home demonstrates her rationalising and processing the work she must do to control the outcome.

Deciding what can be prevented and what must be endured was a fraught process for some participants. Although functional decline was seen as controllable, they acknowledged that changes were not all equal: some *“may not be forever”*

whereas others were “*pretty much irreversible.*” Participant 5 describes needing health investigations and a diagnosis to gain a sense of control over why she has certain illnesses, and what changes can be anticipated:

Participant 5: Another friend, she said, look, it may not be forever. And I said, well, you know, if it was just the knee, I would accept that, but I said, the neuropathy in the feet is pretty much irreversible, and at the moment, we haven't had any investigations into why it's happening, you know, and I need to know why, because then you can go, well, if it's idiopathic, okay, there's nothing that could be done, but it's caused because of you know, I'm not diabetic, I haven't had chemo, that sort of thing. I need to know why. I hate not being in control, and I'm not in control, so maybe using a walker and a walking stick is forever, but if that's going to keep me in my home, that's what I've got to do.

Participant 5's explanation of knowing what might have caused her illness helps her make sense of why these things are happening to her and gives her a sense of control in how she manages her illness. By assembling knowledge of her condition, she can create parameters around aspects that are controllable and those for which nothing can be done. This is not necessarily about controlling all age-related changes, as she categorises some as controllable and others as uncontrollable and treats them differently. This narrative refers to particular changes and conditions that might be caused by something unknown; if she can identify them, she believes they may be controllable.

“No, I’ve Got to Get Used to it”

In addition to being controllable, ageing and decline were often viewed as something that could be managed by employing specific strategies aimed at maintaining independence for as long as possible. In the context of this research, strategies were typically centred around accepting AA and making home modifications to support continued autonomy and enable ageing in place. Across participants, independence was described not only as a practical goal but also as an emotional and moral stance against dependence and institutionalised care. For some, this meant proactively adapting their homes to circumvent future reliance on others, while for others it involved learning to use AA or confronting feelings of pride and resistance associated with their use. Each narrative reflects a desire to remain self-sufficient and to manage ageing on one’s own terms, framing independence as both a marker of control and a way to preserve identity.

When discussing the easiest part of acquiring an AA, Participant 2 signals her independence by talking about how she planned to proactively install rails in her bathroom with the help of her son.

Participant 2: Possibly because my son’s a builder, I’ll just buy one from Bunnings or something, a white one, get him to put it on, he’d be fussy about not cracking the white tiles. So no, I’m very independent. I don’t want to get old. And the more you give up, the more independence you give up, the older you get, very quickly.

In this extract, Participant 2 recounts how she would obtain an AA from Bunnings and have her son, who is a builder, install it for her. Her comments suggest that

relying on her son's skill offers both a practical solution and reassurance that the installation will meet her standards, avoiding any damage to the tiles. She implicitly links AA with getting old and frames independence as something that must be actively defended. Her suggestion that *"And the more you give up, the more independence you give up, the older you get, very quickly"* signals that ageing is a loss of an established identity as capable and self-sufficient. Independence is both an identity: *"I'm very independent"* and supported through examples of proactive decision making and following through with plans: *"I'll just buy one."* Independence is given up, rather than taken; not giving up means accepting AA in her home. While the rails may signal ageing, they help her to retain her independence. In this way, resisting ageing is seen as an act of personal willpower, but it is not without compromise.

Independence is a flexible descriptor that participants were able to define in terms of their own personal preferences. Modifications to the home or acceptance of AA are described as inevitable, *"we would need some help"* and preferable to institutional care. Participant 6 discusses the modifications he and his wife are making to their home to avoid institutionalised care:

Participant 6: *But um, the modifications for this place, we're already thinking of what we're going to do and how we're going to do it. Biggest thing was we recognised what 15 years ago, we knew we were going to at some point in our lives, we would need some help. We also knew that at some point in our lives, we did not ever want to be put in a home, especially with covid and we saw and the scams in the nursing homes and the people crying and dying in*

nursing homes because they weren't being cared for properly. And I thought to myself no way in God's earth. I'm prepared to wake up one morning if I do and she doesn't. I'm prepared to accept that, and she's prepared to accept if she wakes up one morning, and I don't... that's just how it is. Because you're born, you live and you die, but quality of life is something that concerns us, and being able to enjoy what we're doing for as long as possible.

In this narrative, Participant 6 explains how he and his wife are taking a proactive approach to modifying their home so that they can continue living there and avoid entering institutionalised care. He acknowledges that needing help at some point is something they've considered, but emphasises that for them, this does not mean moving into a care facility. Reflecting on the Covid-19 pandemic, he recalls how it exposed neglect within aged care facilities, reinforcing his determination to avoid that path: *"And I thought to myself no way in God's earth."* For Participant 6, dying in his own home is both a practical and symbolic goal. He accepts it as *"just how it is"*, framing this desire as an ideal way to die, one that preserves dignity, autonomy and control. His story concludes with a focus on quality of life, which he closely associates with continued enjoyment of life and self-sufficiency within the familiar environment of his home.

Accepting AA was described as not simply about physical capacity, but about the willingness to adapt as difficult situations arose. Choice was interpreted not as free will but as a set of limited options from which one must choose. Participant 4 describes how the use of her walker enables her to maintain mobility in daily life:

Participant 4: *For me, I didn't have a choice, it was use it or not go anywhere, because I need it. 24/7, particularly as things went on. So for me, it's my pair of legs. So, I didn't have that choice. I think that was, well, I don't really know what Marty's was, but I've heard of people say oh, yeah Mum's got a walker, but she's not using it, she's too embarrassed. You know, again, there's that psychological aspect. But for me, I just had to, and my mum also had a walker too. So it was very familiar, for me.*

In this extract, Participant 4 describes her experience with using a walker as one of necessity rather than preference. She explains that she “*didn't have a choice*” but to accept it, framing the decision as a stark alternative: either use the walker or “*not go anywhere.*” Rather than having no choice, the choices are complex. Refusing the walker is possible – her late husband refused to use one. However, for her, the walker becomes a symbol of continued independence, which she refers to as “*my pair of legs.*” This metaphor highlights how the walker enables her to maintain autonomy and participate in life, rather than being a sign of limitation. Participant 4 contrasts her own acceptance with the experiences of others, suggesting that using a walker was familiar to her; seeing her mother use one made adaptation to functional decline familiar. This comparison underscores her belief that independence is not simply about physical capacity, but about the willingness to adapt. For Participant 4, the walker represents not just mobility, but a conscious decision to remain engaged and independent in her life.

Adaptations to AA require the establishment of new routines and habits. For Participant 5, using AA is not simply about access or function but about forming new habits that allow her to preserve a sense of independence:

Participant 5: *If we're talking about the walker, I use it now if I've got washing to hang out, because the washing basket fits quite handily in that and I go out and, that's fine. And if I go out to put the seed out for the bird, I use it. But you know, then I can think I'm going to put something in the green bin, and I'll be halfway around the side of the house and think you haven't got a walking stick, you haven't got the walker. Be careful. So, yeah, it is habit. Around home, I guess it's habit building. It's like one of the things I got was a tipper kettle. So I've only got to get it out of the box last night. So, it's just a matter of getting used to it. And it's like anything, building habits. You know, how long do you have to keep doing something until it becomes second nature? So, you know that's around home, but you know, when it comes to going out, well, it's a whole different ball game. It's... just pride. And then [a] very wise friend, she said, well, you know that saying about pride, she said, cometh before a fall. Thank you. So, I've just got to, but I don't have to like it.*

In this extract, Participant 5 describes slowly incorporating AA into her everyday routines, such as hanging out the washing, putting out birdseed, and using the kettle. She recounts a scenario when she forgot to take her walker and hears an inner voice reminding her to “*Be careful*”, revealing an emerging internal dialogue around safety and adaptation. These everyday tasks become examples of habit-building as she learns to adjust to the presence of AA in her life. She reflects that with continued use,

adapting to AA will eventually become second nature. However, she contrasts this private adjustment with a different challenge: leaving the house with AA, which she calls “*a whole different ball game.*” This phrase conveys an emotional boundary where pride and self-consciousness complicate the process of adaptation. She acknowledges this tension, describing it as “*just pride*”, something she recognises she must overcome to remain socially active. Her story concludes with a reference to a friend, whom she characterises as wise, who reminds her that “*pride, she said, cometh before a fall.*” This introduces a moment of resolution in which she acknowledges the need to accept using her walker in public, regardless of whether she likes it or not.

Narrative Two: “It Makes me Feel Like I’m on the Downward Spiral”

This narrative uses the metaphor of *the downward spiral*, which participants used to describe a change over time as ageing and functional decline took place. The downward spiral represents this change going in one direction toward further decline and ultimately the end of life. This narrative demonstrates how AA are implicated in the process of decline and considers how older people make sense of adopting and adapting to AA. For many participants, AA served as an unpleasant signal of the beginning of the spiral, including how thinking about and discussing AA with others prompted an acknowledgement of their physical decline. The presence of AA required participants to consider what that meant for how they see themselves now and into the future. This process occurred both internally and in interactions with others. Within this narrative of the downward spiral, participants told stories about their experiences of AA as a signal of decline in different contexts, including both private and public spaces, and how they served as a signal of decline to themselves and to others. These

scenarios were initially assumed as separate; however, as the data shows, they are in fact deeply entangled, highlighting that adopting AA is a process of continuous reconciliation of ageing. Three narratives demonstrated the experience of the downward spiral, including “He Just Didn’t Want it to Look Like I Was Old”, “Accepting the Fact That I Need to Use Them” and “A Wakeup Call”.

“He Just Didn’t Want it to Look Like I Was Old”

For older people, adopting an AA acts not only as a signal of their physical decline to others but ultimately to themselves. In this narrative, the conversations participants had about AA with friends and family members involved reconciling their own ageing and acted as a forewarning of what their future might hold. How older people look out into the world and receive feedback from others is demonstrated across the interviews. How participants see themselves after this forewarning is implicit and latent within the narratives; participants use others as characters in their stories to present possible future selves. This demonstrates how interactions with others teach participants about possible futures and how they make sense of and internalise those futures. Participant 2 describes how she interprets a sense of forewarning from her two sons, who hold differing opinions on the installation of an AA:

Participant 2: *I know my son was really upset when I decided to get that rail on the stairs. Isn’t that stupid? My son lives next door, and he built the house, and doesn’t like the look of things, but my other son put it up for me. And*

yeah, some people just don't like, he just didn't want it to look like I was old, and I needed a rail to hang on to.

In this extract, Participant 2 describes her two sons and their very different reactions to her need for a rail on her stairway. She characterises one son as lacking engagement with the reality of her decline and need for the rail, and the second son as providing a practical solution by installing the rail. Her adult sons offer different ways of interpreting and expressing how they feel about her decline. This is deeply implicated in the fact that at some point on the downward spiral, she will eventually pass away. She tells this story to explain how these changes are unfolding and coming about through this process of seeing the rail, her sons' reactions, and the two ways of responding to a problem. She presents this forewarning of the future through two characterisations: one is to ignore it, and the other is to address what is coming by taking action. These interactions with her sons provide information, imploring her to confront what her future might hold and what this says about her as an ageing person, sensitising her to the time-limited nature of decline.

Conversations with others act as forewarnings of possible futures, imagining what the future of ageing and decline might look like. Participant 5 recounts a story in which a friend's blunt reaction to her reluctance to use a walker in public serves as a moment of forewarning, forcing her to confront the emotional and social meanings of visible ageing:

Participant 5: You know, I haven't gone out with the walker yet. A friend of mine said why not? I said, I forgot to take it. She said, bullshit. I said, all right, fine. I said, look, I have a hard enough time going out with the walking

stick, I said I feel like an idiot. She said, no, an idiot is someone who falls flat on their face because they didn't have something they needed. (...) that walker belonged to a friend of mine. She passed away. And the OT's got one for me, that sort of goes like [gestures a folding motion]. And someone said, well, why do you need that? I said, look, stupidly, but I said I've got a kiddy gate here. Because, if somebody comes to the door, I try and keep the dogs on this side of the gate, otherwise I open up the door and they are gone, like the clappers. And I'm sorry, but I can't go thundering off after them. They will go and they will not come back. So instead of having that where I have to lift it up and over, which with the shoulders, it's like, so, yeah, I haven't gone out with the walker yet. It's impressions.

In this extract, Participant 5 reproduces a slightly fraught interactional dynamic with her close friend about going out in public with a walker. Participant 5 is explaining why she has not gone out in public with the walker, first suggesting that she forgot, which her friend does not believe and pushes her to explain herself further with the response “*bullshit*.” Participant 5 hesitates to disclose her feelings about the reason she has not taken the walker with her, a reluctance that reflects her internal difficulty in acknowledging and accepting her physical decline. Participant 5 admits to her friend that she feels like an idiot, referring to being seen in public with her walker. Her friend responds by presenting her with two options: the idiot who falls down, or the idiot who thinks people are looking at her because of the walker. Her friend warns that worrying about what others think of her with a walker is the kind of idiot who could make things worse, implying that decline is happening whether or not she acknowledges it, but the response is within their control. Her friend's forewarning

teaches her to think carefully about her future and how the decisions she is making not to use her walker might affect her. Her friend is used to demonstrate the consequences of refusing to engage with her walker. Participant 5 presents this interaction as a way of explaining her process of coming to terms with using a walker in public and being perceived as an ageing person. In the second part of her story, Participant 5 introduces another layer of forewarning with the mention of a walker she inherited from a friend: *“that walker belonged to a friend of mine. She passed away.”* The reference to her friend’s passing acts as a tangible reminder of what lies ahead, making the future of ageing and decline feel close at hand. The narrative is shaped by the ongoing discussion with her living friend and the visible absence of the friend who has passed, both acting as markers of forewarning and prompting reflection on what is yet to come.

When asked if she thinks using a walker makes people see her differently, Participant 5’s response reveals how observing others becomes a way of imagining her own ageing and what it might mean for her own identity:

Participant 5: *Yeah. I mean, if I was walking through the mall, and I’m just, you know, you don’t notice most people, but you see someone who’s a bit different, if they’re in a wheelchair, they’ve got a walker, they’ve got a walking stick. And you think, oh, I really shouldn’t care what other people think about me. And you know, I try not to be judgmental when I look at other people, but we do notice people who are different, and I don’t want that, but I don’t think I’m going to have a choice about it, so I’m just going to have to*

find some way of coming to terms with it. I've got a phone consult with the psychologist next week.

While Participant 5's friend tries to teach her to overlook other people's imagined responses, this ignores the way that observing others provides information about possible ageing futures. The interaction with her friend is used to demonstrate how she must consider the consequences of not using her walker; she still resists looking "different", reflecting the deeply implicit ageist stereotypes that are activated when using an AA. She acknowledges that she applies these ageist stereotypes to other people and that she does not wish this for herself. Observing others and reflecting on her responses informs her about how she might be seen when using her walker in public. There is a shifting back and forth between looking outwards to others and then inwards and questioning if she now fits this stereotype, given what she thinks about those she identifies as "a bit different." She resolves the story by suggesting she will discuss it with her psychologist, illustrating that there are multiple characters that help her come to terms with facing her future, each playing a role: the friend offering practical and rational advice and the psychologist to help her work through the internalisation of ageist stereotypes previously reserved for others.

Older people use others' opinions as a feedback loop to update their sense of self, which can become disrupted when they are unable to present themselves in the way they would like. Participant 1 demonstrates how observing other people provides information about possible ageing futures:

Participant 1: *I like people to think, oh, she's working it out, she's in her sixties, she's doing well, and yeah I am, I mean, people should live their lives,*

particularly how they want, any way they want, without worrying about what other people think. But unfortunately, we are connected to each other. We live in a community, in a society, you can't help but think, what other people think, you want people's approval.

Participant 1 describes her belief that, in a fair and reasonable world, people should be able to live free of judgment. Others' approval is important to her, demonstrating her belief that approval can only be granted if she presents as someone who is *"doing well."* Participant 1 demonstrates a narrative that if you are functioning correctly and have a strong sense of self, then other people's opinions are their own concern, and they should not affect you. In this way, she should be an internally bound, complete human who is impervious to the judgments of others. This thinking is explained as a rational, but not realistic, account of human interaction. Participant 1 described the inevitability of human connection in which we learn who we are through a constant feedback loop that updates our view of ourselves. This story ends with how she would like others to see her, mentioning *"you can't help but think, what other people think, you want people's approval."* Participant 1 is aware of how others are evaluating her, which she interprets through a lens of the denigration of people, where perceptions of worth are tied to functional capacity intersecting with age: *"she's in her sixties, she's doing well."*

"Accepting the Fact That I Need to Use Them"

This narrative was reflected in the ways participants felt they needed to admit that there was some loss of physical ability that warranted the use of AA and made ageing a reality, either to themselves or to others. Acceptance varied across private

and public settings, and although these scenarios might be thought of as separate with different levels of acceptance, they are deeply entangled. Participants were willing to accept some assistive devices while rejecting others, demonstrating that adopting AA is a continuous process of negotiation and reconciliation with ageing. The following extract illustrates how Participant 2 negotiates the meaning of AA across different settings, revealing how privacy, visibility, and self-perception shape her willingness to accept them. Participant 2 describes her need for AA in one setting but her reluctance to accept them in another:

Participant 2: *Yes, I do need one in the bath, because it's so deep and I am at risk, but I wouldn't fancy having them in my toilet and bathroom, because it does age you by doing something like that, not age you, but yeah, makes you look older.*

While acknowledging the necessity of a bathroom rail over her bath, Participant 2 is reluctant to accept having them in her toilet, reflecting how she sees herself within the typically private space of the toilet as compared to public spaces where she might be observed. Toilets are typically the most private spaces in our homes, yet she has used the example of having an assistive device in the toilet as something that “*makes you look older.*” In this story, it is unclear who she is referring to, yet she implies that AA make you look older to others, who might use her bathroom as a visitor. This is a moment of self-recognition of how AA in private spaces can age you, which she is unwilling to accept. This demonstrates that acceptance within private or public domains is not as separate as might be expected. For example, the privacy of one's home does not necessarily make the use of AA more acceptable than in public spaces.

Ageist stereotypes are not only activated by being seen by others in public but can also emerge within private settings where older people may internalise these stereotypes themselves. Participant 2 evaluates the spaces within her private spaces through risk, illustrating that she is constantly negotiating between safety and impression management. She is willing to accept AA within an environment she deems necessary for her safety, but not in spaces where others might perceive her as old.

Continual acceptance is also demonstrated as a realisation of being on a path of physical decline, made more evident by the presence of AA. While AA may offer practical support, adopting AA is entangled with accepting decline. Participant 5 discusses how being seen in a public space with an assistive device makes her feel old and on the downward spiral:

Participant 5: It makes me feel like I'm old. It makes me feel like I'm on the downward spiral. And someone said, well, you know, what happens if you get bad enough that you actually need help? I said, I'll fight tooth and nail to stay in my home as long as I can, I said, because to me going into assisted living would just be the beginning of the end I'm 68 years old. I mean, my body is probably older than that, but for anyone who knows me, my mind and my sense of humour, a lot of me still feels like I'm 35. But my body's gone. No, you're not. No, no. Thank you very much. Hello. Let's have a fall, just to remind you, and it plays up with your mental health.

Participant 5 positions the transition to using AA as crossing a threshold in the ageing process, making the reality of the downward spiral feel material. The resistance and

resolve in Participant 5's story highlight her struggle to balance what she believes is practically necessary to manage her physical decline. Participant 5 describes a discrepancy between her ageing body and her young mind, with a fall as a reminder of her decline. In this way, she describes her body as having power over her mind, that in the end, her body has ultimate control over what she must do to avoid institutionalised care. Participant 5's story also provides an example of the fear of institutionalised care in Australian society, where assisted living is shaped by widely held cultural beliefs and expectations about what happens when someone can no longer remain in their own home. Within this narrative, assisted living is often associated with the final stage of life, a place that is implicitly linked to dying and the perceived loss of autonomy. However, for Participant 5, accepting AA, although reluctantly, is helping her to avoid institutionalised care for as long as possible.

Acceptance in a public setting can influence acceptance in a private setting. Ageist stereotypes were experienced as visible and influential outside the home, and being seen in public draws attention to the ageist stereotypes that older people want to avoid. These public experiences deeply influence acceptance within the home, showing how public and private responses to ageism are continually connected and negotiated. Participant 5 discusses going out in a public space with a walker and what she feels that represents:

Participant 5: *I think the biggest difficulty I have, I had, and I still have, is accepting the fact that I need to use them. I use a walking stick when I go out,*

because I've got sensory peripheral neuropathy in both feet, losing feeling. So, my balance is shot. So, I fall a lot. (...), I've had to use stuff that, I just hate it.

Int.: *So, tell me more about that. Why don't you like to use these things? How does it make you feel?*

Participant 5: *Well, if I go out to Castle Plaza or Marion and you see someone with a walker, you generally tend to think that if somebody's got a walker, they're going to have white hair, and they're going to be a little bit stooped or something, and they're gonna look like they're old. I don't want to be like those people, you know, I haven't got the grey hair.*

In this extract, Participant 5 illustrates that while she has had to use AA to prevent falling, using these devices is deeply intertwined with stereotypes of ageing and decline that she is struggling to identify with. There is a deep sense of conflict between who her ageing body presents and how her young mind feels. While she is resolved to the idea that she needs to use AA for her balance and has accepted them in her home, “*I've had to use stuff that*”, this is still an ongoing process of acceptance for her, illustrated by “*I just hate it.*” She contrasts having to use AA at home with going out in public: “*Well, if I go out to Castle Plaza or Marion and you see someone with a walker (...) they're gonna look like they're old.*” In this way, Participant 5 has partially accepted AA and will reluctantly use assistive devices in the home, but being seen in public reminds her of why she hates it. This constructs AA not as something simply accepted in private and rejected in public, but as accepted reluctantly at home and less so in public, where public exposure reminds older people of how ageing shapes their identity through ageist stereotypes across both settings.

Each decision to accept or decline AA is understood as separate rather than as a singular decision that denotes willingness to incorporate AA indiscriminately. The following extract illustrates how Participant 3 frames the acceptance of AA as a set of steps in the process of ageing, where adopting one aid is justified as a means to delay the need for future assistance:

Participant 3: *The person who took me did not pressurize me. So, he has given me two flyers of two models, which we felt was good enough. So, I thought, let my wife come in the evening and we'll talk it out and see which one could be the best. Even if I'm not paying for it, you can't waste it, you want to get the right one. About the availability of these recliners. I only heard about them. I've never used one, and when I sat and tried it out, I knew what I was missing for the last several years now.*

Int.: *And, how in your mind, have you made sense of getting an assistive aid and getting a chair?*

Participant 3: *If I sleep better, in the daytime, I would be less drowsy. I can be more active. Getting a wheelchair would be the next step, but before that, I'm going to try everything possible to see if I can recover from this problem. So, I've given up peanuts, so that I can start taking fish oil capsules so that I can get my omega three a little up. But I also learned that it takes maybe a year or two for the Omega six store to deplete. It's not going to get depleted very*

quickly, just because I'm taking omega three fish oil, so I'm prepared for the long run. I know something good will happen.

In this extract, Participant 3 has just finished describing the process of sourcing a recliner chair and how he believes it will improve his life by enhancing his sleep. When asked how he has made sense of getting the chair, he shifts to the avoidance of further aids. Although Participant 3 is quite accepting of a recliner chair, his future use of it will provide him with the ability to rest, be more active, and avoid further AA in the future. For Participant 3, acceptance of a wheelchair represents dependence, which he resists by taking on dietary modifications. He views this as a long-term project. While it is not explicit, Participant 3's story shows how acceptance of some aids, in this case a recliner chair, is rationalised to avoid the acceptance of further AA in the future.

“Wake-up Call”

Participants described using AA as a “wake-up call”, prompting a shift in identity from capable to reliant on an assistive device. This moment required participants to adjust and reconcile their sense of identity, as they confronted their own ageing bodies. In doing so, they faced the unsettling realisation that the ageist perceptions and stereotypes they had previously associated with being old now also applied to themselves.

Participant 5 articulates the “wake-up call” she experienced when faced with having to use AA. She describes the process as “*hard*” and attributes the difficulty not to external pressures or social stigma, but to her own internal beliefs and “*mental processes*” about ageing. Rather than questioning societal norms, she frames the

experience as an individual struggle, one that required her to reconcile her identity with the realisation that she now might belong to the group she identifies as “*old people*”:

Participant 5: *But this whole, you know, having to use aids, it's a bit of a wake-up call. It's hard. I find it hard, but it's not hard because anyone else has made it hard. It's hard because of my mental processes and the way I feel about it, because it's only old people who use those sort of things. And I don't want to be one of the old people, but, you know, I'm 68. What do I do?*

When asked if she believes she's one of the old people she talks about, she links age with the use of AA as a way to explain that it is not just how old you are, or how old you feel, but the presence of an assistive device that signals that someone is on “*the downhill slide*”:

Participant 5: *Well, I guess people, I mean, I've had people say very kindly to me, oh, you don't look 68. And I say thank you. You know, somebody said early 60s, maybe, and I said oh well that's, you know, lovely. But in my mind, somebody who's in their 60s, is old, and somebody's in their 60s using a walker is old, and they're on the downhill slide, towards you know, see you later. I don't want to be that.*

AA functions as a wake-up call, which is hard to accept, as it provides a signal of what's to come, and for Participant 5, that means the downhill slide toward death, which she describes as “*see you later.*” Participant 5 projects responses and reactions onto imagined others and argues with herself as if they were another person, in this way she rationalises her own reactions, working through and processing how she feels

about using AA in public with herself and within the interview in real time. This demonstrates that the act of using aids cannot be rationalised, as it is an ingrained emotive process. The confrontation of decline was also storied by Participant 1, who stories reconciling who she represents with who she is becoming:

Participant 1: *It's having the thought of having to go out in public with a walking stick or a walker, which is not gonna happen anytime soon. I can tell you that for free. Unless it becomes... mind you, my mum held out. Now she got to 99 she was in a nursing home when she died, but she held out, for the same reasons that Dutch, Dutch background, Dutch determination, not to make anyone else around you think that there's something wrong. I guess I've got a bit of that. I don't know, it's admission that perhaps I'm not what I present, so the picture I present is not necessarily what's real, and I'm not a faker, but at the same time, I like people to think, oh, she's working it out.*

Participant 1's story starts with her having to confront the thought of going out in public with an AA. She describes her reluctance to appear in public as an "admission" that "*the picture I present is not necessarily what's real*", indicating that what she presents to others is a representation of someone who is doing well for their age, and the presence of AA would disrupt this presentation. To follow up, she says, "*and I'm not a faker*", convincing herself and the interviewer of her authenticity, that although she presents herself as capable, this may not be the complete picture. She has a moral imperative not only to be well and functional but to respond proactively and positively to decline; she wants people to "*think, oh, she's working it out.*" Her

comments demonstrate that going out in public with an assistive device is a wake-up call that her body is declining, and this is an admission to herself that she is ageing.

Occupational Therapists

Narrative One: AA Represents the Ugliness of Ageing

This narrative explores the ways older people are described as resistant to AA, and the deeper meanings OTs understand are behind how older people communicate their resistance. OTs engaged in considerable interpretive work to make sense of older people's resistance to the use of assistive equipment, including attributing meanings that were different from those expressed. This is illustrated by one OT who said, *"When they say it's ugly, it's not necessarily that, like a stainless steel grab rail is so ugly, it's just I guess what it represents is, is they feel it's, you know, it's ugly."* OTs across interviews had the sense that older people were not resisting AA for the lack of practical application, but because of what AA represented to themselves and to others - the ugliness of ageing. Although OTs interpreted older people's reasons for reluctance as stigma avoidance, this did not align with the solutions they provided to older people through the prescription of AA, often persuading older people with rational reasons for AA use, despite identifying that decision-making processes are not driven by rationality. Two narratives were used to illustrate the ugliness of ageing, including: "You'd be Surprised How Funny People Can Get About it" and "Rational Solutions for Socially Shaped Concerns".

"You'd be Surprised How Funny People Can Get About it"

OTs understood the resistance older people expressed toward AA as resisting being stigmatised. This resistance led to older people providing various explicit reasons for why they did not want or need AA. OTs reinterpreted these reasons as clients avoiding being stigmatised as they age. In their professional practice, OTs

positioned themselves as having access to the genuine reasons underlying older people's decision-making processes, distinguishing these from the performative reasons they believed older people presented. Some reported reasons were quite practical, such as wanting to avoid adjusting their routine or the inconvenience and practicality of taking an AA with them everywhere they go, and AA appearing as "ugly." Other reasons were social, including not wanting to look old, and the fear of public judgment. Using older people's explicit reasons for resisting AA, alongside behaviours such as trying to conceal the use of aids in public or at home, OTs interpreted this as an effort to maintain independence and preserve both personal and social identity. These actions reflected a fear of looking "old" or incapable, revealing internalised societal stereotypes of ageing and physical decline.

OTs position themselves as having access to the genuine reasons underlying older people's decision-making processes, distinguishing these from the performative reasons they believed older people presented. Below, OT 4 illustrates an explicit and practical reason for resistance to home modification being interpreted as having a deeper implicit meaning:

OT 4: And definitely, there's an element for some people of not wanting to make changes to their house. That's not always a vanity thing. Sometimes it's they don't want to, you know, do any damage to the house, because they're aware that when they pass away, their family are probably going to want to sell the house, and it might impact buyers and things like that. But other times they don't like their house looking like an elderly person, you know, that someone a bit frail lives there, but yeah, it's much the same as with the aids,

really. And it's the same kind of people that resist the aids, that will resist the home modifications and things as well.

OT 4 identifies reasons for resisting home modifications as avoiding burden on others and resisting ageist stereotypes. OT 4 explains that some older clients resist home modifications not out of vanity, but to avoid burdening the family who would be left to sell the house upon their death. This positions home modifications as detrimental and requiring removal to preserve resale value, implying that anything that represents an older person's home should be undone before sale. In this way, OT 4 draws on ageist stereotypes likely without intent about how AA can signal stigma. OT 4 interprets her clients' not wanting to "*do any damage to the house*" as older people wanting to preserve their identity by avoiding home modifications that might highlight frailty.

The following extract is another example of how OTs portray themselves as uniquely able to discern the motivations behind older people's reasons for resistance:

OT 2: And like some people have actually said, I don't want to use it, that's for old people. Yeah, that tells me they're like, no, I don't. That's not what I look like. And that's not what I want to be.

In this extract, OT 2 positions herself as interpreter of her client's resistance to AA, framing refusal not simply as a practical objection but as an expression of identity boundaries. Being an old person is constructed by OTs as an undesirable and stigmatised category against which older people actively differentiate themselves, demonstrating how narratives of ageing are internalised and reproduced within professional practice. This interpretive work reveals how OTs interpret older people's

refusal of AA as a distancing strategy from the negative stereotypes that come with being identified as “*old people*” when AA are present.

OTs described older people as giving social reasons for resistance, despite having frequent falls. Below, OT 4 interpreted her clients’ social reasons for resistance to AA as an indication of deeper self-esteem concerns and a reluctance to accept change:

OT 4: *So people can be resistant for self-esteem reasons, or sometimes people just don't like change. They just don't like the idea of having to start doing things a little bit differently. Walkers are probably a big one. We'll encounter lots of people that are having frequent falls, very, very unsteady on their feet, but they just refuse to get a walker, either because they don't like the idea of how it makes them look, or they don't like the idea of having to take this piece of equipment with them, you know, in their day to day life, when they're not used to doing that. So it can take people a while to come around to accepting using a walker, and showering equipment is another one. Sometimes people think that it makes them look weak if they've got to sit down to have a shower; there are probably other examples, but those are the main two.*

OT 4 suggests that older people “*just don't like change*”, situating reluctance within a broader societal narrative that frames ageing as synonymous with inflexibility. OT 4 highlights walkers and showering equipment as examples of AA that are commonly resisted, interpreting this resistance as a repudiation of a strong voice of internalised stigma associated with weakness. OT 4 draws on patterns she notices across multiple interactions with clients, “*lots of people that are having frequent falls.*” Over time,

these recurring situations are read as evidence of broader tendencies of older people. OT 4 makes sense of older people's decisions as a tension between safety, need and identity. These choices to refuse or delay AA are framed as understandable, within older people's meaning-making processes; older people are not simply non-compliant but are negotiating how AA will change how they see themselves and how others see them. At the same time, by emphasising "*self-esteem*", OT 4 constructs older people as identity-protective, change-averse decision makers.

The extract below demonstrates how older people are portrayed as resisting AA in public, to prevent others from observing them and in private, to avoid confronting their own sense of frailty. OT 4 explains how older people can be reluctant, regardless of space:

OT 4: *I've definitely heard people kind of make comments that suggest that even they don't want their neighbours seeing them out the front with their walker. And it's very much about protecting their kind of self-image. But you'd be surprised how funny people can get about it, even in the privacy of their own home. And then it's about them and how they view themselves in their own home. I don't even want to feel like I'm frail or needing help. I want to feel like I'm capable and I can do things myself. Is kind of what they're saying without saying it, I guess.*

In this extract, OT 4 describes an example of a client feeling uncomfortable about being seen by their neighbours with a walker, reflecting how older people may feel self-conscious. When comparing the public setting to the privacy of her clients' homes, OT 4 advises, "*you'd be surprised how funny people can get about it, even in*

the privacy of their own home” indicating a shared understanding of social life that the privacy of the home is distinct from a public setting because others do not typically witness the use of AA. OT 4 stories her older clients by quoting them as if they are speaking to her about how they really feel, but without saying it. OT 4 borrows from stigma about how the presence of AA can highlight being frail or needing help, which she believes is something they do not want to feel.

The above extract also demonstrates how OTs use older people’s behaviour to interrogate older people’s explicit reasons for resistance. OT 4 draws on the character of the professional who is able to diagnose how older people are feeling and what it might mean when they do not want to be seen in public with an AA. OT 4 casts herself as the understanding OT who recognises that resistance to AA is not about the item itself, but about protecting a self-image of capability and self-reliance. By indicating that clients “*kind of make comments*” that suggest reluctance to be seen with AA in a public setting, she points to how she makes educated connections about what her clients are saying to her, indicating that they do not directly describe wanting to protect their self-image. OT 4 interprets older people’s reluctance to AA as not wanting to “*feel like I’m frail or needing help*” and instead wanting to maintain a sense of independence. OT 4 constructs herself as knowing what her older clients are saying without them having to say it, reflecting her ability to read between the lines and her understanding that internalised societal stereotypes of ageing and physical decline are implicit in her clients’ reasons for resistance.

Men were seen as more resistant than women, which OTs interpreted as reflecting concerns over loss of masculinity and diminished strength. The following

extract from the interview with OT 1, demonstrates how her older clients resist AA differently:

Int.: Can you think of a time where you've had a scenario of someone being resistant to something that you've recommended?

OT 1: Definitely have encountered that scenario, it's not the majority, but it has certainly happened where they've either been completely resistant to the idea of an aid at all, or they've been resistant to what I'm recommending specifically, because they might have their own thoughts on what they're wanting that is more acceptable to them. Quite often, I would say when people are very resistive to getting aids, it tends to be more men than women. I've noticed, I think, for men, especially, that stigma about appearing sort of frail or weak is still very much a thing with the generation that I that I'm working with, and particularly sort of being in a more regional area where you're meeting a lot of people that were farmers and things like that back in the day, they don't want to be seen as anything less than able bodied.

In this conversation, OT 1 generalises resistant clients into categories of either entirely resistant to AA or resistant to something she has recommended and distinguishes between men and women, suggesting that men are more resistant to AA. OT 1 uses the term “*that stigma*”, drawing on cultural narratives of masculinity that construct men as strong and independent, and therefore less willing to accept help. OT 1 suggests that the men she categorises in her story do not “*want to be seen as anything less than able-bodied*”, interpreting their resistance to AA as an attempt to avoid being stigmatised as weak or frail, viewing AA as a threat to the symbolic status

of the *strong male farmer*. This demonstrates how OTs evaluate, interpret, and make sense of the behaviour, language, and context of older people in light of their various characteristics. Their profession as OT positions them to make sense of why older people are making decisions about AA resistance.

“They’re Very stubborn in Their Thinking Sometimes”

OTs attempt to overcome older people’s resistance to AA by applying rational arguments of the practical value of AA. OTs addressed socially concerned and stigma-avoiding older people’s decisions by providing practical and rational advice in terms of AA safety, functionality, and the risks associated with non-use. OTs had a sense that argued properly, they could overcome socially situated concerns by convincing older people of the practical benefits of AA. OTs engaged with older people as socially concerned and stigma-avoiding, yet provided practical and rational advice in terms of safety and functionality of AA and the risks associated with non-use. Part of this was OTs’ characterisation of older people as having particular attributes which impeded good decision making; older people were characterised by OTs as cute, stubborn, resistant, frugal and overthinking others’ reactions and fixated on exercising autonomy in ways that lead to unsafe or unwise decisions: “*they’re very stubborn in their thinking sometimes.*” These characterisations underpinned OTs beliefs that older people resisted AA for social, emotional, or aesthetic reasons, rather than making practical, rational decisions that OTs deem safe and optimal. In the extract below, OT 3 uses paternalistic language to describe her older clients: “*Most of the DVAs are really cute [Department of Veterans Affairs]*” constructing older people as childlike and not to be taken seriously. Although “*really cute*” appears benign or

apparently positive, it is an ageist framing that positions older people as less competent decision-makers. This can shape how OTs interpret and respond to older people's reasons for resisting AA. Ageism functioning in professional practice makes it possible to doubt the veracity of older people's reasons for resistance toward AA.

OT 3: *Last week, we saw a client who has, a taper thing, that's a homemade one, to get into the bed and to get out of the bed, which is really unsafe because it's very tiny, if you put one foot in and then the other, it's really hard. We were like, would you like a hospital bed, the High, Low bed, which would go down when you sit, and then when you want it, you can raise it up. And "no, no, no, no. This is fine. This is working perfectly. I don't think I need more money" [from MAC] or "I don't want to waste it" (...). They don't want to spend everything on every item. They think that it is not necessary. They should be managing with what they have. And you need to really tell them, No, no, no, this is what it's going to do. And then you show them. I usually have a catalogue with us, and we'll show this is how it works. Now we have an iPad, and we can type on the product and say, See, this is how it works, and some are really receptive, and some think that [they are] independent already, that that tool is helping me anyway, "I don't need fancy stuff", that's their thinking most of the time. Most of the DVAs are really cute, like they go, "oh, I just need one bar in the shower," but it won't even meet the standard criteria (...). And then you feel like there should be one more rail just outside the shower, so they can get out of the shower easily and safely. They'll be like, "no, no, this is what I want, and this is what I'm getting." They think that they are very independent still, and they're very stubborn in their thinking sometimes, and*

they think that they don't need it, especially the mobility aids. Some people would walk with a single-point stick, and we feel like he would be really unsteady on his feet. And a frame or four-wheel walker would be good for balance and coordination. No, they say, "oh, this is fine." I think in their mind they are able, but their body is not able. That doesn't communicate. That's how we feel sometimes, like maybe it's not connected.

OT 3 illustrates how her client provides explicit reasons for resisting AA, her interpretation of these reasons, and the solutions she provides. OT 3 recounts an example of an older client who handcrafted his own assistive device to get in and out of bed, which she felt was unsafe. In offering a more suitable solution through their My Aged Care package allocation, her client was not willing to “waste” money. OT 3 interprets this as obscuring the real reason he is not willing to accept a hospital bed, which is that he feels he should be managing on his own. OT 3 positions herself as the advocate who provides practical advice and demonstrates to him how AA can be used to improve his safety. OT 3 interprets clients’ rejection of AA as rejection of what AA signals in terms of dependency. This points to a tension in her story that clients are “very stubborn in their thinking sometimes.” She frames her client’s resistance as unwilling to take her professional advice, concluding her story with “*That’s how we feel sometimes, like maybe it’s not connected.*” Here, she constructs her clients as having a disconnect between their physical ability and capability.

Across narratives, OTs recognise that rationality is not the only decision-making tool that older people use and understand that resistance to AA stems less from the devices themselves and more from the social stigma attached to their use. The below extract demonstrates how OT 5 understands her father-in-law’s reluctance

to be seen in public with a wheelchair as a preservation of his self-image, yet offers rational solutions for his concerns:

OT 5: *And I know my father-in-law, we've tried to get a wheelchair so that we, you know, we had a day where we went to Hahndorf as a family, and he ended up going home with my husband whilst I went for a walk with my mother-in-law. And I said to him, you know, if we had a wheelchair where we could push you, you could have come with us, and he still could have walked around the shops and things, but we could have used it for the longer distances, but he can't get over the idea of being seen out in public in a wheelchair, so he won't go.*

In this extract, OT 5's story is located within a narrative of professional OT and family member drawing on the character of a devoted daughter-in-law who has a professional interest in older people's safety. She characterises her father-in-law as being resistant to using a wheelchair because *"he can't get over the idea of being seen out in public in a wheelchair, so he won't go."* OT 5 describes how her father-in-law chose to return home with her husband rather than join the family for a walk, explaining that while the outing was interrupted by his decision, she understands his desire to prioritise the preservation of his self-image. OT 5 uses rationality to describe how accepting the wheelchair could have resulted in his joining them for a long walk. There is a tension in her story that she struggles to resolve; a frustration that her rational solution is not suitable to solve his concern about being stigmatised by the presence of a wheelchair. When asked if she thinks his reluctance to be seen in public with a wheelchair is driven more by others' views or by his own self-perception, OT 5

illustrates how, although she identifies that decision-making processes are not driven by rationality, she uses rationality to explain how older people should respond to concerns about how they are perceived by others:

Int.: And do you think that's as much as what he believes that says to other people, or is it more about what it says to himself?

OT 5: I think it is. My belief is I think people are quite egotistical out in the world and have their own stuff going on. I just don't think people, maybe I don't notice because I see it as part of my work. But I really don't think people notice it as much as they think. And I think people socially also have an expectation that, as an older person, you may require a walking aid, and so people don't notice it. I think if you had someone who was 20 and walking with a four wheeled walker, you might look at it and go, Oh, that's unusual, I think, for older people, and maybe that's a sad sign of ageism. But I actually think people expect that, and so don't necessarily notice.

In this extract, OT 5 recognises her father-in-law is concerned with what being in a wheelchair might communicate about him to himself as much as to others. His sense of self appears entangled with the symbolic meanings of dependency and decline that the wheelchair represents. Yet OT 5 contrasts the concern by suggesting that other people “*are quite egotistical out in the world and have their own stuff going on.*” In doing so, she exposes a tension between the internalised stigma of ageing and decline, and the more accepting social reality she perceives around her. Although OT 5 recognises her father-in-law's preoccupation with how wheelchair use might impact his self-perception, she redirects the narrative away from this inner concern, focusing

instead on the indifference and acceptance she perceives in others around them. This narrative shift downplays the emotional complexity of his experience, emphasising instead her belief that social responses are neutral and implying that his concerns may be misplaced. In doing so, she reframes the issue as one of personal perception, rather than broader social stigma.

Although OTs describe their clients as making decisions based on faulty logic, they attempt to overcome the socially situated concerns that older people have about AA with rationality. While OTs understand this resistance as a response to stigmatisation, they seek to solve concerns with practical and pragmatic strategies. Below, OT 1 discusses how reluctance to accept AA stems from how older people feel they are perceived by others, and provides a practical reason for why a walker should be adopted:

OT 1: Definitely with mobility aids. That's often the case. You'll often hear the phrase "I'm not old enough for that yet", but they'll be like 85, and I'm like, well, how old do you have to be to use a walker? (Chuckles) So again, those mobility aids, some people are reluctant because it makes them look vulnerable to outsiders. And you know, the risk of being robbed. I've had one client that was really reluctant to use a walker even though I was trying to say to her, like, you could put your purse in the seat and, you know, you're holding on to it. But yeah, she was really. And people get like that with handrails and ramps and things that their front entrance and even the little key box that you see, which has got a code with a spare key, people can be reluctant to that because of safety. And they don't want the house to look

obviously like an older person lives there, cause that makes it more vulnerable and open to break-ins or whatever.

In this extract, OT 1 explains her client's reluctance through a narrative of both practical safety concerns and ageist assumptions about visibility. OT 1 provides an example of an older woman who had concerns about *"the risk of being robbed"* due to the presence of a walker. The character of the older woman in OT 1's story positions outsiders as potentially dangerous if her client is to show visible signs of vulnerability to people who might want to take advantage. The fear of crime is mediated by stereotypes about older people as exploitable; therefore, security is not neutral and is bound up with ageist assumptions. OT 1 draws on the character of the understanding professional who offers a rational and practical solution to *"put your purse in the seat and, you know, you're holding on to it"*, to which she infers her client was not willing to accept. In this way, OT 1 argues for safety, using rational arguments to convince people to use AA. OT 1 concludes the story with *"And they don't want the house to look obviously like an older person lives there, cause that makes it more vulnerable and open to break-ins or whatever"* providing an example of how older people feel reluctant to show outward signs of vulnerability with the presence of AA.

While OTs recognise that older people may resist AA for aesthetic reasons, they often reframe these responses as unrealistic expectations about ageing that need to be adjusted. OTs position themselves as the voice of practicality, positioning resistance to the *"ugliness"* of ageing as understandable but ultimately something

older people must come to terms with. Below illustrates how OT 4 frames older people who resist AA for aesthetic reasons as unrealistic:

OT 4: *When they say it's ugly, it's not necessarily that, like a stainless-steel grab rail is so ugly, it's just I guess what it represents is, is they feel it's, you know, it's ugly. And they're not wrong. Like some aspects of growing older and losing your independence and becoming more disabled and more frail, I guess, are ugly, but, you know, it's life isn't it?*

OT 4 positions the view that AA are “ugly” not only in their aesthetic qualities, but in what they signify. The object embodies the experience of ageing, constructing ideas of vulnerability, dependence and physical decline as “ugly.” Through this interpretation, AA becomes a material expression of the shifting relationship between self, body and autonomy. OT 4 articulates that some aspects of becoming older are ugly, making the connection between older people being reluctant to accept AA and being reluctant to become old. However, OT 4’s sentence “*but, you know, it's life isn't it?*” draws on a fatalistic assessment that there is no option but to grow older and to accept it, that anything else is unrealistic. OT 4 stories this from the perspective of a relatively young and able-bodied person who has not experienced what it is like to be older or experience the stigma of ageing. Although she has articulated the ugliness of ageing that shapes resistance toward AA, without personally inhabiting the embodied experience of what it is to be older and experience the *ugliness* of ageing, her perspective is shaped by her professional role as an occupational therapist, one that is orientated toward decision making, being practical and realistic.

Narrative Two: “I Hear From Almost Every Client I See, I Just Want to Stay in My Own Home”

This narrative explores the shared goal that OTs describe between themselves and their clients: supporting older people to remain in their own homes and to delay or avoid institutionalised care for as long as possible. OTs present this as the ultimate outcome for their clients and describe employing a range of approaches to achieve this goal. While OTs report that older people express the same goal, their approaches to achieving this goal are not always aligned with older people’s preferences. OTs emphasise safety as a primary concern, whereas they describe older people as prioritising independence. Although both parties prioritise remaining in the home, OTs describe needing to manage older people to achieve this shared goal, particularly through promoting AA to increase mobility and prevent falls. OTs use the phrase *dignity of risk* to describe how they provide all the information to clients, but the final decision is up to the older person:

OT 2: That’s kind of weighing up the clinical reasoning behind what we’re recommending. The responsibility we have to try and keep people as safe as possible while also giving people dignity of risk. Taking into consideration their personal preferences for things that are happening to them. But yeah, it can be it’s a difficult mix.

OTs navigate between their professional goal of keeping clients “*as safe as possible*” and respecting the agency of their clients. The phrase “*dignity of risk*” acknowledges older people’s right to make choices that may involve some degree of danger, and that ultimate agency belongs to the client. OT 2 uses this example to story the tension she

faces in balancing recommendations with older people's choices, describing it as "*a difficult mix*"; the recommendations she deems safe are not always accepted. This highlights that while safety is the priority of OTs, older people may prioritise other goals, such as preserving autonomy above safety. This disjunction is explored using two aspects of this narrative of ageing at home: "Letting Them See What it is That They Need" and "They Just Want to be at Home".

"Letting Them See What it is That They Need"

In their professional practice, OTs prioritised the safety of their clients, which they viewed as preventing older people from injury as a result of falls in the home. Walkers to support balance, and home modifications that assist with getting up and down were prescribed to increase safety. OTs saw AA as a way to prevent falls and provide a safer way of performing daily tasks for older people. Conversely, OTs described their clients as primarily concerned with avoiding appearing dependent, which they felt was visibly signalled by the presence of AA. This created a tension between OTs and their clients, who had different priorities and did not always see AA in the same way. For older people, independence is constructed not merely as physical self-sufficiency but as a deeper sense of autonomy and control over one's daily life, encompassing the ability to maintain privacy in routines like self-care and sustain residence in one's own home without reliance on others. Strategies OTs used included education, which they described as explaining the possible risks of not adopting AA, offering older people the chance to trial AA before committing to its use and negotiating other, more subtle aids as alternatives. Somewhat surreptitious in nature, OTs believed that attempting a slow introduction of AA into older people's lives and

routines was an effective way to convince older people of their use. OTs believed that if older people could be convinced about AA's functionality, they could sidestep any of their social concerns. OTs saw the implementation of AA as the key mechanism for operationalising this safety priority within their professional practice. The following extract demonstrates how AA were viewed as an item that could prevent falls while side-stepping the reluctance of her client.

OT 1: *I guess it starts with education around, like if there's a particular aid that I think someone might be, you know, it might find useful, for example, like a four-wheel walker. So I had a lady that really didn't want to use one. She was using a walking stick, and she'd had 12 falls in the last 12 months or something ridiculous. So clearly the walking stick wasn't providing enough support for her.*

In this extract, safety emerges as OT 1's primary concern, evidenced by concern regarding the client's "12 falls in the last 12 months." This quantification underscores the urgency of her professional intervention, positioning the walking stick as not "providing enough support." OT 1 characterises her client's decision to use a walking stick as "ridiculous." OTs prioritise safety as paramount, interpreting repeated falls as definitive evidence that the client's choice compromises their safety and necessitates intervention through more supportive AA to address fall risk. The client's reluctance "really didn't want to use one" is acknowledged, yet the OT sidesteps confrontation by focusing on the functional support AA can provide, rather than the basis of the client's preferences or identity concerns. By highlighting her client's multiple falls and the walking stick's functional failure to provide adequate

support, OT 1 orients the focus to safety benefits without engaging the client's deeper personal objections. In this way, AA are recast as a pragmatic tool that can bypass emotional or symbolic barriers.

When the clients of OTs were reluctant to accept AA, OTs often employed stealth or the slow introduction of AA as a strategy to convince older people of their use. The following extract demonstrates how OT 5 employed negotiation as a way to convince their client to use AA.

OT 5: So I think very much as an OT we can offer support and advice. But at the end of the day, if people understand the risks and they weigh it up differently to what we do when they choose not to use something, then I think we have to be willing to accept that and try and put other opportunities in place. I remember working with an older man who didn't want to use a walking frame, was at high risk of falling, and so in the end, he was convinced that, would he at least wear an Alert Bracelet so that if he fell, he could call for help. And so, and sometimes it's just an iterative thing, kind of working on people towards accepting or letting them see what it is that they need.

This extract demonstrates how OTs employ subtle, stealth tactics as a strategy to encourage clients' acceptance of AA and mitigate safety risks. OT 5 positions herself as offering support and advice while ultimately respecting her client's autonomy, especially when clients "weigh it up differently." Here, OT 5 acknowledges that her clients might not agree on the definition of risk and "choose not to use something." Using the example of an older man resistant to using a walking frame, OT 5 describes a gradual, iterative approach, encouraging an alternative alert bracelet as a

compromise. This tactic is characterised as a process of “*working on people*”, a form of gradual persuasion, encouraging the client to acquiesce to any safety measures while working on them to advance her own goal of safety.

OTs used increasingly targeted strategies to persuade older people to adopt AA, typically beginning with general education and progressing to specific techniques such as leaving an aid with the older person so that they could try it and experience its usefulness firsthand. OTs understood acceptance as a process that could be fostered over time through repeated exposure and engagement with assistive devices. The following extract demonstrates how OTs used strategies of education and the trial of AA as techniques to convince their clients of their use.

OT 1: And what we did is we obviously started with some education around how walkers can provide more stability and we looked at some pictures on my computer of different walkers and then what we did is actually brought one back to her house to do a trial and she was open to that, which was good and we did a trial at her house, which even then she was still a little bit reluctant. And then we agreed for her to hire the walker for a month to see if she used it. And that was a bit of a gentler approach that got her over the line because I think she thought in her mind oh I won't use this and I won't need it.

OT 1 describes a tiered approach to convincing clients to adopt AA. Education is described as the obvious first step, where stability is described as the benefit for their client: “*how walkers can provide more stability.*” OT 1 interprets her client as someone who believes they do not need and will not use a walker, positioning the client as “*a little bit reluctant*” and in need of convincing of AA’s benefits. When

education alone is not enough, OT 1 employs a second strategy of suggesting a trial of a walker, which she suggests her client is open to. This demonstrates how OTs employ various increasingly directive strategies to try and convince older people to adopt AA. The final strategy OT 1 employs is for her client to hire the walker, hoping that by having a walker in the house, her client may try it and become convinced of its stability benefits. OT 1 signals that this final approach works: *“that got her over the line.”* Installing the equipment in the client’s house is the outcome of various increasingly directive strategies, which indicate a successful outcome.

OTs primarily saw the safety of their clients in terms of minimising falls. Recognising that surgical interventions might increase fall risk, OTs saw this as a moment to introduce the topic of implementing AA. The specific situation of surgery, the temporary need for support, and the commonality of the situation were used to present AA at this time as *“a good idea”*:

OT 2: *But what I would need to be sure of is that I spoke to them about the reasons why I thought it might be a good idea, and that includes things like safety. And I would let them know about you know it’s quite common for people to go home after surgery and fall in their home environment when they’ve never fallen before.*

In this extract, OT 2 explains how she will discuss the high risk of falls after surgery with clients. This demonstrates how, in a post-surgery scenario, discussions about falling due to age-related physical decline can be circumvented by a focus on immediate risk related to surgical intervention. In this way, AA becomes a tool

focused on recovery from surgery and can be viewed as a short-term solution, making its use more palatable for older people.

OTs feel they need to navigate a delicate balance when convincing older people to adopt AA. This includes being tactful yet firm with clients in order to minimise risk. The account below demonstrates how OT 4 approaches this balance; it describes how tact and reason are essential, and the work of OTs is to build awareness of identified risk rather than to alter the priorities and preferences of older people:

OT 4: So obviously, I try to be very tactful in how I go about that, respecting that I am going into other people's homes, you know, and, I can't go in there sort of all guns blazing and tell them you have to do this or something going to happen. But going in and tactfully say, look, you know, for these reasons, based on how I've assessed you and what I've seen, I think that this would be beneficial, and this is important for you to consider. You know that I'm recommending whatever it is. I just need you to be aware that if you continue the way you are, you don't sort of implement whatever changes I'm suggesting there is the risk of whatever the outcome is, you know, continued falls or injury or whatever, and just try to have those conversations with them and reinforce, in a firm but tactful way, why I've made the recommendation.

In this extract, OT 4 constructs herself as respectful and a responsible risk manager. The story centres on the tension between preserving her client's autonomy in their own home and fulfilling her duty of care by communicating risk. OT 4 describes how she tries “*to be very tactful*” in her approach, recognising that while it is her job to prescribe AA, she cannot enforce devices or home modifications on her clients which

is characterised as *“all guns blazing.”* Her description of practice follows a narrative sequence of assessment: *“based on how I’ve assessed you and what I’ve seen”*, recommendation: *“I think that this would be beneficial”*, and an invitation to consider: *“and this is important for you to consider”*. This approach frames OT 4’s actions as rational and evidence-based and casts her recommendation as something to be thoughtfully weighed by her client rather than obeyed. OT 4’s softening phrases, *“But going in and tactfully say, look, you know, for these reasons”*, work to construct the conversation as reasonable and tactful.

OT 4 frames risk as a possible outcome of inaction by suggesting *“if you continue the way you are”* and *“don’t sort of implement whatever changes I’m suggesting, there is the risk of whatever the outcome is.”* OT 4 uses a conditional approach that positions risk as something that can be mitigated if the client makes the choice she is recommending. In this way, the narrative shifts responsibility; OT 4 fulfils her obligation by making risk visible and then the client becomes responsible for deciding whether to accept that risk. The extract concludes with her aim to *“reinforce, in a firm but tactful way”*, demonstrating a tension that she must be *“firm”* enough to convey risk and stand by her professional judgement, yet *“tactful”* to maintain rapport and respect her clients’ autonomy. This narrative constructs her practice as a continual negotiation between risk communication and sensitivity to her client’s autonomy, an autonomy based in the site of the interaction, *“I am going into other people’s homes.”* Risk is framed not only as a clinical issue related to falls or injury, but also as the risk of undermining her client’s autonomy.

“They Just Want to be at Home”

OTs positioned themselves as problem solvers with strategies to reframe AA for their clients as tools that preserve rather than undermine independence. OTs report older people as being receptive to AA when it is framed as a means to remain in their own home and avoid institutionalised care, a goal that overrides initial resistance. OTs emphasise that AA can provide clients with independence, defined as the ability to continue living in one's own home and carrying out activities of daily living without requiring external help with personal care. Fear of losing independence, linked to having to leave the home, is a recurring theme in OTs' accounts, where they describe older people as more willing to accept AA when it is presented as a tool to prevent this loss. Acceptance of AA becomes less about signalling dependence to others and more about what they make possible. In this way, AA is reframed as a resource that provides access to independence by helping older people shower or use the toilet independently without fear of falling. AA were recast from a symbol of frailty into a means of sustaining control, choice and continued residence in the home. The extract below demonstrates how older people are reported as accepting of AA when it allows them to remain in their own home:

OT 4: You get some people that are, you know, delighted with it, cannot wait to get these things, because they know it's going to make things easier for them. They know it's going to make them safer and hopefully be able to stay in their home longer. You get those people that will basically, the attitude is, give

me whatever you can, because I want to be here as long as I can. And they believe that those aids will help them do that.

This extract presents a narrative framing older people's acceptance of AA as deeply connected to their desire to remain living at home. OT 4 describes a subset of older people who are "*delighted*" and eager to receive AA, perceiving these aids as enablers of safety and ease in their daily life. The phrase "*cannot wait to get these things*" conveys older people as enthusiastic and proactive, contrasting with accounts of reluctance or resistance. This extract constructs the decision-making and priorities of older people as wanting to stay in the home longer. OT 4 reinforces this by reporting that some clients adopt an assertive stance of "*give me whatever you can*", which indicates active engagement with AA as a strategy of preserving independence and home life. In this way, acceptance of AA is framed by OT 4 as a rational and positive choice grounded in older people's priorities. This story implies a shared understanding between OT 4 and her clients regarding the role of AA in enabling a safe and manageable lifestyle that aligns with older people's broader life goals.

OTs recognise that for some older people, acceptance and receptiveness of AA can have a deeper meaning built on the fear of institutionalised care. OTs will often use this fear to encourage older people to consider AA or overcome their reluctance to use AA. The extract below demonstrates how OT 4 interprets older people wanting AA as wanting to stay in the home.

OT 4: There's a lot of factors that go into it, but, I think for most people, it's not that they want a walker, or they want all these things. They just, they just want to be at home. Yeah, usually that's the implication. I don't want to go

into a nursing home, because a lot of the times, people don't have family that they could go and live with. So it's either manage at home, you know, myself, with the supports, or the alternative is I'll end up having to [go into] permanent aged care and they don't want that.

OT 4 acknowledges that older people's acceptance of AA can be influenced by fears beyond immediate physical needs and that willingness to accept AA reflects a deeper motivation to avoid institutionalised care. OT 4 frames the choice to use AA not as a genuine preference for the equipment itself, but as a strategic means to “*be at home.*” OT 4 positions older people as having two choices, one is to “*manage at home.... with the supports*” and the other is to “*end up having to [go into] permanent aged care.*” The emphasis on “*they just want to be at home*” and the desire to avoid institutionalised care: “*they don't want that*”, positions AA acceptance within a broader social and emotional context where the fear of losing the home is interpreted as weighing heavily on the choices older people are faced with. This narrative demonstrates a nuanced understanding of AA as more than functional and how they are understood as entwined with older people's efforts to maintain autonomy and control over their living circumstances amid limited options. By linking receptiveness to AA to the avoidance of aged care facilities, OT 4 conveys awareness of how the fear of institutionalism underpins acceptance.

OTs frame AA as facilitating emotional well-being and home-based independence. This avoids any need for external help or institutional care, particularly amid fear of falling. The extract below demonstrates how previous falls drive older people's reported acceptance of AA to sustain this autonomy:

OT 5: *I think there is the mental health side of it as well, particularly with some of the small assistive devices that you can offer for people that just allow them to have independence around personal care. You know, being able to go to the toilet on your own and being able to have a shower on your own is quite a big thing, and so you know, for a lot of people, having that sense of safety that they're not going to fall over in the shower, or being able to have the dignity of being able to do it on their own, I think can be really empowering for a lot of people. I have met, you know, a lot of particularly older people, who are really grateful for a walking aid, for instance, because they knew that they weren't confident in walking and were feeling quite unsteady. And then if you've had a fall before, your fear of falling again can be quite significant. So then having something that gives you a chair to sit down on, you know, if you go a bit too far, or knowing that you can call for help, you know, if you were to fall, or just having something to help balance you I think can be really reassuring. So, yeah, I think that is really helpful.*

In this extract OT 5 links previous falls to an intensified fear of falling again: “*your fear of falling again can be quite significant.*” Within this context, AA are framed as mitigating that fear by providing practical safety and reassurance: “*having something to help balance you I think can be really reassuring.*” This highlights how OT 5 foregrounds mental health by linking AA to the empowerment through independent personal care routines such as showering and toileting: “*the dignity of being able to do it on their own, I think can be really empowering for a lot of people.*” This emphasis positions AA as a tool to preserve dignity and autonomy, which OT 5 considers necessary to remain safely at home without carers. What remains unspoken

in this extract is that although older people may be “*really grateful for a walking aid*”, acceptance of AA may be seen as a strategy to avoid institutionalised care, rather than any enthusiastic acceptance of the device itself. While OT 5 celebrates AA as psychologically “*reassuring*” and dignity preserving, the broader fears around loss of home that OTs report elsewhere as key motivators for AA acceptance are not mentioned. In this way, empowerment is constructed in clinical terms rather than acknowledging older people’s strategic navigation of institutionalised care.

OTs view staying in the home as the ultimate goal and report this as a shared goal with older people, even as the specific pathways to achieving it demonstrate underlying tensions in priorities and risk perceptions. The extract below demonstrates that, although the goal itself is shared, the pathways to achieving it are not always aligned:

OT 4: *And I guess, you just kind of hope that eventually they’ll come around to accepting things that are very much there for their own good and to keep them in their home, which is always the goal at the end of the day.*

This extract demonstrates the belief that older people will come around to AA once they realise that it is the ticket to remaining in their own home. The phrase “*which is always the goal at the end of the day*” constructs home residence as the best possible option, implying that it is what both OTs and older people desire. OT 4 expresses “*hope*” that “*eventually they’ll come around to accepting things that are very much there for their own good*” framing AA as a way to achieve this common goal. This hopeful tone acknowledges that while staying in the home might be mutually desired, older people take some time to accept AA and therefore require persuasion. The

reported acceptance of AA appears pragmatic and conditional in nature insofar as it enables staying home, not as an enthusiastic endorsement of AA itself. OT 4's reporting of older people's reluctance demonstrates a misalignment where OTs view AA as attaining a mutual goal, and older people are constructed as slower to recognise that accepting AA is synonymous with staying in their own home.

Comparing Personal and Professional Narratives

Together, these narratives demonstrate how AA are implicated in the ageing process. They are seen as both causing and preventing ageing; at times, they are seen as giving in to a declining body. At other times, they are seen as enhancing mobility and therefore improving the ability to continue daily living as physical decline takes place. In both cases, the chronological advance of time is ignored, and ageing becomes defined by what is made possible or not possible due to physical decline; AA are deeply implicated in this process.

Older people and OTs share a core aspiration, remaining at home and preserving everyday autonomy; yet they approach this goal through differently weighted meanings of ageing, risk and AA. Older participants narrated ageing both as something that could be actively controlled through behaviours and determined effort, and as a one-way "*downward spiral*" in which AA marked visible thresholds of decline. Participants described making tactical adjustments such as changing how and when they did tasks, "*being careful*" or selectively adopting low-visibility aids as ways of preserving a sense of self-governed autonomy rather than relinquishing control. AA emerged as both a practical means of sustaining independence and a powerful symbol that activated internalised ageist stereotypes, prompting ongoing

work to reconcile “*feeling 35*” with an ageing body and visible markers of frailty. OTs echoed many of these sentiments in reporting what older people said about AA, but reframed these nuanced and fraught negotiations through a professional lens that foregrounded safety, functionality and clinical responsibility. OTs characterised resistance to AA as rarely about the device itself and more about what it represents: being “*old*”, frail or dependent, yet OTs often translated these social concerns into problems to be solved with rational argument, education and practical solutions. Similarly, OTs positioned themselves as working toward the same home-based goal as their clients but did so through strategies such as gradual introduction and trials coupled with appeals to fall risk.

Across these accounts, important similarities are evident: both older people and OTs understand the home as the preferred place to age, and both recognise AA as central to maintaining mobility, privacy and control. At the same time, the narratives show that older people and OTs often talk at cross purposes. Older people’s stories are saturated with concerns about self-image, pride, stigma and the emotional weight of “*crossing a line*” into visible old age, whereas OTs tend to reinterpret these concerns as issues of lack of insight, self-esteem or “*stubbornness*” that can be addressed by their perceived expertise in ageing and professional practice. In this way, older people use AA to negotiate who they are becoming, while OTs use AA to manage risk and operationalise safety. Bringing together the results from the narrative analysis suggests that resistance and acceptance of AA cannot be reduced to compliance with professional advice. Negotiating AA is better understood as a process in which personal and professional narratives about ageing, independence, and risk intersect, clash, and occasionally align.

Chapter 7: Discussion and Conclusion

The current study demonstrates how ageing and AA are understood differently by older people and OTs who support them as they age. Older people describe ageing as an undesirable, yet ultimately inevitable process that is heightened by the presence of AA. OTs also describe ageing as undesirable and unavoidable, and respond by adopting a practical, often inflexible approach to ageing and to the prescription of AA within their service capacity. As evidenced by multiple scholars, AA frequently become symbolic of ageing, bringing a shift of identity through processes of self-stigma and ageism (Jensen, 2014; Peek et al., 2015; Yusif et al., 2016). Comparing the narratives of older people and OTs offers a novel perspective on the shift in identity that AA represents. For older people, adopting AA raised complex questions about what it means to confront an ageing body. For OTs, AA offers practical solutions that older people may resist due to stubbornness or a desire to avoid appearing dependent.

One implication of these differing narrative constructions is differences in how OTs and older people understand independence and autonomy. Independence is reified by OTs as a fixed outcome characterised by functionality, with AA viewed as crucial to improving functionality and reducing risk. For older people, independence is understood as autonomy, characterised by a desire to adapt to an ageing body while maintaining autonomy in daily decision-making and routines. Further, acceptance of AA is underpinned by constructions of choice, including being in control of how they frame their choices to accept or resist AA. Finally, the analysis reveals how power dynamics operate between older people and OTs. This is reflected in OT's expectation that older people are frail, thereby making risk mitigation the focus of

rational decision-making. This shapes how choice is experienced by older people, as not accepting AA is seen as acceptance of risk and therefore the wrong choice. This power dynamic shapes the delivery of services.

Independence as Autonomy versus Safety

Both older people and OTs position independence as a central goal, and both groups view AA as a means of achieving it; however, they understand and pursue it in markedly different ways. Negotiating AA is framed as encouraging independence, but older people and OTs locate these negotiations in different moral and practical worlds. OTs view independence as increasing functionality to mitigate physical decline and as a risk-reduction tool, whereas older people describe independence as the retention of autonomy and the protection of dignity and identity.

Equating functionality with independence is a recurring theme in the OT literature. Occupational therapy is widely regarded as a leading intervention for enhancing functionality (Courtney et al., 2012; De Coninck et al., 2017; McIntyre & Wilson, 2013). Professional practice is often focused on functionality as a strategy for reducing the care burden on others (Fricke & Unsworth, 2001; McIntyre & Wilson, 2013). This is supported by evidence that health professionals view everyday tasks such as bathing, dressing, and mobility as essential forms of *care* for the ageing physical body (De Coninck et al., 2024; Edemekong et al., 2025). AA play a key role in OT intervention as they are considered a means of improving physical functioning (De Coninck et al., 2017). This attention on increasing functional capacity is intended to enhance community participation and support the maintenance of health, well-being, and quality of life for older people (Knightbridge et al., 2022).

OTs also view safety and risk reduction as a way to increase older people's independence. Studies show 50% of older people aged 80 years and over suffer a fall annually, and falls are one of the primary causes of hospitalisation. Consequently, falls are the second leading cause of accidental death in older people (Masud & Morris, 2001; Miranda-Duro et al., 2021). Occupational therapy practice commonly links functional independence with reduced fall risk, and fall prevention outcomes are often treated as key indicators of intervention effectiveness (S. Elliott & Leland, 2018; Nagayama et al., 2016). Fall prevention interventions often include the prescription of AA and home modifications (S. Elliott & Leland, 2018; Miranda-Duro et al., 2021; Nagayama et al., 2016), with AA use linked to a reduction in falls when combined with in-home hazard assessments (Nagayama et al., 2016).

For older people, independence is not understood in terms of physical functionality and fall risk. Independence is instead understood as autonomy, the ability to continue to make decisions about one's daily life. Independence is a complex term, but is widely understood in the literature to encompass the absence of reliance on others (Fisk, 1986; Secker et al., 2003). For older people, independence is understood as a broader concept encompassing self-reliance, self-esteem, self-determination, purpose in life and autonomy (Hillcoat-Nallétamby, 2014; Secker et al., 2003). The difficulty in distinguishing the definitional boundaries between autonomy and independence is well documented (Ball et al., 2000, 2004; Hillcoat-Nallétamby, 2014; Kemp et al., 2012; Perkins et al., 2012). Furthermore, there is limited research that captures older people's own understandings of independence (Hillcoat-Nallétamby, 2014). However, research suggests that older people value the

ability to implement decisions on their own terms, which helps preserve a sense of self-identity and self-sufficiency (Hillcoat-Nallétamby, 2014).

Research supports that OTs and older people understand and prioritise independence differently (Fricke & Unsworth, 2001; McIntyre & Wilson, 2013). One study found older people rated leisure-related activities (e.g., communicating with others, transportation, and reading) as most important, whereas OTs rated self-care activities (e.g., medication management and food preparation) as most important (Fricke & Unsworth, 2001). In the present study, independence was viewed by older people as the retention of autonomy and the protection of dignity and identity, specifically, the capacity to make decisions aligned with their own priorities, even if those choices may not prioritise functionality and risk reduction.

Functional approaches that focus on mitigating physical decline and on providing solutions to support self-care can overlook the social and situated nature of ageing (Hoyt et al., 2025). In the current study, the professional response of OTs typically centred on providing tools such as AA to address frailty and facilitate task completion to increase independence. This task-oriented perspective foregrounded what AA enabled an older person to *do*, emphasising its functional and mechanistic potential. Further, the emphasis on risk among OTs reflects broader professional discourses linking safe ageing to *good* ageing (Langmann & Weßel, 2023; Rose et al., 2023). While being safe is seen as good ageing by OTs, it may reduce ageing to a set of decisions aimed at reducing fall risk or other safety issues. However, prioritising safety may come at the expense of autonomy and can generate tension for older people who seek the independence to make choices on their own terms (Marnfeldt &

Wilber, 2025). The analysis demonstrates that, for older people, independence was not simply the absence of help but was understood as an ongoing practice of self-sufficiency for as long as possible. This included active negotiation over which AA were acceptable and when they were appropriate to use. This understanding aligns with relational accounts of autonomy, which emphasise adaptation and negotiation, as well as the social components of self-concept (Christman, 2004). For older people, independence was experienced through socially situated and continually negotiated practices of managing support, resources and relationships in ways that sustained a valued sense of self.

Acceptance of AA

The current study reveals a clear disjuncture in how older people and OTs understand acceptance of AA. For older people, acceptance is a process of identity work, negotiating what ageing means for autonomy and daily routines. Acceptance happens over time and requires careful consideration of what accepting an assistive device means for their identity. In contrast, OTs often view acceptance as a complete and singular decision to adopt AA and see resistance as a sign of failing to accept both AA and the realities of ageing. This divergence highlights how acceptance is embedded in different frameworks.

An understanding of what it means to age and how older people adapt to and accept ageing has been approached from multiple perspectives within the literature, including social, psychological, and biological (De Magalhães, 2025; Marshall, 1980; Shaw & Langman, 2017). The term successful ageing, coined by Rowe and Kahn (1987), is often used to understand the process of ageing. However, the definition of

successful ageing is contentious (Carpentieri et al., 2016; Depp & Jeste, 2006; Waddell et al., 2024). Successful ageing models have been criticised for their focus on maintaining physical functioning, prioritising the absence of disease, and promoting idealised outcomes in later life (M. M. Baltes & Carstensen, 1996). The model of selection, optimisation, and compensation (SOC), while still providing a model for thriving in later life, focuses on the process older people go through to maximise gains and minimise losses in response to activities of daily living and in response to functional decline (M. M. Baltes & Carstensen, 1996; P. B. Baltes & Baltes, 1990; Napolitano & Freund, 2021). In the SOC model, selection occurs through elective selection (e.g., increasing physical activity) or loss-based selection (e.g., giving up running and adopting a mobility-based goal). Optimisation involves devoting time and resources to maximising gains related to goals (e.g., daily walks). Compensation involves managing apparent losses in functioning by adjusting (e.g. walking instead of running). SOC is particularly relevant to the acceptance of AA as it considers how older people might adjust to the loss of physical functioning by using assistive devices as compensation. Viewing acceptance as active and ongoing explains the identity work older people undertake and how they process gains and losses over time. This compares with viewing acceptance of ageing as a single act that occurs in relation to the age-related changes older people experience.

For older people, acceptance of AA is bound up with a process of identity work in becoming old and negotiating what ageing means for autonomy and daily routines. Research suggests that older people often reject the idea that ageing fundamentally differentiates them from younger people or their younger selves, a premise Nelson (2005) identifies as the basis of ageism. A fit and healthy body serves

as a key reference point for judging how well older people are managing the ageing process (Higgs & Gilleard, 2016). Introducing AA can then serve as a reminder of physical decline and exacerbate experiences of ageism and stigmatisation (Jensen, 2014; Yusif et al., 2016). The present study demonstrates that AA are implicated in how older people relearn and reinterpret their bodies, rather than AA simply mitigating the anticipated progression of frailty as professionals and society anticipate. Within the SOC model, functional or cognitive losses might be approached by optimising and compensating with new strategies (M. M. Baltes & Carstensen, 1996), including the use of AA. Framing acceptance as a process that older people experience and navigate within societal structures is an important nuance to understanding older people's experiences of ageing and AA.

OTs view resistance to AA as evidence of a failure in acceptance, which is manifest as both failures to accept AA and refusal to accept the realities of ageing. Studies show that OTs view older people's resistance as resulting from inaccurate self-assessment, self-directed ageism, and denial of physical or cognitive decline (Jaana et al., 2025; Yaddaden et al., 2026). Lack of accurate self-evaluation and limited capacity for judging functionality are reported by OTs as factors in older people's resistance to AA; acceptance is also closely tied to the older person's motivation and belief in the usefulness of a device (Yaddaden et al., 2026). Self-directed ageism is also reported as underlying resistance. Research suggests that due to ageist stereotypes, older people believe they are too old to learn new technologies (Yaddaden et al., 2026). Further, research shows that OT's believe feelings of dependency and loss of dignity were key reasons for older people's resistance to AA as they saw the device as a representation of weakness or reliance on others, framing

AA as symbols of decline (Jaana et al., 2025) This highlights how OTs may view older people's resistance as a rejection of the negative factors of ageing, not necessarily the device itself, and how social factors of ageing contribute to how older people process the need for an assistive device.

The analysis shows that older people are undergoing a process of acceptance that co-occurs with chronological ageing, illustrating how they undertake considerable work to come to terms with ageing as a concept that Western society has vilified. Older people demonstrate through their stories that it is difficult, that they “*don't have to like it*”, but they accept they are ageing, and this has implications for identity and sense of self. This meant that coming to terms with accepting an assistive device was tied to accepting their own ageing, and acceptance unfolded over time, rather than occurring as a single event. This reflects psychological understandings of ageing as a process of active acceptance (M. M. Baltes & Carstensen, 1996; Napolitano & Freund, 2021). Research shows that acceptance of ageing is associated with greater emotional awareness and understanding and with lower negative affect (Charles & Piazza, 2009; Shallcross et al., 2013; Velaithan et al., 2023). This demonstrates that ageing is not only viewed negatively by older people, but as a constructive process of emotional growth and adaptation. Although the analysis revealed that OTs acknowledged that AA resistance was about what it symbolised in terms of being “old”, the predominant response remained oriented towards overcoming reluctance rather than engaging with these layered meanings of acceptance and resistance. This expands on existing research that emphasises the importance of older people retaining control and autonomy over their lives, particularly in the context of care and intervention (Grenier & Phillipson, 2013).

Power

OTs occupy a socially powerful position relative to older people by virtue of their professional expertise in aged care. They are perceived by older people, their families and broader healthcare systems as experts in ageing (Doyle, 2014; Eliassen, 2016; Klein & Liu, 2010; Mortenson & Dyck, 2006). This establishes a power imbalance within which interactions between OTs and older people occur. OTs particular lens of expertise emphasises risk reduction and increased functionality, eroding older people's agency to set their own priorities and manage ageing in line with their preferences regarding AA. Furthermore, older people's choices regarding AA acceptance are not treated as equally valid; OTs position AA rejection as accepting risk and thereby frame it as making the wrong choice. This power differential between older people and OTs also has the capacity to exacerbate ageism, as lay-professional imbalances are intensified when the layperson holds a denigrated social identity, such as that of an older person.

Power differentials between healthcare professionals and older people are well established. These encompass experiences that influence older people's autonomy, with health professionals often concentrating on pathologies or deficits of ageing. They also involve instances of ageism and oppression, as well as how institutional practices can affect client treatment (Doyle, 2014; Eliassen, 2016; Klein & Liu, 2010; Mortenson & Dyck, 2006; Pooley & Beagan, 2021). Power differentials often stem from an imbalance in authority between groups, with authority shaped by societal structures of education, occupational status, or medical authority. These differences position one party at an advantage in the health interaction. For example, in a

healthcare setting, technical expertise and familiarity with the healthcare system and procedures position the professional as having greater authority and status than patients (Eliassen, 2016). This can result in the OT's opinion being accorded greater authority over the older person.

Research indicates that a pathology and deficit-focused approach by healthcare professionals tends to reinforce stereotypes of frailty and dependency and frames older people as a vulnerable group requiring special care (Doyle, 2014; Eliassen, 2016). Institutional concern with frailty and dependency can often shape how OTs treat their clients, leaving older people feeling disempowered (Mortenson & Dyck, 2006; Rebeiro, 2000). Further, the concern with frailty can overshadow older people's identities as health professionals focus on mitigating deterioration in functioning over time. Professional intervention can also enable greater regulation of older people's bodies, leading to the perception that ageing increases the need for assistance (Doyle, 2014; Powell, 2009). This is further supported by an Australian study showing that older people receiving government aged care packages underwent extensive assessments that categorised them into levels of frailty (Doyle, 2014). While this resulted in access to necessary services, it also reinforced power differentials. Older people in Doyle's (2014) study felt that decisions about service levels were imposed on them in a way that felt like ageism or, in some cases, elder abuse. Within OT practice, independence in daily activities is often treated as the ideal goal for older people (Klein & Liu, 2010), which can produce power-laden interactions that do not always align with older people's priorities.

Older people's rejection of support is often framed as a morally questionable choice in OT practice. For example, when an older person's choice aligns with valued positions of independence, compliance and safety, these choices are ratified as evidence of good judgment, whereas choices that disrupt those positions are reinterpreted as symptoms of denial (Langmann & Weßel, 2023). Further, Mortenson and Dyck (2006) found that OTs' concerns about safety discourage client choice, limiting older people's autonomy and influencing decision-making around which interventions are deemed appropriate. The impact of power differentials can leave older people feeling oppressed and without viable choices (Doyle, 2014). While these findings highlight choices as morally unequal, it is important to acknowledge that health care professionals understand this dilemma and find it challenging to balance their concern for risk with the older person's free will (O'Donnell et al., 2023). Their concern about making the right decision is tied to normative ideas about the duty of care and medical best interests. These normative concepts are linked to ideologies of paternalism and protectionism (O'Donnell et al., 2023). Consequently, healthcare professionals navigate a tension between upholding their duty of care and honouring older people's autonomy.

Power differentials between older people and OTs reflect social structures but also play out in interpersonal interactions. Studies have found that OTs' professional processes often disempower clients by discouraging reasonable risk-taking and focusing on illness (Mortenson & Dyck, 2006; Rebeiro, 2000). In doing so, they shift decision-making authority away from older people, positioning professional judgements about safety and deficit as more legitimate than clients' own priorities and understandings of their own lives. The current study finds that while OTs consider

older people's agency and dignity of risk, they do so with explicit recommendations and warnings about what might happen if those recommendations are not followed. This produces particular moral worlds of ageing, within which some choices are rendered reasonable and others "*ridiculous*". Within the analysis, choice operates as a normative ideal which OTs must be seen to honour, but which is often constrained and shaped within their professional practice, where the language of choice functions as a moral yardstick which differentiates responsible, agentic older people from those seen as passive or risky. In this way, the same *choice* is read differently depending on the identity assigned to the older person. For example, "*stubborn*", "*cute*", "*frail*" or "*realistic*" about ageing. Importantly, there is a tension between allowing choice and simultaneously denigrating the chooser. For example, positioning someone as stubborn or cute can make space for minor low-stakes choices, while casting the person as childlike or irrational may erode claims to full adult agency (Gendron et al., 2016; Raina & Balodi, 2014). This pattern aligns with what Dunn (1999) calls conditional autonomy, in which older people are permitted choice only when it does not disrupt professionals' assessments of risk, resource allocation, or what counts as a reasonable way to age. The present study demonstrates that power differentials exist between older people and OTs when it comes to decision-making about AA.

Power dynamics positioning OTs as the primary experts on ageing, including decisions about risk avoidance and functionality, can overlook the priorities of older people and reinforce ageism (Doyle, 2014; Klein & Liu, 2010; Mortenson & Dyck, 2006; Rudman, 2015). Studies show that ageism is exacerbated in environments where power operates to reduce older people's involvement in care-based decisions and where health professionals tend to override older people's voices and experiences

(Doyle, 2014; Rudman, 2015). In OT practice, independence in daily activities is commonly assumed to be the goal for most clients; however, this is not always accurate. This emphasis on independence, paired with deeply entrenched Western values and norms of self-reliance, can perpetuate ageism (Klein & Liu, 2010). Although these findings point to issues of power, pathologisation and ageist assumptions within health care more broadly, it is important to acknowledge that OTs hold more positive attitudes toward older people than health professionals in general and are less influenced by societal negative attitudes in clinical decision-making (Klein & Liu, 2010; Weir, 2004). Therefore, processes of ageism do not originate with OTs themselves but reflect societal understandings of older people, which, when combined with OT professional practices of mitigating decline, play out in interpersonal interactions with older people.

Limitations

As mentioned in the introduction, accessing support in the form of AA is often carried out via MAC, which involves a series of steps and processes that older people undertake over time. This process can take anywhere from six to 18 months. Narratives for the present study were collected within a single time point, limiting insight into how acceptance, identity work and resistance to AA evolve longitudinally. As previously mentioned, the study design aimed to speak with older people aged 65 or older, the age at which they are eligible for MAC support. This allowed participation in the study at any point along the journey to accessing support. However, it is possible that people consider AA prior to the age of 65 years and go through identity work in the lead-up to requiring or seeking AA support. Research

indicates that older people's self-perceptions of ageing tend to change over time (Velaithan et al., 2023), providing support for longitudinal approaches to ensure acceptance processes are captured over time. Further, OTs often focus on the single decision of AA acceptance, which might overlook the ongoing experiences of accepting AA.

The analysis was situated within the specific welfare and funding context of the Australian Government MAC system, which shapes the experiences of older people and OTs. OTs working with older people operate within a specific funded system that establishes structures and methods for engaging with older people, thereby shaping specific types of relationships. The Productivity Commission's Report on Government Services 2026 suggests that approximately 310 per 1000 people aged 50 years or over (Aboriginal and Torres Strait Islander) and people aged 65 years or over (non-Indigenous) accessed MAC (Productivity Commission, 2026). While not all older people require support, this suggests that some may access it through other means. For example, older people may access AA directly through retail channels, the second-hand market or via family members. These pathways may include varying experiences of acceptance and choice, where the older person controls processes of autonomy and what is deemed the correct decision. Therefore, the particular process that participants in this study went through may not be representative of all older people's pathways to support and AA adoption, limiting these findings to those navigating government-funded aged care services.

The findings from the OT interviews reflect the Australian Government MAC system, whereby OTs tend to homogenise older people by defaulting to the

mainstream stereotypical older person. Therefore, the experiences of older people reported by OTs are unlikely to be representative of the diverse experiences of AA acceptance. OTs may also homogenise the experience of ageing, defaulting to a perceived average mainstream population experience, by predicting a standardised trajectory of physical decline that may differ across populations.

A notable limitation was the lack of diversity in the older participants' demographic characteristics. The recruitment approach of using social media, the use of English language, and the age specification of 65 years may have shaped recruitment. Aboriginal and Torres Strait Islander peoples can access MAC at age 50, meaning the age limit may have excluded their participation. Indigenous communities may also access MAC differently than other older populations. The lack of diversity in ageing research is noted in the literature as requiring attention (Zubair & Norris, 2015). In Australia specifically, research suggests there are a range of barriers experienced by Aboriginal and Torres Strait Islander peoples to accessing health services (Wettasinghe et al., 2020). These encompassed cultural and transportation barriers, as well as the absence of appropriate health programs (Wettasinghe et al., 2020). Moreover, the experience of ageing among Aboriginal and Torres Strait Islander peoples appears markedly different from that of non-Indigenous Australians, as outlined in the National Aboriginal Health Strategy. For example, health is defined as a holistic concept that extends beyond physical health or functional capacity and includes the social, emotional and cultural well-being of the whole community (Department of Health, 2025). The ways in which Aboriginal and Torres Strait Islander peoples experience ageing and AA are unlikely to be reflected in mainstream health systems or the present study, which focuses on dominant service models.

Future Directions

Using narrative analysis, the present study offers a unique perspective on how both older people and OTs make sense of AA's adoption in retrospect. To further explore these contrasting interpretations and to reveal what remains unsaid, future research could advance understanding through an ethnographic study of the consultation process between the older person and OT. Recording and analysing these interactions and analysing them using conversation analysis (CA) would expose micro-level dynamics of power, positioning and repair work between OTs and older people (Wilkinson & Kitzinger, 2008). Unlike narrative methods, CA highlights turn-taking, silences, and implicit negotiations that shape decision-making, offering granular insights into how resistance or acceptance emerges interactionally.

The current analysis found that AA acceptance is an ongoing, dynamic process for older people that involved gradual recognition of change and daily negotiation of ageing and AA, yet OTs often framed it more statically. To uncover earlier, less obvious stages of acceptance, longitudinal studies could trace adaptations from the outset of ageing identity work, prompting questions like: "What was the very first change you made at home?". This might reveal *invisible* strategies, such as reorganising furniture, repositioning everyday items (e.g., chairs) or switching to a car with a more suitable height for easy entry and exit, which prefigure formal AA use. Such natural adjustments blur distinctions between AA and routine adaptations, challenging professional categorisations and highlighting the organic responses to ageing over time and place. Research suggests that the seemingly ordinary routines of daily life are important for understanding the broader aspects of ageing (Andrews &

Grenier, 2018), while a focus on the materiality within ageing research highlights the meanings older people attribute to the material dimensions of space (Martin & Pilcher, 2024).

Finally, future work should purposively include minority groups, such as Aboriginal and Torres Strait Islander peoples, whose experiences of ageing and AA may face amplified marginalisation within mainstream services. This should also apply to those providing OT services to older people whose approaches may differ from those within the dominant mainstream system. Ethnographic CA approaches could illuminate how cultural mismatches exacerbate power imbalances, while longitudinal designs might document culturally distinct processes of acceptance (Rawls & Lynch, 2024).

Implications

Findings underscore the need for OTs to distinguish between their dominant frame of independence, as functional self-sufficiency, and older people's emphasis on relational autonomy, dignity, and identity preservation. OT interventions could explicitly frame resistance as meaningful identity work rather than as rejection. Interventions could also include dialogue about what ageing means and feels like for older people, as well as discussions on stigma, during consultations. However, proper training would be essential to carry this out in a psychologically safe manner.

Additionally, OT training programs frequently emphasise risk reduction by addressing functional decline (S. Elliott & Leland, 2018; Fricke & Unsworth, 2001; Miranda-Duro et al., 2021). However, to more effectively serve older people, OT education could be improved by incorporating more knowledge of social gerontology,

ageism, and health interactions. These approaches might help to address the limitations in understanding between OTs and older people and instead foster a gradual, client-led acceptance process.

Conclusion

The present study illuminates different narratives of ageing and AA between older people and OTs, revealing tensions in identity, independence, acceptance, and power. Older people frame ageing as a process intensified by AA's symbolic reminders of decline, stigma and disrupted autonomy, rendering them characters in ageist stories where AA evokes the frailty they observe and denigrate in others. Older people negotiate acceptance through gradual identity work involving coming to terms with ageing itself. OT's interpret acceptance or resistance to AA as a response to ageing and adopt a pragmatic, functionally focused lens, prescribing AA to enhance safety and reduce risk while often unintentionally overlooking emotional or social meanings of AA. This positions OTs as ostensibly preserving client agency, yet assumes rational, autonomous decision-makers, unbounded by the weight of ageism. These contrasts matter in unequal power dynamics: OTs' authority allows functional narratives to predominate, subordinating older people's stories and risking older people's autonomy through unaddressed ageism. Without ageism, AA would simply facilitate living; its symbolism highlights how social meanings influence how older people experience and accept AA.

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Appendices

Appendix A: Information Sheet – Older People



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Exploring the use of Assistive Aids in later life

INFORMATION SHEET FOR OLDER PEOPLE

Introduction – who is doing this research?

Hello, My name is Alina, and I am a psychology student studying at Massey University from Adelaide. For my Master's thesis, I am conducting research to find out how people understand and use assistive aids as they get older. To find out about the use of assistive aids in later life, I wish to interview both older people and occupational therapists who work with aged care clients.

This research aims to explore how older people experience the use of assistive aids. My project is supervised by Dr Mary Breheny from the Health and Ageing Research Team (HART).

This information sheet explains the project and what you can expect if you decide to participate. If you have questions about any aspect of the project at any time, please get in touch with me using the contact details below. Thank you for taking the time to consider my invitation to participate in this project.

Project description

I wish to interview people aged 65 years or over who are thinking about or are in the process of acquiring an assistive aid. Therefore, I am interested in talking to you about your thoughts and experiences.

Who can participate

You can participate in the study if:

- You are aged 65 years or over.
- You are thinking about or in the process of acquiring one or more assistive aids, including equipment that aids your day-to-day living, including:
 - Walking frames
 - Lifters
 - Adaptive utensils for tasks like eating, writing, gripping
 - Adaptive equipment for using the bathroom or showering
 - Rails

What the participation involves

If you fulfill the requirements above and decide to participate in this research, I will interview you to talk about a range of different topics related to your experience with assistive aids in your day to day life (approximately 45 – 60 minutes). The interview can take place in your home or in a public setting at a time that is convenient to you. I'll ask you to sign a consent form to acknowledge that you're willing to participate and to confirm that you understand what is involved in the research process.

The interview will be audio recorded. You may ask me at any time for the recording to be paused or not to use a piece of information.

To recognise your time and effort invested in participating, you will receive a \$30 fuel or grocery voucher.



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What happens with your data

I will transcribe the interview without identifying information. A pseudonym will be used in place of your name and only my supervisor and I will have access to the data.

Results from this project will be included in my thesis without any identifying information. De-identified results may further be used for scientific publication, reports or presented at conferences.

Participant support and well-being:

It is very unlikely that we will talk about any distressing details. However, if at any point during or after our interview, you experience extreme discomfort or distress when talking about the use of assistive aids, you can withdraw from the study, we can notify a family member, and you may be assisted with mental health support (free of charge; toll-free call lines):

- Lifeline: 13 11 14
- Beyond Blue: 1300 224 636

Your rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any particular question;
- ask any questions about the study at any time during participation;
- provide information on the understanding that your name will not be used;
- ask for the recorder to be turned off at any time during the interview.

Project contact details:

If you would like to contact me at any time, my contact details are:

Alina Godfrey

Ph: +61 [REDACTED]

Email: alina.godfrey.1@uni.massey.ac.nz

This research is under the supervision of Dr. Mary Breheny, Massey University;

Email: M.R.Breheny@massey.ac.nz

Ethics

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researchers named above are responsible for the ethical conduct of this research.

If you have any concerns about the ethical conduct of this research that you want to raise with someone other than the researcher(s), please contact Massey University Human Ethics by email: humanethics@massey.ac.nz.

Appendix B: Information Sheet – Occupational Therapists



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Exploring the use of Assistive Aids in later life

INFORMATION SHEET FOR OCCUPATIONAL THERAPISTS

Introduction – who is doing this research?

Hello, My name is Alina, and I am a psychology student studying at Massey University from Adelaide. For my Master's thesis, I am conducting research to find out how people understand and use assistive aids as they get older. To find out about the use of assistive aids in later life, I wish to interview both older people and occupational therapists who work with aged care clients.

This research aims to explore how older people experience the use of assistive aids. My project is supervised by Dr Mary Breheny from the Health and Ageing Research Team (HART).

This information sheet explains the project and what you can expect if you decide to participate. If you have questions about any aspect of the project at any time, please get in touch with me using the contact details below. Thank you for taking the time to consider my invitation to participate in this project.

Project description

I wish to interview occupational therapists who support older people to access assistive aids and/or to make adjustments to their homes. Therefore, I am interested in talking to you about your thoughts and experiences.

Who can participate

You can participate in the study if:

- You are an Occupational Therapist;
- You work with or have worked with aged care clients;
- You have experience in supporting older people in acquiring assistive aids or modifications to their homes. This includes the following:
 - Walking frames
 - Lifters
 - Adaptive utensils for tasks like eating, writing, gripping
 - Adaptive equipment for using the bathroom or showering
 - Rails

What the participation involves

If you fulfill the requirements above and decide to participate in this research, I will interview you to talk about a range of different topics related to your experience with older people seeking aged care support in the form of assistive aids (approximately 45 minutes). The interview can take place over Zoom or at a time and place convenient to you. I'll ask you to sign a consent form to acknowledge that you're willing to participate and to confirm that you understand what is involved in the research process.

The interview will be audio recorded. You may ask me at any time for the recording to be paused or not to use a piece of information.

To recognise your time and effort invested in participating, you will receive a \$30 fuel or grocery voucher.

Appendix C: Participant Consent Form



Exploring the use of Assistive Aids in later life

PARTICIPANT CONSENT FORM

I have read and I understood the Information Sheet. I have had the details of the study explained to me. My questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary.

1. I agree to the interview being sound recorded.
2. I agree to participate in this study under the conditions set out in the Information Sheet.

Declaration by Participant:

I [print full name] _____ consent to take part in this study.

Signature: _____ Date: _____

Appendix D: Question Guide



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Exploring the use of Assistive Aids in later life: A narrative analysis

INTERVIEW GUIDE

The following set of questions will guide the conversation with participants using an unstructured in-depth approach. Not all questions will be asked or asked in a set order. Questions are designed to be open-ended and broad inviting participants to tell a story about assistive aids in the context of ageing.

Introduction

- Greetings, introductions, and introduction to the purpose of the interview
- Clarify the session is audio-recorded
- Room for questions before starting

Key Questions:

How do participants construct their experience of AA use?

- What 'truths' about the experiences of using AA are constructed, and what are their consequences in a public setting?
- How do these constructions affect what they say, feel or do?

Occupational Therapists:

What it is like to support older people to access assistive aids?

Can you tell me how you approach working with older people when it comes to prescribing assistive aids?

How have you come to develop the approach?

Can you tell me about a time when an aged care client was reluctant to acquiring an assistive aid?

Can you tell me about a time when an aged care client was willing and accepting of assistive aids?

Older People:

What it is like to begin the process of accessing assistive aids for older people.

Can you tell me what prompted you think about getting an assistive aid?

What was the easiest part? What was the hardest part?

Can you tell me about how you feel about the idea of getting an assistive aid?

If a participant already has an AA: how do you find using your assistive aid in public?

Can you tell me how you've made sense in your mind about getting an assistive aid?

Can you tell me about a time when you felt embarrassed in a public or private setting because of an assistive aid? (NOTE: only ask if previous answer has led to this).

Prompts:

- Tell me more....
- What happened then.....

Background Information

- Basic information (age, gender, type of Assistive Aid/s used)

Conclusions

- Room for ad hoc questions and additional comments: Is there anything else you would like to share?
- Discuss the next steps and how to contact the researcher
- Thank the interviewees for their time and participation, and provide a voucher

Appendix E: Recruitment Poster – Older People

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TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

LOOKING FOR VOLUNTEERS

Are you considering an assistive aid?

My name is Alina, and I am a psychology student studying at Massey University from Adelaide. For my Master's Thesis, I am doing research to find out how people understand and use assistive aids as they get older.

Who is eligible:

- > People 65 years or older.
- > Getting an assistive aid (e.g. walker, lifter, shower chair, bathroom rails, grab bars, or devices to help perform tasks such as cooking, dressing, grooming, etc).
- > Available to be interviewed in person in Adelaide.

What is involved:

- > One 45 - 60 minute interview, during which you will have the opportunity to share your stories.
- > You will receive a \$30 gift card as a thank-you for participating in the study.

If you are interested in hearing more about this research, **contact me via email at**
alina.godfrey.1@uni.massey.ac.nz or [redacted]

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher named above are responsible for the ethical conduct of this research. If you have any concerns about the ethical conduct of this research that you want to raise with someone other than the researcher(s), please contact Massey University Human Ethics by email: humanethics@massey.ac.nz.

Appendix F: Recruitment Poster – Occupational Therapists



COLLEGE OF
HUMANITIES AND
SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

LOOKING FOR VOLUNTEERS

Do you work with aged care clients?

My name is Alina, and I am a psychology student studying at Massey University from Adelaide. For my Master's Thesis, I am doing research to find out how people understand and use assistive aids as they get older.

Who is eligible:

- > Occupational Therapists who work with aged care clients.
- > Have experience working with older people seeking aged care support in the form of assistive aids.
- > *Assistive aids include: walkers, lifters, bathroom rails, grab bars, shower chairs, devices to help perform tasks such as cooking, dressing, grooming, etc.*
- > Live in Adelaide, and can be interviewed in person or over Zoom.

What is involved:

- > One 45 - 60 minute interview, during which you will have the opportunity to share your experiences.
- > You will receive a \$30 gift card as a thank-you for participating in the study.

If you are interested in hearing more about this research,

contact me via email at

alina.godfrey1@uni.massey.ac.nz or [REDACTED]

This project has been evaluated by peer review and judged to be low risk. Consequently, it has not been reviewed by one of the University's Human Ethics Committees. The researcher named above are responsible for the ethical conduct of this research. If you have any concerns about the ethical conduct of this research that you want to raise with someone other than the researcher(s), please contact Massey University Human Ethics by email: humanethics@massey.ac.nz.

Appendix G: Meta Recruitment Campaign – Older People

LOOKING FOR VOLUNTEERS

Are you considering an assistive aid and available for a 60-minute interview?

Who is eligible:

- > People 65 years or older.
- > Thinking about or in the process of getting an assistive aid (e.g. walker, lifter, shower chair, bathroom rails, grab bars, or devices to help perform tasks such as cooking, dressing, grooming, etc).
- > Available to be interviewed in person in Adelaide.



MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
TE KURA PŪKENGĀ TANGATA

LOOKING FOR VOLUNTEERS

Are you considering an assistive aid and available for a 60-minute interview?

Who is eligible:

- > People 65 years or older.
- > Thinking about or in the process of getting an assistive aid (e.g. walker, lifter, shower chair, bathroom rails, grab bars, or devices to help perform tasks such as cooking, dressing, grooming, etc).
- > Available to be interviewed in person in Adelaide.



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TE KURA PŪKENGĀ TANGATA

LOOKING FOR VOLUNTEERS

Are you considering an assistive aid and available for a 60-minute interview?

Who is eligible:

- > People 65 years or older.
- > Thinking about or in the process of getting an assistive aid (e.g. walker, lifter, shower chair, bathroom rails, grab bars, or devices to help perform tasks such as cooking, dressing, grooming, etc).
- > Available to be interviewed in person in Adelaide.



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Alina Godfrey - Master of Science

Business chat

You opened this conversation through an ad. When you reply, Alina Godfrey - Master of Science will be able to see your public info and which ad you clicked.

Hi Alina! My name is Alina, I am doing research to find out how people understand and use assistive aids as they get older. Can you confirm you're 65 years or older and are thinking about or are in the process of getting an assistive aid?





Aa




Appendix H: Meta Recruitment Campaign – Occupational Therapists



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UNIVERSITY OF NEW ZEALAND

COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
TE KURA PŪKĒNGA TANGATA

LOOKING FOR VOLUNTEERS

Are you an OT who works with aged care clients and available for a 45-minute Zoom interview?



Alina Godfrey - Master of Science
Ad · 🌐

⋮ ×

Are you an OT and have experience working with aged care clients?

LOOKING FOR VOLUNTEERS

Do you work with aged care clients and available for a 45-minute interview?

Who is eligible:

- > Occupational Therapists who work with aged care clients.
- > Have experience working with older people seeking aged care support in the form of assistive aids.
- > Assistive aids include: walkers, lifters, bathroom rails, grab bars, shower chairs, devices to help perform tasks such as cooking, dressing, grooming, etc.
- > Available to be interviewed over Zoom



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MESSENGER
Contact me

 **Send message**

👍 6

2 comments

👍 Like

💬 Comment

➦ Share



Alina Godfrey - Master of Science
Business chat

⋮ ×

You opened this conversation through an ad. When you reply, Alina Godfrey - Master of Science will be able to see your public info and which ad you clicked.

Hi Alina! My name is Alina, I am doing research to find out how people understand and use assistive aids as they get older. Can you confirm you're an OT and have experience working with aged care clients?





Aa


