Joseph Sheldon, the British geriatrician whose survey *The Social Medicine of Old Age* (1948) became a leading reference for identifying the features of ‘normal’ population ageing, was also one of the first physicians to recognize the problem of falling. In his paper, ‘On the natural history of falls in old age’ (1960), Sheldon categorized 500 falls (experienced by 202 people) primarily into ‘accidental falls,’ followed by ‘drop-attacks’ (falling without warning), ‘trips’ and ‘vertigo.’ Some falls happen for unknown reasons. While Sheldon offered medical explanations where possible, what strikes today’s reader is his attention to his subjects’ experiences, including the challenges to getting back on their feet after falling. They understand their falls as a part of a bodily negotiation with gravity and thus they ‘complain bitterly of inability to preserve their balance as they did when they were younger’ (Sheldon 1960: 1685). Environments (including stairs), illumination, slippery surfaces and obstacles matter as much as physical stability. In the end, Sheldon says that falling in old age is fascinating ‘because at this stage of life Nature resembles the engineer who may release the unexpected’ (Sheldon 1960: 1690).

After Sheldon, fall research developed slowly (see Speechley 2011), perhaps because fallers were not yet problematized as clients of expertise and falling itself was still considered an incidental and often inexplicable aspect of the ageing process. As mainstream gerontology drew stark medical, residential and moral boundaries between independence and dependence, older people would naturally come to fear falling as a stigmatizing decline in status and sense of resilience. For these reasons, researchers discovered that falls could be trivialized or underplayed by older individuals, even though fall research consistently neglected to take their stories into account or acknowledge ‘the unexpected,’ as Sheldon had done. Newall and colleagues comment that ‘while everyday minor problems might be understood as exacerbated in older age, the converse may be said for some major problems’ (2006: 337). This statement is relevant to the relationship between fall expertise (research and prevention) and faller experience because, while falls have become a global health issue, they are also trivialized, paradoxically, at the level of embodied experience. Thus, falls form an intersection point between the inside and outside of ageing, which this chapter takes as an opportunity to review the research and professional discourses on falls and falling in old age. In particular, the focus is on the subjective dimension of the ageing body, including the phenomenology of gravity and its material contexts, with examples drawn mainly from Britain, Canada and the United States. The concluding section explores the
importance of the falling body to the critical conversation between ageing studies, body studies and cultural gerontology.

The scope of falls as a major social problem

The professional literature portrays falls as a major problem of rising injuries, hospitalizations and deaths amongst ageing populations. In America, between 45 percent and 61 percent of nursing home residents fall each year, resulting in significant cases of hip fractures, with the mortality rates in the year following the fracture estimated at between 14 percent and 35 percent (Carroll et al. 2008: 213). In Canada falls have become a main cause of injury, a reason for entering care facilities, a factor in morbidity and a growing expense to the healthcare system. According to Ward-Griffin and colleagues, ‘Falls are the second leading cause of hospitalization in Canada for women 65 years and older and the fifth leading cause of hospitalization for men of this age’ (2004: 308). The annual direct healthcare costs of falls in Canada are $2.4 billion. In the UK, 50 percent of older residents in hospitals and care homes fall at least once a year (Oliver 2008: 248) and hip fractures result in more hospital admissions than any other type of injury (Bunn et al. 2008: 450). Falls are also the most common cause of accidental death for those 75 years and older. While the fall rate for community-dwellers 65 years and older is 30 percent, it is 40 percent for those 80 years and older. Other studies note that rates of falls amongst discharged patients are higher than in the community at large (Hill et al. 2011) and that falls are higher amongst women than men (Horton 2006). The World Health Organization’s WHO Global Report on Falls Prevention in Older Age (2007, hereafter referred to as the WHO Report), estimates that between 28 percent and 35 percent of people 65 years and older fall each year, with the fall rate and cases of death by injury increasing with age (WHO Report 2007: 1–2).

While this statistical picture on falls leaves little doubt that a healthcare disaster is in the making, what is typically missing from it is the person (and the body) who falls. The WHO Report, in articulating a global perspective on fall research, fits within current health and welfare policies that cluster somatic status in old age around factors of residence, dependency, mobility and social support. As such, here and in related literature, the ageing body is configured as a risky body, with over 400 risk factors assumed to be related to falling (Speechley 2011). For those individuals who do fall and are subject to one or more risk factors, their bodies not only fall down but also fall out of the social sphere’s functional spaces of certainty, utility and mobility. In the terrible moment of a hard, unintentional fall, our culture’s ambivalence about the ageing body as one that lacks the control to ‘hold on’ or ‘stay up’ comes tumbling to the fore. The failure to resist gravity, both as an outside force and as a bodily ‘center,’ while acceptable in many other circumstances at many other ages, is a signifier of decline when it happens in later life. Thus falling is not an isolated event but a phenomenological process that transforms a person into a ‘faller’ and mobilizes a point of entry for them into the multiple professional worlds of care, risk and prevention programs; hospital and community centers; and insurance and medical planning.

The WHO Report states that a fall is ‘inadvertently coming to rest on the ground, floor or other lower level, excluding intentional change in position to rest in furniture, wall or other objects’ (2007: 1). Such an operational definition is needed, states the Report, because otherwise research would leave ‘room for interpretation to study participants’ resulting ‘in many different definitions of falls. For example, older people tend to describe a fall as a loss of balance, whereas health care professionals generally refer to events leading to injuries and ill health’ (WHO Report 2007: 1). Yet, as Sheldon illustrated, ‘many different definitions of falls’ are an advantage to understanding the fall experience as is the role of personal interpretation and narrative (1960). Loss of balance along with ‘trips’ and ‘slips’ are primary reasons people cite for falling, because they
describe what it feels like to fall in an embodied, phenomenological sense. However, these feelings, where gravity overwhelms in unexpected ways and uncertain places, can become trivialized within a global and static risk model of the ageing body, a problem that is exacerbated in fall prevention programs.

**Fall prevention and the administration of risk**

Given the scope of the financial and human costs of falls, fall prevention has become a sizable field of its own. It ties together health governance, research, community living and professional care, with microsociological concerns about lifestyle, behavior, environment and intervention. The fall prevention literature’s lengthy list of ‘multifactorial’ causes includes problems with medications, unsafe environments, assistive technologies, physiological and vision limitations, and psychological states such as fear of falling. To counter these problems prevention programs work through the promotion of healthy choices for individuals to change behavior around exercise, diet and lifestyle, and to adapt supportive home modifications (e.g. Prevention of Falls Network Europe, www.PROFANE.eu.org). Again, the WHO Report is a model discourse in this regard by posing ‘active ageing’ as a key preventative strategy, especially for women assumed to be challenged by muscle and bone density decline following menopause (WHO Report 2007: 18). While research indicates that ethnicity is a factor for differences in fall rates (Stanaway et al. 2011) and that various cultural resources exist for fall prevention (Reyez et al. 2006), the point is that a globalizing discourse linking risk, ageing and falling prevails.

Fall prevention is also the subject of a growing advice industry, with popular titles such as *The Complete Guide to Fall Prevention* (2012), *How to Prevent Falls: Better Balance, Independence and Energy in Six Simple Steps* (2007), and *Fall Prevention: Don’t Let Your House Kick You Out* (2006). Hence, prevention discourse adds older individuals’ lifestyle, residence and, above all, bodies to the risk inventories for falls. For instance, the epidemiological risk of falling for a person 65 years or older supposedly rises to one fall per year. Thus, ‘the best approach to preventing falls in any group of older persons requires knowledge of where that group sits on the risk spectrum, because this will determine the type and amount of services required as well as the program effectiveness’ (Markle-Reid et al. 2010: 121). However, some analyses have shown that the costs of fall prevention services are not always knowable and in some instances can even ‘cost more than they save’ (Jenkyn et al. 2012: 133).

Where fall prevention aims at lifestyle risks, not all lifestyle risks of falling are actually risks or causes of falls (Speechley 2011). In addition, the coordination of fall evaluation or home inspection expertise designed to assess risks is complex and not standardized (Tinetti et al. 2006). Even individual choices about installing assistive, risk-preventative devices such as grab-bars, non-slip surfaces and easy-to-reach faucets evoke larger issues of social support and affordable ‘age-friendly’ housing. For example, in Canada, where 10 percent to 15 percent of all at-home falls not due to loss of consciousness happen in bathrooms, fewer bathtub grab-bars are installed in privately owned than publically owned buildings. Since one-third of all Canadian seniors live in apartment buildings, this is a political issue about imposing safety regulations around residential upgrading (Edwards et al. 2006). Meanwhile, the risks of institutional environments that contribute to falls can be underplayed; for instance, in hospitals and care institutions older patients frequently fall in their rooms, hallways and bathrooms, due in part to staff shortages or lack of training (Zecevic et al. 2012). Institutional settings may also contribute to under-reporting, since falls have few witnesses and data become of questionable quality due to staff time pressures (see Peel 2011).

But the central problem with fall prevention is the lack of participation by older people themselves. When consulted about their views on fall prevention programs, older people think
that falls are less important than other health factors, which the professional documentation of risk fails to acknowledge (Ballinger and Payne 2002, Bunn et al. 2008). In an Australian study of post-discharge fall prevention for older individuals, the authors discover that ‘program designers had little knowledge about older peoples’ views about falls and their perceptions of barriers that prevented engagement with risk reducing behaviours’ (Hill et al. 2011: 654). Further, in the research literature ‘no studies have evaluated older peoples’ knowledge or self-efficacy about falls and falls prevention strategies in the post-discharge period’ (654), despite the fact that ‘suggested strategies such as being careful, moving slowly, or avoiding hazards did not appear to be conceptually supported by the research evidence’ (Hill et al. 2011: 658). However, older people are keenly aware of the phenomenological relationship between their ageing bodies and their material environments (see Mahler and Sarvimäki 2010).

When older people are judged to be at risk of falling, their participation in a fall prevention program can be stigmatizing, which can amplify the fear of falling and, paradoxically, create resistance to healthy (and fall-preventing) physical activities (e.g., Edwards et al. 2003, 2006). Certainly the unappealing advice given to women to wear unattractive hip padding or special shoes can only add to the visibility of this label (Yardley et al. 2006: 512). For these and other reasons, fall prevention participation can affect a person’s sense of their own biographical ageing. As Paul Kingston notes, falling is ‘a powerful metaphor of decline’ (2000: 218) and a ‘status passage’ because falls are embarrassingly publicized and become part of one’s bio-identity. Thus fall prevention, where it centers on the measurement of risk factors to the exclusion of a person’s responses to falling (Laybourne et al. 2008) and narratives of experiences over time (Oliver 2008), creates a conflict between a self-understanding of embodied life and a risk-embedding, evidence-based assessment of it. It is not surprising that positive programs that stress maintaining independence, weight reduction, having fun, building strength with confidence, and, above all, not being judged by age, are the most successful (Nyman 2011).

Finally, gender rarely figures in fall professional discourse except where it notes that women fall more often and suffer more injuries than men. The patronizing double image that both naturalizes women as physically weaker and more risk-prone (especially after menopause) and reviles feminine strength and risk-taking as unfeminine encourages older women to see their own bodies as vulnerable (Reventlow et al. 2006, Grenier and Hanley 2007, Horton 2006, Martin 2011). But gender differences in the risks and experiences of falls have cultural determinants. For example, women are often given a higher number of medications compared to men, which can cause dizziness and loss of stability. A British study also found that in cases of injury recovery at home, female carers encouraged autonomy, self-esteem and reasonable risk-taking, while male carers practiced more protective and sometimes coercive caring styles, especially where the care-recipient was female (Horton and Arber 2004). Hence gendered relations of power can become concentrated in the treatment of women fallers, whose older bodies may have already been subject to a stereotyping ‘misery perspective’ (Krekula 2007).

The falling body and cultural gerontology

The relationship between the human body and the phenomenology of falling lies at the core of our human bipedal evolution. As Garrett Soden states, the challenge to consciously control falling and stay upright has meant that:

playing with gravity may provide the most intense examples of the flow phenomenon, because gravity is the constant and unyielding force in which we evolved; it unfailingly arouses our primal brain; it lets us reliably slip in and out of our protective frame without
the vagaries of a human opponent; and it unequivocally focuses all our attention on the here and now.

(Soden 2003: 272)

Indeed, the making of our biological and social bodies could only happen through risk-taking and ‘playing with gravity’ because these are the means by which we explore our environments and animate our competence. Walking, shopping, visiting, wandering, dancing, gardening and playing might all involve some level of risk of falling, but an exclusive focus on preventing falls may also cut the health benefits of such activities and reinforce passive behavior (Ballinger and Payne 2002). If we expect older people to be responsible self-carers, then we have to respect the risk-taking and experimentation that comes with the adjustments to ageing. These include a better sense of how the phenomenology of gravity, as a fluid and nomadic experience, intertwines reasonable risk-taking and risk-prevention as embodied skills.

We also need to rethink the connection between walking, staying upright and falling. For example, in the community, professional definitions of walking and falling can narrowly assume that ‘walkable’ environments are also accessible, safe and risk-aversive. However, in parallel to fall studies, walkability research sidelines the perceptions and experiences of residents by focusing on the particular features of their environments, such as pedestrian-friendly streets (Andrews et al. 2012). Different bodies and mobilities are also measured against active and able-bodied individuals who walk in unaided and unencumbered ways. Thus, the research ‘reduces the challenges faced by disabled people to a “dilemma of access” rather than addressing the significant embodied experiences and emotions of being “out of place” in disabling city environments shaped by economic, political and cultural forces’ (Andrews et al. 2012: 1928). For older people at risk of falling, walking is not simply ‘exercise,’ but a relay of challenges filled with hard surfaces, unexpected obstacles, speeding vehicles and dizzying social spaces.

How would urban design, community planning and fall prevention programs be different if older people were better consulted or if their embodied experiences were better understood? While we cannot trust our bodies not to fall, neither can we understand or prevent falls without including the phenomenological and material relationships between body, environment, experience and subjectivity. This call to critical thinking links the sociology of the falling body with current work on embodied ageing in cultural gerontology (Calasanti 2005, Twigg 2006, Tulle 2008, Gilleard and Higgs 2013), which stresses the inseparability of physical ageing from lived material contexts. Twigg’s work on ageing and clothing argues that the meaning of growing older is culturally and reflexively mediated through the clothes we wear (Twigg 2013). Tulle’s work on sport running (2008) elaborates the materialization of embodied ageing as grounded in routine athletic practices and the maintenance of physical capital. Other research on the embodied experience in dementia has produced imaginative therapeutic models of personhood that restore the centrality of the body to considerations of person-centered care and treatment (Kontos 2005, Kontos and Naglie 2009, Leibing 2008, Ward et al. 2011).

Such critical inquiries constitute a field of the materiality of embodied ageing that draws on the structural, feminist, and phenomenological work of Bourdieu, Butler, Elias, Foucault, Merleau-Ponty and others to draw attention to the absence of bodies and embodiment in social research on ageing. In so doing, they cast the materiality of embodied ageing into a perspective that includes the physical exigencies of ageing within the lived everyday experiences of older people. In particular, the materiality of embodied ageing challenges the tendency to obscure or biologize the body in Fourth Age or old, old age in relation to overly positive successful models of Third Age lifestyles (Katz 2005). The promotion of the diversity and possibilities of healthy ageing in retirement has actually deepened the negative aspects of ageing and dependency.
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associated with the Fourth Age as a kind ‘a metaphorical “black hole” of ageing’ where active agency, cognitive mindfulness, physical mobility and biographical selfhood are seen to collapse (Gilleard and Higgs 2010: 125). At the same time, the focus on the material conditions of bodily life counteracts social constructivist models that, while criticizing dominant medicalizing narratives, also neglect the physical realities of ageing and disabled bodies, leaving them outside of culture, history and experience. As James and Hockey comment, ‘All too often within contemporary sociological theorizing about health, the brute material facts of sickness, disability and disease, and the physical changes that occur in the body, become bracketed off’ (2007: 11). Thus, the issue of falls and the materiality of the ageing body converge as a nexus connecting the physical, biographical, phenomenological and cultural realms, where embodiment becomes the material ground from which to challenge both biological and constructivist reductionism.

Conclusion

An older individual who reaches for a grab-bar to facilitate a bathtub transfer on a slippery bathroom floor as they attempt to manage the risk of falling is moving within a materialized microcosmic world of the grab-bar, the bathtub, the bathroom and the residence. These elements, in turn, coalesce into an intimate assemblage of spaces and relationships tied to resilience and dependence, as they intersect with macro-worlds of health, safety, social support and quality of life. It is also a moment of negotiation between the body and its environment in an ageist culture obsessed by the fear of loss of physical control, where a fall commonly symbolizes a passage into declining old age. Yet the older body that falls, resists falling or is at risk of falling is a window through which to view the contingent nature of the ageing process itself, and the ways in which biography, culture, politics and biology are braided together. Just as the embodiment of ageing has a subjective dimension, the subjectivity of ageing has a physical dimension that is materialized in the activities, environments and social systems in which we grow older and find meaning, including those disregarded spaces and trivialized moments where bodies might fall and drop out. In these ways, falls provide a multidisciplinary opportunity for all of us in the sciences, the professions, the social sciences and the humanities to advance critical and caring perspectives on the ageing body and the human spirit.

References

Ageing, risk and the falling body


Prevention of Falls Network Europe (n.d.) www.PROFANE.eu.org


