

2021-07-03

# The meaning of confidence from the perspective of older people living with frailty: a conceptual void within intermediate care services

Underwood, Frazer

<http://hdl.handle.net/10026.1/17047>

---

10.1093/ageing/afab109

Age and Ageing

Oxford University Press (OUP)

---

*All content in PEARL is protected by copyright law. Author manuscripts are made available in accordance with publisher policies. Please cite only the published version using the details provided on the item record or document. In the absence of an open licence (e.g. Creative Commons), permissions for further reuse of content should be sought from the publisher or author.*

**The meaning of confidence from the perspective of older people living with frailty: a conceptual void within intermediate care services**

**Journal: Age and Aging**

**Acceptance Date: 7 April 2021**

**Short running title: The meaning of confidence for older people**

Frazer Underwood<sup>1,2,3</sup>, Jos M. Latour<sup>2,3</sup>, Bridie Kent<sup>2,3,1</sup>

<sup>1</sup> South West Clinical School in Cornwall, Royal Cornwall Hospitals NHS Trust, Truro, UK

<sup>2</sup> Faculty of Health, University of Plymouth, Plymouth, UK

<sup>3</sup> University of Plymouth Centre for Innovations in Health and Social Care: A JBI Centre of Excellence. Plymouth, UK

Address correspondence to: Dr Frazer Underwood, South West Clinical School in Cornwall, The Knowledge Spa, Royal Cornwall Hospitals NHS Trust, Truro, Cornwall TR1 3HD. Tel: +44 1872 255043. Email: [frazer.underwood1@nhs.net](mailto:frazer.underwood1@nhs.net) [2, 4]

## **ORCID**

Frazer Underwood <https://orcid.org/0000-0001-9130-033X>

Jos M Latour <https://orcid.org/0000-0002-8087-6461>

Bridie Kent <http://orcid.org/0000-0001-9550-1913>

## **Supplementary Data**

Supplementary data mentioned in the text are available to subscribers in Age and Ageing online.

## **Acknowledgement**

We are grateful to the participants of the study for sharing openly their experiences that have contributed so richly to these findings.

## **Declaration of Conflicts of Interest**

No conflicts of interest declared.

## **Declaration of Sources of Funding**

The Royal Cornwall Hospital NHS Trust funded the Doctor of Philosophy academic study costs of the first author of which this research contributed.

## **Declaration of funding:**

The first author is a NIHR 70@70 Senior Nurse and Midwife Research Leader and receives funding from the National Institute for Health Research. The views

expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

## **Authors' contributions**

F.U. conceived the study; B.K and J.M.L. made substantial contributions to its further development and design. F.U. was responsible for sampling, data collection and phenomenological analysis. All authors contributed to the final analysis and interpretation of the data. F.U. wrote the first draft of the manuscript, all authors critically reviewed and revised drafts. All authors read and approved the final version of the manuscript.

## **Key Words**

Confidence, Older People, Frailty, Intermediate Care, Phenomenology, Qualitative Research.

Age and Ageing - Accepted 7 April 2021

## **Abstract**

### **Background:**

Confidence is a cornerstone concept within health and social care's intermediate care policy in the UK for a population of older people living with frailty. However, these intermediate care services delivering the policy, tasked to promote and build confidence, do so within an evidence vacuum.

### **Objectives:**

To explore the meaning of confidence as seen through the lens of older people living with frailty and to re-evaluate current literature-based conceptual understanding.

### **Design:**

A phenomenological study was undertaken to bring real world lived-experience meaning to the concept of confidence.

### **Methods:**

Seventeen individual face-to-face interviews with older people living with frailty were undertaken and the data analysed using van Manen's approach to phenomenology.

### **Results:**

Four themes are identified, informing a new conceptual model of confidence. This concept consists of four unique but interdependent dimensions. The four dimensions are: social connections, fear, independence and control. Each is ever-present in the confidence experience of the older person living with frailty. For each dimension, identifiable confidence eroding and enabling factors were recognised and are

presented to promote aging well and personal resilience opportunities, giving chance to reduce the impact of vulnerability and frailty.

**Conclusions:**

This new and unique understanding of confidence provides a much needed evidence-base for services commissioned to promote and build confidence. It provides greater understanding and clarity to deliver these ambitions to an older population, progressing along the health-frailty continuum. Empirical referents are required to quantify the concept's impact in future interventional studies.

Age and Ageing - Accepted 7 April 2021

## Introduction

Worldwide, the range of rehabilitation services that sit between an older person's primary health provider and acute hospital services go by different names and are delivered by a variety of providers. In the UK, this is no different, where over the last twenty years, a tier of services known as intermediate care has evolved. England's Department of Health states: *Intermediate care should ...encompass a wider preventative role, aiming to promote confidence building and social inclusion, thus avoiding the need for institutional care or intensive home care at a later date* [1: 11].

England's National Health Service (NHS) Long Term Plan [2] recently committed to grow this tier of services over the next ten-years. The UK's National Institute of Health and Care Excellence reinforced the connection between confidence and intermediate care service delivery in its guideline [3]. They recommended that intermediate care practitioners: *...build the person's knowledge, skills, resilience and confidence, with reablement... aiming ...to help [older people] recover skills and confidence and maximise independence* [3: 5 and 17].

Unfortunately, little is found in the current evidence-base to inform practitioners' understanding of what confidence means in the context of older people living with frailty. Recently, asset models that focus on physical health and mental well-being have been promoted as recognising characteristics of successful ageing that connect resilience to confidence [4], as opposed to the more negative focus on frailty and vulnerability that are predominantly cited in connection to the cumulative deficit models in the literature [5]. A reported metasynthesis of very few published accounts of older people speaking of their confidence in the qualitative literature tentatively concluded that confidence was reflected as a sense of *vulnerability* [6: 1326]. The

authors called for better clarity to inform practice through more research. A concept analysis of confidence that drew on a wider literature review was undertaken and developed the first concept of confidence in an attempt to try and close the gap between policy and evidence [7]. This highlighted three interconnected attributes of confidence: physical, psychological and social, with a strong central feature influencing them all, identified as personal control. Despite this clear conceptualisation, the true voices of older people remained mostly absent.

This paper reports on research undertaken to capture and analyse these absent voices using phenomenological enquiry to bring meaning and understand to the notion of confidence through the lens of older people living with frailty. The study aimed to strengthen the conceptual understanding of confidence for this oldest-old population in society to better inform and direct intermediate care services and its practitioners with effective interventions and use of resources.

## **Methods**

### **Study design**

The phenomenological enquiry followed the methodological structure for human science research set out by van Manen [8, 9]. This method has an important philosophical context but is also acknowledged for its practical orientation that generates meaningful characteristics of the studied phenomenon [10]. In this interpretive phenomenological approach there is a search to identify what gives itself 'as' lived experience through a three-stage approach to analysis:



- individual interview analysis, describing the phenomena through a process of listening, writing and rewriting of the experience and in creating incidental themes.
- meaning and understanding review, identifying statements and phrases that illustrate the incidental themes.
- guided existential inquiry, requiring further comprehensive reading of the interviews to identify how the lived experience is revealed across dimensions of spatiality, corporality, temporality, rationality and materiality [8, 9].

The outcome sees essential themes developed from the incidental themes and richly written materials emerge to describe the phenomena, which are able to evoke its sense, or essence in others.

This study is reported in line with COnsolidated criteria for REporting Qualitative research (COREQ) [11].

### **Participant selection**

To avoid participant selection bias in understanding the phenomena of confidence, only those who spontaneously spoke of their 'confidence' triggered consideration for study inclusion. Therefore, older people (65 years or older) living with frailty (clinical frailty scale score of 5 or greater [12]) with no significant cognitive impairment (score of 7 or greater on Abbreviated Mental Test Score (AMST) [13]) who directly spoke of their confidence to a registered healthcare professional were approached to participate in the study. Eligible participants had the study explained verbally and were given a written participant information sheet. Those willing to participate were asked permission to be referred to the study team. Potential participants were visited by the primary researcher (FU) to describe the study further and seek permission to

be contacted, following their discharge from hospital, to arrange an interview. Participants did not know the researcher; however, they were aware he was a senior clinical nurse and a PhD student. All participants provided written informed consent prior to interview. Fourteen participants identified and approached to participate did not proceed to interview (Table 1). The main reasons for non-participation were not wanting to be involved in research when at home, or family members refusing researcher access to the individual once at home. The study protocol was therefore adjusted, following ethics committee approval to enable interviewing of participants in hospital. All participants were asked if they wished to receive a summary of the study's draft findings to check resonance in respect to their lived experience (member checking).

Table 1: Details of non-recruitment and non-participation to the study

- Declined to participate further in the study once at home n=6
- Family declined access / participation once at home n=2
- Uncontactable once at home n=1
- Unable to recall the use of the word confidence n=3
- No mental capacity to consent n=2

## Setting

Recruitment occurred in one of three older people's post-acute and intermediate care wards in two hospitals in the South West of England.

## **Data collection**

Data were captured through interviews with older people, conducted between May 2017 to March 2018 in either hospital, waiting for discharge home (n=12) or in the participant's own home (n=5) by FU. Two interviews conducted in participants' homes had a family member present (P01, and P03). Interviews were semi-structured, principally using recall of the trigger word confidence in a conversational style interview [14]. The interviews were digitally recorded. Interview duration ranged from 22 to 56 minutes. These were transcribed for analysis. Reflective field notes were made following each interview. The checking for the emergence of any new ideas following the first ten interviews and each interview thereafter confirmed final sample size [14].

## **Data analysis**

Phenomenological analysis used van Manen's three-stage approach: individual interview analysis; meaning and understanding review; and guided existential inquiry [9]. Analyses were conducted by FU, paying attention to the phenomenological epoché-reduction (awareness of their suspension of judgment and openness to the exposure of the phenomena), constantly being recorded in field and later analysis notes. The outcome of data analysis for each participant was an individually written, first person confidence narrative (Table 2), presented alongside emergent incidental themes of their confidence experience. The incidental themes were cross referenced with supporting text from their interview transcript to provide evidence of contextual meaning and understanding, before final consideration against the five existential elements to explore and understand how the phenomena was exposed. (see supplementary data, Appendix S1, available in Age and Ageing online for a detailed

example of data analysis). These analyses were checked, challenged and confirmed by JML and BK.

The final stage of data analysis was the development and description of the phenomena's *essential themes* [9]. Here incidental themes are grouped together where commonality is clearly seen. Determination of an essential theme reflects the view that, if it were to be excluded, the phenomena would no longer be what it is; van Manen calls this *free imaginative variation* [8:107], Finally, essential themes are supported by narrative descriptions to evoke the sense of the phenomena for the reader. The process of writing and rewriting the descriptions of confidence, referring back to interview data and existential exposure of the phenomena, were guided by van Manen's own writing and publications [8, 9, 15]. Participants had the opportunity to comment on developing themes, since these were included as topics within subsequent interviews as the study progressed. Half of the study participants agreed to comment on the draft findings, three returned feedback comments (via post) concurring congruity with their lived experience.

Table 2: Data extract from an Individual interview analysis – describing the phenomena of confidence (Participant 11)

*Communication has a central role to play in how your confidence is experienced and lived. In exploring frailty, even when your confidence is good, it exists in a delicate and fragile state. However, this balance can easily tip by being let down by poor communication. In these cases your confidence lowers, you can become easily intimidated and unable to defend yourself. You become more vulnerable and fragile. Poor communication can cause a mental torment that connects to your confidence and erodes it away. This personal,*

*internal weakness is hard to admit to. Frailty feels like not being able to defend yourself, it makes you angry and this anger leads to frustration and disappointment. This frailty and lack of confidence is like being out-of-control, a helplessness, it can open you up to abuse. It comes on and goes slowly, it also has an accumulative effect and links to other factors, like physical weakness and loneliness. Fear, however, overrides all of this and has a destructive affect to your confidence. You need to fight fear to overcome low confidence. You must fight to say what you want to say. If you cannot defend yourself, you cannot have confidence.*

*Coming into hospital is a most frightening time, it is always linked to losing your confidence. In hospital you struggled to communicate, to be understood, to be listened to. Sometime when in hospital you are not in the right state of mind – delirium – it's like a mental stroke – you have strong, uncontrolled raw emotions, it feels like you are out-of-control, it is horrific. You might be in tremendous pain, but not able to get through to those around you – you lose confidence in them and the situation you are in...*

*... Good communication is confidence giving, but it is rare to truly find.*

## **Ethical approval**

The study received UK Health Research Authority approval (reference number: 16/YH/0363).

## **Results**

### **Demographics**

Seventeen older people participated in the study. Their age range was between 70 and 95 years old and levels for frailty ranged from 6, moderate frailty to 8, very severe

frailty on the Clinical Frailty Score (CFS) scale [12] (Table 3). One participant reported ethnicity as White European, whilst all others were White British.

Table 3: Characteristics of study participants.

Participant number	Gender	Age	CFS	Admission trigger	Interview location
P01	Female	95	8	Fall at home	Home
P02	Female	90	6	Fall at home	Home
P03	Female	80	6	Fall at home - fractured pubic rami	Home
P04	Male	70	6	Fall at home - alcohol related	Home
P07	Female	87	6	Fall at home	Home
P08	Female	84	6	Fall at home	Hospital
P09	Female	86	6	Fall at home	Hospital
P10	Female	85	6	Fall at home - fractured humerus	Hospital
P11	Female	74	7	Pulmonary embolism	Hospital
P12	Female	85	6	Pulmonary oedema	Hospital
P13	Female	79	6	Fall at home and haematuria	Hospital
P15	Female	80	7	Fall at home and bilateral septic leg ulcers	Hospital
P18	Male	90	7	Shortness of breath	Hospital
P19	Female	80	6	Community acquired pneumonia	Hospital
P20	Male	86	6	Discitis and duodenal ulcer bleed	Hospital
P21	Male	87	7	Fall at home	Hospital
P22	Male	82	7	Cardiac arrest - hyperkalaemia	Hospital

*\*participant withdrawal post study commencement means numbering is not sequential.*

## Key findings

Four essential themes emerged from the phenomenological analysis to form four dimensions of confidence.

These are presented below; by dimension title and description, followed by a selection of their incidental themes and direct quotations from participants that shaped these final findings.

All individual interview analysis of confidence and incidental themes are referenced in supplementary data, Appendix S2, available in Age and Ageing online.

## **The four dimensions of confidence**

### 1. The interpersonal impact on confidence through social connections with others: a social dimension

The social connection of others to an older person's confidence is as unique as the individual themselves. This interpersonal connection is relational. It is a social association between them and the significant other(s) in their life and then their confidence. This dimension takes countless forms and characters. It appears as a social bond that forms and shapes their confidence. These social bonds, or connections can be with family (partners, husbands or wives, with daughters and sons, or with siblings and their children), friends (neighbours or carers), with health professionals in hospital or in the community, or with a religious faith and spiritual being. In turn, these social bonds, that are the personal, social connections to confidence, can be strong or very fragile. In strength, the connection with family, friendship and companionship give confidence, hope and optimism. However, if this bond to others is broken, either permanently or temporarily such as through loss of a spouse or abandonment of friends or to the fleeting trust held in the carers supporting them, this broken connection leaves a person holding on to a frail or vulnerable confidence.

This explanation is reflected in incidental themes, including:

Being a burden on others affects your confidence

*“... you get up and go when you have got confidence and I’m afraid I’ve not been able to do that for a long time. I just think, well I am a nuisance to my son [becomes upset and cries].” (Participant 12, starts line 28)*

Social isolation and loneliness are linked to confidence loss

*“I think [having the fall,] that’s the start of somebody becoming isolated, you know, because they don’t have the confidence to do these things. They stay in and think, ‘Well, I’ll not go out in case this or that happens’. So, you could, through a lack of confidence, become very lonely. You could be sitting in your house feeling really miserable, you know, you haven’t got the confidence and then somebody might come in and say, ‘Arh, come on, I’ll come with you, we’ll go down so-and-so, you’ll be alright’. You know, unless you are really bad, you would say, ‘I’m not going’. If you got the chance you would go. I think that’s boosts your confidence again, you see. So, in a way, you start off again. But, its whether you get that, because as you get older you haven’t got the mobility to get out and speak to people, yet you have got to wait for them to come to you really, particularly if you are on your own.” (Participant 13, starts line 80)*

## 2. The relationship of fear to confidence exposes a powerful and emotive effect: a psychological dimension

Fear (also referred to as dread, anxiety, fright, panic or worry) is tethered to the confidence for older people living with frailty. Whether triggered by an incapacitating fall, an illness such as delirium or, through the treatment or care received; fear can powerfully erode a person’s inner confidence. This fear



resides in the person's mind, playing psychological games. For some, they can speak to the confidence inside and try to bargain and rationalise with it, in some convincing way. These internal conversations attempt to overcome fear's ability to wear or tear away at the person's confidence. For others it completely disables their desires, leaving them helpless and hopeless, and for some completely mentally debilitated and depressed. For them, confidence is consumed by fear.

To illustrate this are the incidental themes:

Confidence is connected to fear

*"...the fear in that [describing her experience of delirium and confidence loss] is terrible because you can't do anything to get through [to others]. ...Fear is something different, something awful erm, its much worse than frailty ...fear is a real stopper."* (Participant 11, starts line 166)

Another participant thinking about fighting fear stated:

*"...you got to acknowledge you can fight the fear because without that confidence to fight the fear you won't fight it. That's what I feel, 'Why can't everyone feel confident?', 'Why do they have to become frail?' and er, vulnerable and, that's life isn't it."* (Participant 11, starts line 233)

A further incidental theme was:

Fearful of falling knocks your confidence

*"Like in my case, I've had several horrendous falls, you know, ...I have a dog and I go walking but I find that my confidence has been knocked by these falls, so when I'm walking I always keep my elbow crutch with me, erm, but, it*

*takes your confidence as though, you're sort of walking along and I'm thinking, 'I mustn't fall, I mustn't fall down' or anything like that. So, sometimes when things like that happen you can say that knocks your confidence."*

(Participant 13, starts line 7)

### 3. Physical independence is a stimulus to confidence: a physical dimension

The determination to be independent is a physical driver for confidence.

Confidence's connection to physical functioning is one that is important to maintain. The person's body, and its physical strength, is important in sustaining their independence and overcome the limitations the person living with frailty increasingly faces in later life. Confidence is often undermined or lost as a result of the physical effects of accident, injury or ailment. Quickly the person's ability to physically look after themselves, to self-care, can be affected. For some, a growing dependency appears to sit beside a fading confidence – an uncomfortable and sometimes painful companion. For others the desire to physically overcome a feeling of frailty, lays witness to a growing confidence.

A contributing incidental theme was:

Confidence is connected to being independent

*"If you lose your confidence, you can't do much then. It [confidence] means get up and go. You got to, you can't always rely on others, ... you got to do somethings yourself. Not sit in a chair and say, 'I'm not going to do anything', [say,] 'I AM GOING TO DO IT' [laughs]"* (Participant 08, starts line 51)

Another:

Frailty and ill health are connected to confidence

*["Its] just to have confidence to do things, you know, before I never thought twice before doing anything. Now I think, 'I don't know whether I can do that'. You know... [these leg ulcers have been debilitating, significantly affecting my mobility] ...it does affect your confidence. You're not sure about anything. On whether I'll do that or not. Before, you'd just get on and do it you know."*

(Participant 15, starts line 5)

4. The control of confidence is fundamental but not always achievable. Control exists at the crux of vulnerability and resilience: a control dimension

The control an individual has over their confidence is variable. Some older people living with frailty have a natural belief in the control they have over their confidence. These people often refer to their experiences of confidence over their life-course, a confidence that has been shaped not only by themselves but often by others. This confidence carries forward into older age. However, as frailty becomes recognisable in their bodies and minds, the vulnerability of control over their confidence may falter and they become hesitant. This vulnerability is influenced by a reliance on other social, psychological and physical factors. For example, social connections (family, friends, healthcare professionals, neighbours or carers) in older peoples' lives can be control givers or control removers. A strong connection to a social group, to family and friends, can liberate a person's control over a vulnerable confidence. The opposite sees loneliness and isolation limiting control and

removing their resilience and then their confidence. Mental or psychological control over matters of confidence helps some people, but mental fragility removes this control quickly and can rapidly take confidence away. Regarding physical factors and independence; strength building and activities such as goal-planning and target setting to regain mobility and self-care capabilities help gives control back. For others, their control over confidence in physical matters will always be a struggle, overwhelmingly influenced by complex health problems, impairments and disabilities. There is a constant tension between the person's internal control over their confidence and external control or controlling factors that affect their inner confidence.

An incidental theme for this dimension was:

Control and 'getting back to normal' are linked to confidence

*[Describing confidence] "...well you don't feel as if you are in control. Erm (.) and not doing things you used to take for granted and do. (.) do the best you can, ..."* (Participant 15, starts line 53)

Another participant stated:

*"You feel a little bit lost and not in control of what you are doing. Er, that's about it. (...) we hope that we get back to normal."* (Participant 15, starts line 103)

A further incidental theme was:

Confidence is being in control

*"[Confidence is] being in control. I think then when you get out of bed, you do need some confidence. Because everything seems to go haywire. You can't*

*get your balance. Your head can't get right. Your body cannot cope, to whatever has been done. I think that is the word confidence comes into that lot.*" (Participant 20, starts line 12)

Another stated:

*"Well, you just get on with it, for sure you know, I don't know how long the confidence will take. It's a difficult thing to say, but, erm, I want to be out of here as soon as possible now. Now I am up and at it. I have just got to keep going, to my estimation, the full recovery and all this comes when you get home. You're in your own home, you're in your own surroundings..."*

(Participant 20, starts line 53)

The four dimensions of confidence were then reimagined to create a new conceptual framework of confidence.

### **Conceptual design**

A concept of confidence existed, based on recent published literature exposing attributes and perspectives of older people living with frailty [7]. This concept analysis highlighted three interconnected attributes with a strong central control feature. This was similar to that which emerged from this phenomenological study, however this was now enhanced through the analyses of the unique lived-experiences of these participants, providing deeper and richer personal understanding of confidence. Thus a new and rigorous conceptual framework was

created. Figure 1 illustrates a comprehensive conceptualisation of confidence in older people living with frailty.

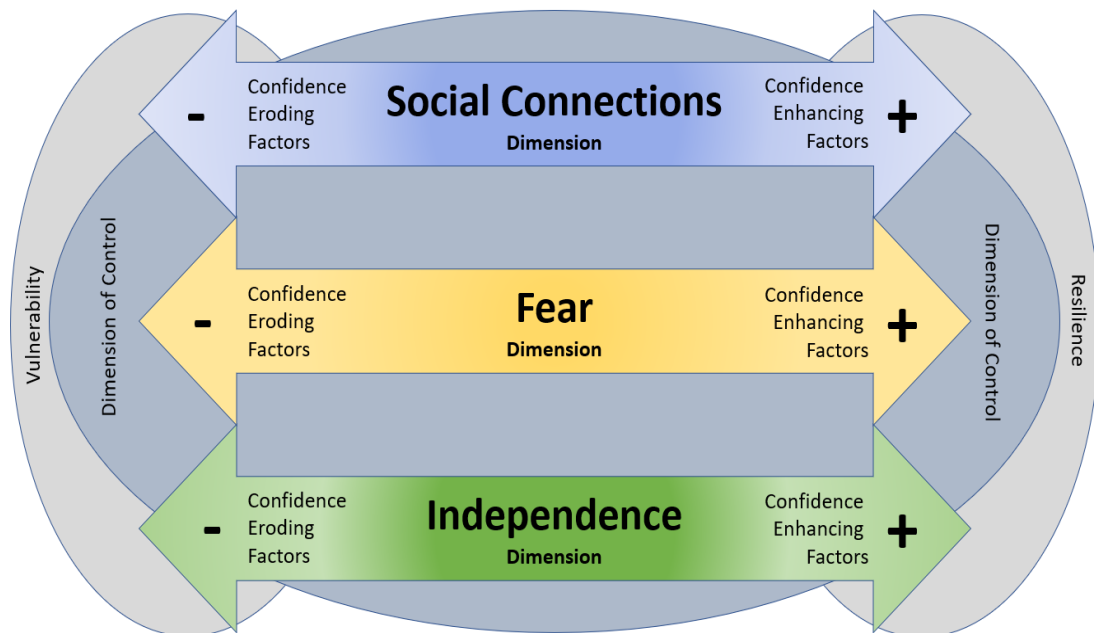


Figure 1: conceptualisation of confidence through the lens of older people living with frailty.

### Conceptual description

For an older person living with frailty, confidence sits on a continuum between vulnerability (a fragile state of well-being [6]) at one end and resilience (the ability to adapt to adversity [4]) at the other. Confidence is a dynamic and interdependent concept, directly influenced by the individuals' perceptions and lived experiences of social connections, fear and independence. These three confidence dimensions can either be enhanced or eroded by the fourth dimension, control. The concept of confidence seems receptive to change through targeted interventions to strengthen resilience across these four dimensions.

## Discussion

Study findings from this phenomenological research have enriched the conceptual understanding and meaning of what confidence means for older people living with frailty. Rich narrative descriptions of confidence have allowed the dimensions of social connections, fear, independence and control to be identified as its essential themes. This new knowledge enhances the previously higher-level descriptions of a literary-based concept analysis [7] and provides a tangible construct to inform intermediate care practice and service response.

Social connections to confidence in this study highlight the importance of social bonds to older people living with frailty, whether strong or very fragile. Directing practitioners to recognise and acknowledge the significance of social health, which includes: control over life circumstances, support networks, engagement activities, social capital and social cohesion [4] is essential. The conceptual opposite of social health in the literature is social vulnerability, understood to mean the susceptibility to physical, functional and psychological health problems triggered by an individual's social situation [16]. Here the continuum between social health (and resilience) and social vulnerability is reflected in the conceptual illustration (Figure 1). Practitioners are encouraged to strengthen social connections by working with the individual to tackle confidence eroding factors, such as isolation, or the emotional impact from the loss of a spouse, and promote social dimension enhancing factors.

The phenomenological analyses specifically identified a dimension of fear, but one with a broad reach and subsequent impact. Fear manifested in physical concerns and psychological illness, as well as in the torment from other dimensions such as, being a burden on family (social connections) and feelings of helplessness (control).

A phenomenological study exploring confidence in stroke survivors similarly identified a broadly defined theme of fear, which included worries about a further stroke, fear of stigma, going outside and the fear of falling [17]. The fear of falling phenomena is a frequently cited sequel of old age [18] and is associated with reductions in physical and social activities and quality of life consequences [19]. Fear of falling literature has long referenced confidence [20-22], but never explored its true meaning. With such prominence, practitioners must now be mindful of these new studies that present meaning and understanding of confidence. They show wider experienced fear factors, beyond an association with falls and their consequences.

The physicality of frailty is dominant in the literature. Independence, the physical dimension of confidence, has synergy with the concept of self-determination that resonates in the *'I'm going to do it!'* attitude of Participant 08. In this, older people emphasises independence and control factors, such as having the cognitive ability to make a decision or having the knowledge to act [23], and is linked to personal motivation as an actualisation of self-care [24]. Knowledge and education are important components to greater physical independence [25] and strongly connect to the wider asset building attributes [4] that intermediate care services need to respond to.

The final dimension of confidence is control. The Unifying Theory of Control developed by Walker [26], despite not living up to its initial hype [27], presents an insightful presentation of a theory and useful adjunct to understanding the control dimension in the context of this concept. Walker contextualises perceived levels of support and control to recognise that, when both are in their lowest state, hopelessness and helplessness exist, but when both in their highest state (a high



level of perceived support and a high level of perceived control) confidence presides [26]. Control here is fundamentally connected to support, in its social context, which reinforces the interdependent aspect of the constructs four fundamental, but individually recognisable, dimensions.

This study was triggered by the lack of older people informed conceptual insight and knowledge of confidence within the context of services maximising the independence of this population in response to acute illness. The findings addressed this deficit in the evidence-base by presenting a revised conceptual framework that can be used to develop new models of care delivery. Thus it is now possible for practitioners working with older people, particularly in intermediate care services, to apply a pragmatic conceptual framework, directly informed by the voices of service users, to help them respond to older persons' confidence-related issues.

### **Strengths and limitations**

This phenomenological enquiry importantly introduced the voices of older people living with frailty to enrich a literature based concept [7]. This has informed, changed and significantly strengthened understanding to enable the production of a practice-relevant conceptual framework, previously missing from national intermediate care policy and guidance. The framework's limitations must be acknowledged however. The sample was drawn from a post-acute care patient population, but protocol revision meant that the majority of interviews were conducted in a hospital setting that may have influenced responses. However, it is likely that the reduced time interval between the spontaneous use of the word confidence and the interview enhanced lived experience recall, thereby adding strength. The sample was

ethnically homogeneous and participant voices came from just one region of the UK, thereby potentially limiting transferability. Finally and in line with previous confidence concept developments publications [6, 7], this study maintained the separation from Banura's social construct of self-efficacy [28] on the grounds that Bandura viewed confidence as a '*colloquial term*' [29: 382], one not linked to self-efficacy in any way.

### **Implications for research and practice**

For research, the conceptual framework provides new knowledge, and its usefulness to practice must be explored further. The development of measurement tools to quantify confidence is a priority since this will help optimise the evaluation of future confidence-related interventional studies. For practice, translation of the concept into 'confidence conversations', which naturally align to comprehensive geriatric assessment processes, would further optimise person-centred asset and deficit recognition to promote well-being.

### **Conclusion**

This study has revealed new understanding about confidence in the context of older people living with frailty, a word that has not been truly understood. The emergent concept of confidence compellingly compliments existing frailty models, exposing essential well-being assets equally as well as deficits. It is important that this new evidence-base is used to inform commissioned intermediate care services in the UK, and elsewhere, thereby reviewing their approach and response to confidence building and promoting activities.

## References

1. Department of Health. *Intermediate Care – Halfway Home Updated Guidance for the NHS and Local Authorities Intermediate Care* Department of Health; 2009.
2. NHS England. *The NHS Long Term Plan*. London, UK: NHS England; 2019.
3. National Institute for Health and Care Excellence. *Intermediate care including reablement* 2017 1st September 2018: Available from: <https://www.nice.org.uk/guidance/ng74/resources/intermediate-care-including-reablement-pdf-1837634227909>.
4. Rahman S. *Living With Frailty - From Assets and Deficits to Resilience*. Abingdon, Oxon: Routledge; 2019.
5. Dent E, Kowal P, Hoogendijk EO. Frailty measurement in research and clinical practice: A review. *European Journal of Internal Medicine*. 2016 2016/06/01;31:3-10.
6. Underwood F, Burrows L, Gegg R, Latour JM, Kent B. The meaning of confidence for older people living with frailty: a qualitative systematic review. *JBI database of systematic reviews and implementation reports*. 2017 May 2017;15(5):1316-49.
7. Underwood F, Latour JM, Kent B. A concept analysis of confidence related to older people living with frailty. *Nursing Open*. 2020 2020/05/01;7(3):742-50.
8. van Manen M. *Researching Lived Experience: human science for an action sensitive pedagogy*. New York: State University of New York; 1990.
9. van Manen M. *Phenomenology of practice: meaning-giving methods in phenomenological research and writing*. Moore J, editor. Walnut Creek, California: Left Coast Press Inc.; 2014.
10. Errasti-Ibarrondo B, Jordán JA, Díez-Del-Corral MP, Arantzamendi M. van Manen's phenomenology of practice: How can it contribute to nursing? 2019;26(1):e12259.
11. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007 2007-12-01 00:00:00;19(6):349-57.
12. Rockwood K, Song X, Macknight C, Bergman H, Hogan DB, McDowell I, et al. A global clinical measure of fitness and frailty in elderly people. *CMAJ : Canadian Medical Association Journal / Journal de l'Association Médicale Canadienne*. 2005;173(5):489.
13. Hodkinson HM. Evaluation of a mental test score for assessment of mental impairment in the elderly. *Age and Ageing*. 1972;1(4):233-8.
14. Braun V, Clarke V. *Successful Qualitative Research: A practical guide for beginners*. London: SAGE Publishing; 2013.
15. van Manen M. *Writing in the dark: phenomenological studies in interpretive inquiry*. Ontario, Canada: The Athlone Press; 2002.
16. Andrew MK, Keefe JM. Social vulnerability from a social ecology perspective: a cohort study of older adults from the National Population Health Survey of Canada. *BMC Geriatrics*. 2014 August 16;14(1):90.
17. Horne J, Lincoln NB, Preston J, Logan P. What does confidence mean to people who have had a stroke? – A qualitative interview study. *Clinical Rehabilitation*. 2014 2014/11/01;28(11):1125-35.
18. Kumar A, Delbaere K, Zijlstra GAR, Carpenter H, Iliffe S, Masud T, et al. Exercise for reducing fear of falling in older people living in the community: Cochrane systematic review and meta-analysis. *Age and Ageing*. 2016;45(3):345-52.
19. Schoene D, Heller C, Aung YN, Sieber CC, Kemmler W, Freiburger E. A systematic review on the influence of fear of falling on quality of life in older people: is there a role for falls? *Clinical interventions in aging*. 2019;14:701-19.
20. Legters K. Fear of falling. *Physical Therapy*. 2002;82(3):264-72.
21. Parry SW, Bamford C, Deary V, Finch TL, Gray J, MacDonald C, et al. Cognitive-behavioural therapy-based intervention to reduce fear of falling in older people: therapy development and randomised controlled trial - the Strategies for Increasing Independence, Confidence and Energy (STRIDE) study. *Health Technol Assess*. 2016 Jul;20(56):1-206.

22. Scheffer AC, Schuurmans MJ, van Dijk N, van der Hooft T, de Rooij SE. Fear of falling: measurement strategy, prevalence, risk factors and consequences among older persons. *Age and Ageing*. 2008;37.
23. Ekelund C, Dahlin-Ivanoff S, Eklund K. Self-determination and older people – A concept analysis. *Scandinavian Journal of Occupational Therapy*. 2014 2014/03/01;21(2):116-24.
24. Soderhamn U, Dale B, Soderhamn O. The meaning of actualization of self-care resources among a group of older home-dwelling people: a hermeneutic study. *International Journal of Qualitative Studies on Health and Well-being*. 2013;8:1-9.
25. Skymne C, Dahlin-Ivanoff S, Claesson L, Eklund K. Getting used to assistive devices: ambivalent experiences by frail elderly persons. *Scand J Occup Ther*. 2012 Mar;19(2):194-203.
26. Walker J. *Control and the psychology of health: theory, measurement and applications*. Buckingham: Open University Press; 2001.
27. Wallston K. Book Review: *Control and the psychology of health: Theory, measurement and applications*. *J Health Psychol* 2005. p. 301-2.
28. Bandura A. Self-efficacy. Reprinted in H Friedman [Ed], *Encyclopedia of mental health* San Diego: Academic Press, 1998. [Chapter]. 1994;4:71-81.
29. Bandura A. *Self-Efficacy: The Exercise of Control*. New York: W.H. Freeman and Company; 1997.

Age and Ageing - Accepted 7 April 2021

# Supplementary Appendices

## Appendix S1

### Data extract from the Individual interview analysis – describing the phenomena and identifying the incidental themes (Participant 02)

You lose confidence following a fall and when you lay there and cannot get up, but it's hard to explain. Lying there on the floor, you have a strange empty feeling, your confidence just takes something away. Confidence is about regaining something you have lost. It is connected to the need or desire to do something, something about the situation you are in. In your mind you cannot do these things – You have the desire, but not the confidence. It might be down to nerves and worrying about falling again.

Nervousness plays a part in your confidence. You can struggle to let go; letting go of the help and support intermediate care services have offered this last six weeks and worrying what that might mean. There is a nagging in your mind to keep some level of support going, it may be lonely otherwise, you might not manage. That nagging maybe more a fear of letting go and becoming dependent on just yourself again.

Confidence starts to grow as you start to achieve things, being less dependent on carers for example. As you become more independent you don't need them to call in and support you as much. However, this contrasts with that other struggle you have to deal with, to feel confident to let go. Becoming less dependent on others is an achievement that helps your confidence to grow. It is a struggle to mentally get there, but you are determined to do so. Confidence is something you must work at. It builds as you achieve things, like walking well with your frame. You balance in your mind wanting to do well, with a fear of just doing it, it is scary.

#### Incidental themes:

- **Falls affect your confidence**
- **Confidence means regaining and building back something you have lost**
- **You become confident when you achieve what you desire**
- **Being fearful (of falls and of loneliness) has a negative effect on confidence**

### Data extract from the meaning and understanding review to evidence the incidental theme (Participant 02)

#### **Being fearful (of falls and of loneliness) has a negative effect on confidence**

*Falling again (.) and your legs get wobbly. This is all part of the (.) and worry I suppose (.) and worry is all part of it. (P02 starts line 69)*

*I know I can do it but then I am scared to do it (.) and that where I have lost my confidence.*  
(P02 starts line 91)

*...because they say you're coming in in the morning, why are we bothering to come in because you are dressed and so (.) I suppose that is a step forward and that's what they are supposed to be doing, that [Intermediate Care Service]. But I don't have the confidence again to say don't come any more (.) not the sort of afternoon, the evening one I quite look forward to that one...* (P02 starts line 111)

*What's holding you back then, to say, to, to keep them coming in...*

*...fright.* (P02 starts line 118)

*I don't mind being left alone I, I just don't know. Perhaps it is the fright of being left alone...*

*Or is it anything else?*

No.

*I don't want to put words into your mouth, its...*

*No, but they can (.) they say good night and I can get myself to bed and all that sort of thing...* (P02 starts line 123)

*Sometimes I think I'm better just left to get on with it now err, you know, 'You can do it, just get on with it' (.) right, which I hope I will soon. There's something, a little something at the back, a little bit nervousness...* (P02 starts line 131)

*Have a think, what do you think that niggle is that says, that says I'm not quite ready...*

*Fright, yes...*

*...its being frightened?*

*Yes, I suppose that covers it.* (P02 starts line 138)

*What's it like to lose your confidence after a fall? What does that feel like?*

*(.) well sort of strange empty feeling I suppose, urm, well I suppose it's fright (.)*. (P02 starts line 152)

## Data extract of the guided existential inquiry (Participant 02).

**Lived body:** Physical falls are central to this participant's lived-experience of confidence. Her wobbly legs (line 69) are referenced as is her overreaching that has caused her to fear a fall (line 75), both bodily connections to confidence affecting falls. There is a constant narrative through the conversation linking her battle with frailty to the ambition of regaining her physical independence.

**Lived space:** The participants internal space is most evident in this conversation, her mind's role in overcoming this lived fear of falling is ever present. She talks it through to herself throughout the conversation: 'I can't do that, oh yes I will' (Line 76); 'I've got to walk with a frame ... my confidence will come back' (lines 85 and 87); and 'I've got the desire ... I'm independent' (Line 96). There seems a perpetual mind game of confidence promotion and management connected to her lived-experience of confidence.

**Lived time:** The only connections to time and confidence is recalled in her seeing herself age:

*Because of the falls and I still have. And I'm not really back to how I used to be and I don't know whether I really will be, because I have got little bit older. Losing your confidence, you see (.) yes, its if (.) I can't explain exactly. (P02 starts line 33)*

*Exploring a little about health and frailty in the last couple of years she recognises her ambitions are not always as achievable: '...of course I've got older ... I can't achieve what I want to (...) and that is annoying in a way' (P02 starts line 166).*

**Lived self-other:** This participant lives alone and mentions no others apart from the temporary cares visiting her from the intermediate care service. She describes, without being explicit, the worries of recovery being balanced with a loss of social contact. Confidence is entwined within this. She is clear confidence grows as you become independent and as you set your goals (your desires) to achieve. She worries about the withdrawing service staff. The sentence where she mentions missing them 'say good night' (line 128), really connects to the deep tension she faces, and sadness for a loss of social (of human) connection.

**Lived things:** In some way the entity of the intermediate care service that is attending her three times a day is seen in the conversations as a material lived-experienced connected intrinsically to her confidence. It holds confidence giving opportunity to meet her ambitions for independence with the negative aspect as dependency on the services poses a significant wrench when withdrawn. This contradictory emotional or psychological dependency that grows and maybe dependency is realised throws up the complexity of this lived-thing. Confidence is connected throughout this singular lived-experience of the intermediate care services. These services can be seen as societal or political things, responding to moving care from centralised and costly institutions (hospitals) to our more personal concern, those of our own homes, back in our communities.

## Exploring the epoché and conducting the reduction – a methodological examination of separation and the reductive reflection of the emerging phenomena (Participant 02).



This participant, like some others I later interviewed, could not re-call themselves talking about confidence whilst in hospital to the care team at the start of the conversation. Therefore, the start of this conversation I re-set the scene for her. This was based on the refers information and on the communication I had with the participant in hospital, where I talked about study participation.

*Conscious of not wanting to lead this participant and introduce any bias (in the way of provoking sub-conscious thought to be come conscious, to emerge and start to be reflected upon) in data gathering. I was required to present some circumstance to her mentioning and talking about confidence in the first place. I believe I presented only factual prompts, taking her back to that time we met in hospital and hoping for the lived-experience she had then to appear to her now, and emerge in this conversation. (post-interview notes)*

*Reading and re-reading the transcript, there reads a nice natural flow into her first descriptions of confidence. Therefore, followings some context setting, based on the fall experience she had recounted to me in hospital, it felt like we had a moment of mutual understanding – that explaining what confidence is, 'is quite hard' (line 35 and 36). From this, the natural emergence of regaining something lost came out (line 39) and later the desire to do something (line 44). These were her ideas that were sustained in the conversation. (post-analysis notes)*

This was my very first interview of this study and my post-interview notes reflect the apprehension I felt. I noted how easy the conversation struck-up and started to flow, following the time taken to reset the scene at the start of the conversation. I recall how I felt, by re-connecting her back to her previous un-remembered experience of confidence loss.

*I believe I reached her conscious lived-moment of confidence loss and her falls, where what she goes on to describe seemed to effortless and fluently flow. (post-interview notes)*

In the conversation I asked her if she thought confidence was a physical or psychological entity (starting line 54), based on the findings of the systematic review. (At the start of these interviews I was uncertain how much the findings should be drawn into conversations, in a way to test their trustworthiness with lived-experience. Later in the study, they were only used a prompt when conversations struggled, in favour of natural conversations that were explorative of lived-experience, free from headings or claims.)

*These introduced to her two abstract words to those descriptive words she was using in the conversation - of regaining confidence and desiring confidence. However, those words were not picked up on, she did not pre-consciously connect to them in her story. She did state that she thought confidence as both a physical thing and a psychological one (line 57) in response to my direct question, but really recognised:*

*"...in my mind I think I can't do these things (.) I think that might be able to explain some of it (...) I haven't lost the desire. I still have the desire to want to do it, but I haven't got the confidence." (P02 starts line 59)*

*Here, despite my clumsy question, I feel she is making an important connection to desire being a mental state of mind, a psychological association to confidence and being able again to 'do these things' links to a physical need that drives confidence. (post-analysis notes)*



I write in my post-interview notes about my awareness of potential leading questions slipping in to conversations. I also note how I felt that the participant really thought about the questions I was asking, and the positive use of silence enabled some further meaningful insights to this idea of confidence to emerge. The pause at line 169, where she is thinking back on her recent health situation, a pause to think about frailty, she acknowledges that she is getting older; that she is not able to achieve all that she wants to; and this annoys her, but she accepts it as inevitable.

*When asked if she should just accept it, she laughs after starting a sentence where she says she doesn't really have to accept the situation if only she just had the confidence to do what she needed to do. The pause allowed her time to realise – it all comes [a]round to the same discussion again (line 173) - confidence. (post analysis notes)*

*The conversation felt like we were both exploring confidence's meaning, both adventurers unpicking its true understanding. I note in my records I repressed a 'reflection-in-practice' moment that may have influenced her told story by simplifying her experience of desiring to be independent (line 96) and substituting it with a short-cut, interpretive judgement to simply be all about her motivation. (post-interview notes)*

This first interview informed me about the importance of having a fully open mind during the interview to allow all sorts of confidence connections to emerge and exist as they naturally are. The noting and recording of them, in the interview or post-interview are important and supports post-interview interpretation and analysis, as it allows me now to see if motivation emerged from the wider reading of the whole conversation, which it did not..

*Linking confidence to thoughts on frailty were a little awkward, maybe shying away from the direct use of the frailty word. I spoke about her recent health and well-being (line 163). But interestingly she turned the conversation back to her desire to be confident and independent – getting back that thing that has been taken away. This conversation felt very much on-message for rooting out the essence, for her, of what confidence was. (post-interview notes)*

# Supplementary Appendices

## Appendix S2

### Interview findings

These findings arise from the interpreted stories of confidence that give a powerful connection to the lived-experience. Detailed re-creations of lived experience stories have been extracted from phenomenological analysis of the recorded conversation and transcripts. Each one is rewritten in an attempt to connect the reader to the true nature of what confidence means to these people.

### Participant 01 – Individual interview analysis

Worrying about being in hospital and the thought of not being able to come home affects your confidence. It also lowers your mood (making you become *low in thought*).

Looking at others around you when in hospital and seeing them getting on, makes you feel you can get on too. However, when you get home, and realise you are on your own, especially at night and that's a worry, you lose your confidence.

Losing your friends as you get older is not pleasant. You have memories of good times, but also bad times too, this leads to some loneliness that affects your confidence.

It hard to explain how the help received from an informal carer (a neighbour) helps your confidence. When you are not able to do something, they will always help, unreservedly. They come in in the evenings, every evening to check up on you, this helps you maintain your confidence. It is reassuring that someone is there and that they care about me enough to bother. You are not as confident in yourself when they are away on holiday for example, your confidence drops. You are always looking forward to when they come back.

Falling over and laying on the floor for a long time (up to eight hours), you are there trying to get up but struggling. In the end, realising you are not physically able to get up is a worrying experience that affects your confidence. Not having a lifeline to call for help leaves you feeling vulnerable. Now, having a lifeline makes you feel more confident, you can get help quickly. The being able to call someone, knowing someone will come and rescue you helps remove that fear of falling again and gives a boost to your confidence.

**Unique incidental themes:** (bold highlighted themes indicate stronger evidenced themes from the interview).

- Worrying about not getting home from hospital affects your confidence and mood.
- Looking at others like you, doing well, helps your confidence.
- **Knowing someone is there for you, looking out for you, is reassuring and helps your confidence.**

### **Participant 02 - Individual interview analysis**

You lose confidence following a fall and when you lay there and cannot get up, but it's hard to explain. Lying there on the floor, you have a strange empty feeling, your confidence just takes something away. Confidence is about regaining something you have lost. It is connected to the need or desire to do something, something about the situation you are in. In your mind you cannot do these things – You have the desire, but not the confidence. It might be down to nerves and worrying about falling again.

Nervousness plays a part in your confidence. You can struggle to let go, letting go of the help and support intermediate care services have offered this last six weeks and worrying what that might mean. There is a nagging you in your mind to keep some level of support going, it may be lonely otherwise, you might not manage. That nagging maybe more a fear of letting go and becoming dependent on just yourself again.

Confidence starts to grow as you start to achieve things, being less dependent on carers for example. As you become more independent you don't need them to call in and support you as much. However, this contrasts with that struggle you have too, to feel confident to let go. Becoming less dependent on others is an achievement that helps your confidence to grow. It is a struggle to mentally get there, but you are determined to do so. Confidence is something you must work at. It builds as you achieve things, like walking well with your frame. You balance wanting to do well with a fear of just doing it, it is scary.

#### **Unique incidental themes:**

- **Falls affect your confidence.**
- **Confidence means regaining and building back something you have lost.**
- **You become confident when you achieve what you desire.**
- **Being fearful (of falls and of loneliness) has a negative effect on confidence.**

### **Participant 03 - Individual interview analysis**

Confidence means being independent and physically well. Confidence is affected by a fall and is connected to the inevitability of getting older and frailer. You lose your confidence when you fall, each fall takes a little bit more away and with it you lose

your judgement. Losing your judgment, negotiating the home environment with poor confidence makes you hesitant, you are thinking about tripping over and seeing the things you can trip over, it is there all the time.

You can be particularly hesitant and lack confidence when going up and down stairs, especially when you are feeling weaker and less strong following a fall. Being taught techniques on how to get up and down stairs and using your stronger leg to steady you, gives you confidence – a feeling ‘you can do it’.

Losing your confidence or having your confidence knocked after a fall makes you more vulnerable. Dealing with or managing the things you used to do before becomes more difficult. You worry about falling again. Building your confidence takes a while to do. You have to start building yourself up, rehabilitating yourself and setting out what you need to achieve next to see progress – goal setting. Your confidence grows when you set personal goals and you achieve them. Your confidence can grow with determination.

#### Unique incidental themes:

- **Confidence is connected to being independent.**
- **Confidence loss is caused by falls.**
- **Lacking confidence makes you more hesitant.**
- Losing your confidence makes you more vulnerable.
- **Teaching you new ways to manage helps your confidence grow.**
- Building your confidence takes a while.
- **Confidence can grow by setting yourself goals to achieve.**
- Confidence can grow with determination.

#### Participant 04 - Individual interview analysis

Multiple falls lead to you losing your confidence and that feeling you cannot manage as you used to. Losing your confidence means you lose your drive, your *get up and go*.

When you are coming home from hospital your confidence is affected. You think about how poor your mobility is following the fall, being restricted by using a walking frame and being alone, when you get home, affects your confidence. Alcohol dependence has connections to confidence too. For when you are drunk you clearly don't worry about your confidence, however, when you are sober and face the consequences of the drink. An example is when sober you realise that the fall you have had creates a new dependency, a physical one. You then realise how on your

own you are and that you are not managing at all well; all the things you drink to forget are the things that come back to negatively affect your confidence.

What confidence actually means is hard to put into words and explain. When confident you see yourself getting on well, managing. When you are like this you have a *jump* (line 165) in confidence, a boost. But falling over a second time, just takes it away. Once it's gone it's hard to get it back.

#### **Unique incidental themes:**

- **Falls take your confidence away.**
- **Coming home from hospital affects your confidence.**
- **Losing your confidence, you just feel you cannot manage (be bothered).**
- **Being restricted and confined by things out of your control affects your confidence.**
- Alcohol dependency can give and take away confidence.
- Getting back to normal gives you a confidence boost.

#### **Participant 07 - Individual interview analysis**

Being scared of having another fall affects your confidence, you are then always scared it's going to happen again. You are scared of slipping and losing your balance all the time. Your confidence then stops you doing the things you used to do without thinking about it. You then worry you are becoming a burden of your family when you are this vulnerable. This worry affects your confidence too.

#### **Unique incidental themes:**

- **Confidence is affected by being scared of falling.**
- **Not being able to do the things you used to affects your confidence.**
- **Worry affects your confidence.**

#### **Participant 08 - Individual interview analysis**

Your confidence goes when you fall and when you cannot get back on your feet or if you fall and don't do anything to help yourself. Confidence loss should be a temporary state, provided you help yourself get over the obstacles in your way. Confidence means 'get up and go', without it you can't do much to help yourself. You have to be determined, your determination to get on with it is connected to your confidence. You have to be determined to achieve these goals, this builds your confidence – you need self-belief. When you achieve you goals your confidence

grows, and this can be seen. Others comment on the difference they see, and again this positive affirmation boosts your confidence further.

Determination and confidence is connected to your mentality and how you have been brought up. Being brought up to be independent and self-sufficient, many needed to during the war years for example, and being a farmer's daughter, working the land, shapes your attitude to get on and to have a determination to achieve what you set out to do. There is a self-belief connected to confidence through this determination.

#### Unique incidental themes:

- **Confidence is lost when you fall.**
- **Confidence is connected to your determination to achieve your goals.**
- **Confidence is connected to being independent.**
- **Staff can help grow your confidence.**
- Confidence feels like something you need to reach for and grasp hold of.
- When you lose your confidence, you become lost too.
- Losing your confidence is frightening.

#### Participant 09 - Individual interview analysis

Confidence relates to the confidence you have in those caring for you as an older person living with frailty. The 'right type' of carer, one that gives you confidence, is the one with the right attitude, the right manner and one that is sympathetic. Their physical presence '*beside you*' is important, giving you a simple, a '*just able to see you*', level of assurance and an occasional reassuring hand on you that expresses support. Male carers give you greater confidence too, as they are stronger, able to support you if you stumble.

There is a fearfulness that when you call for help, the 'wrong type' of carer comes to help you. They don't have the same kind of time to help you. Carers in hospital are more likely to be the wrong kind of carer, as those at home with you are more familiar with you and give you more confidence, as you are confident in them.

Being in your own home environment gives you a greater confidence walking about, as compared to being in hospital. In hospital there is a less familiar environment as the height of beds, chairs and distances are all wrong for you. However, being alone at home when you need help causes confidence to be lost.

Following a fall at home you are not as confident as you might think. It is the panic that sets in a little later, when you think you cannot carry on like this. When this panic sets in, you have to give yourself a good talking to, to not allow it to affect your

confidence. Panic is connected to a lack of confidence as you age and as you become frailer and more dependent.

There is an element of comparing yourself with others while sharing a living space with others in hospital, particularly in a physical mobility and judging your limitation sense.

#### **Unique incidental themes:**

- **Support given by carers is important to give you confidence.**
- **Familiarity with your own home environment gives you confidence.**
- **Anxiety (panic and fear) has a link to confidence.**
- Comparing yourself with others more able than you reduces your confidence.

#### **Participant 10 - Individual interview analysis**

Following many falls at home that cause injury and long-lasting impairment, limiting your function, you lose your confidence. Confidence is linked to your ability to move around and to be independent. When you lose your confidence, it is important to have your family around you to help you get it back. Family support is helpful to you at these times, they help your confidence grow by adapting and accommodating to your new needs. There is a need for two-way respect in these situations to maximise your confidence. You will always worry about how much of a burden you may be on them though.

As losing your confidence following a fall is scary, you can quickly lose your independence and ability to move around. Wearing a life-line alarm to call for assistance, if you fall, gives you confidence. Regaining your confidence, you seem able to *manage* again, carrying out basic activities of daily living, such as going to the toilet independently and mostly getting in and out of bed with little help. Having others around helps your confidence too.

#### **Unique incidental themes:**

- A fall causes you to lose your confidence.
- Family and carers are connected to getting your confidence back.
- **Moving around independently is connected to the feeling of confidence.**
- Confidence loss is scary.
- Being a burden on others affects your confidence.
- Life-lines give confidence.

#### **Participant 11 - Individual interview analysis**



Communication has a central role to play in how your confidence is experienced and lived. In exploring frailty, even when your confidence is good, it exists in a delicate and fragile state. However, this balance can easily tip by being let down by poor communication. In these cases your confidence lowers, you can become easily intimidated and unable to defend yourself. You become more vulnerable and fragile. Poor communication can cause a mental torment that connects to your confidence and erodes it away. This personal, internal weakness is hard to admit to. Frailty feels like not being able to defend yourself, it makes you angry and this anger leads to frustration and disappointment. This frailty and lack of confidence is like being out-of-control, a helplessness, it can open you up to abuse. It comes on and goes slowly, it also has an accumulative effect and links to other factors, like physical weakness and loneliness. Fear, however, overrides all of this and has a destructive affect to your confidence. You need to fight fear to overcome low confidence. You must fight to say what you want to say. If you cannot defend yourself, you cannot have confidence.

Coming into hospital is a most frightening time, it is always linked to losing your confidence. In hospital you struggled to communicate, to be understood, to be listened to. Sometime when in hospital you are not in the right state of mind – delirium – it's like a mental stroke – you have strong, uncontrolled raw emotions, it feels like you are out-of-control, it is horrific. You might be in tremendous pain, but not able to get through to those around you – you lose confidence in them and the situation you are in. Or you may have a raging temperature, you feel frightened and unable to communicate effectively, wanting to cool down by fighting your clothes off. You cannot make yourself understood, you quickly lose confidence in the whole system.

It is not just this mental torment where poor communication affects your confidence, living with physical weakness affects it too. Often people misinterpret your actual needs, and this leads to confidence loss. Because of this physical dependence on others you may need to live in a care home. Experiencing, even temporarily, a care home can have a devastating effect on your confidence. You may witness and be subject to the most de-personalising experience through social isolation and the lack of mental and physical stimulation you can imagine. Good communication is confidence giving, but it is rare to truly find.

Living your life with a long-term mental health problem, with depression, is another example of where you can lose your confidence. It is one where communication with health professionals becomes important, but often through poor communication, trust and confidence are significantly affected and this in turn can have a detrimental effect on your health status and well-being.

#### **Unique incidental themes:**

- **Confidence goes when communication is not effective.**



- **Confidence is connected to fear.**
- **Confidence is lost when not in control of yourself or the situation you are in – a helplessness.**
- Depression can take your confidence away.
- Confidence is linked to social isolation.

### **Participant 12 - Individual interview analysis**

Confidence focuses on functional physical activity attributes: the ability to get up from a chair, the ability to walk to the toilet, the ability to go and wash yourself. Being frightened of falling when carrying out these activities and being active is connected to the experience of your first fall, and the vulnerable state this left you in - being unable to attract attention to your situation or call for help. This frightening experience generates a fearfulness associated with daily living activities. This is a fear described as being present when walking for example and is a fear that holds you back from doing the things you want to do.

Confidence is also connected to loneliness and social isolation. The raw emotions of bereavement, through losing your spouse in later life; changes to established social networks with their individual connections and dynamics; losing friendships and links to past journeys; feelings of becoming and being a growing burden on you children. These sentiments, as you become more dependent, have an emotional toll on your confidence. Family connections are important to help you feel confident and connected. However, the feeling of being a burden on others becomes emotionally charged and something else that is always on your mind. This view is reinforced when looking at the burden others with dependency and disability have on close family members and friends. You can see how dependency affects other people they socially connect with, relationships become more difficult and contact becomes less. In turn as, you get older and frailer you see how you are becoming that burden on your direct family, with your dependency. This dependency and its transferable consequences have a direct effect on your emotional well-being and confidence. It may also influence how you see your own health and well-being needs – in a negative way, further affecting your confidence.

When feeling unwell and frightened (vulnerable), trusting others, healthcare professionals for example, to do as they say is important. Losing confidence, maybe 'losing faith' in others, can erode any state of well-being. Moving from hospital back home causes worry too, you question how well you will cope. This transition of care challenges the notion of confidence when being discharged from hospital, as it seems important that when in hospital you can get the help you want. Looking to going home, this is not so readily available. To go home and re-establish yourself with the cares and help you have around you at home needs a leap of faith, a mental adjustment, a shift of mind-set, that has an important connection to confidence too.

### Unique incidental themes:

- **Confidence is connected to physical function.**
- **Falling and the fear of falling affects your confidence.**
- **Confidence is connected to loneliness and isolation.**
- Being a burden on others affects your confidence.
- Trusting others to do the right thing is important, otherwise you lose confidence.
- Confidence is necessary to have during transitions of care – from hospital to home.

### Participant 13 - Individual interview analysis

Falling and having multiple falls 'knocks' your confidence. It causes you to worry about falling. The fear of falling is constantly on your mind, when walking or carrying out other daily living tasks, such as showering, this continuous fear affects your confidence. The way people talk to you, about your fall, can affect it too. Negatively, people can cause you more worry, telling you to *be careful, not to do this or not to do that*. These curtailments cause an apprehension that strips away your independence and this influences your confidence too. This may lead to isolating yourself from others and this has further consequences. However, having the right walking aid with you, to overcome the fear of falling, can help your confidence.

The other thing that 'knocks' your confidence is when those caring for you have the wrong attitude. They can be quick, strict, demanding and sometimes unkind. This attitude erodes your confidence – having someone caring for you over-night for example, someone that is sharp or short with you, makes you fearful to ask for help.

Exploring confidence through the life-course – confidence is something that is seen necessary to have and hold onto, to 'take you through' that life-course. However, as you get older, it is harder to keep hold of. As you get older, life seems to speed-up and keeping hold of your confidence becomes more important, but your general state of mental well-being needs to be strong to do this. There are two types of people with describable confidences. There are those born with it, they have good confidence 'from birth' and it takes them through life's course. The others are those who struggle with it from an early age, at school, exam performance for example, they may be stifled by silly mistakes or nerves. This can have lasting and repeated consequences throughout life, with driving as another example, where nervousness can affect confidence and performance.

Getting old is frightening and becoming dependent on other people looking after you is too. Looking around at others in hospitals, you see their vulnerability, these older people are frightened and are lacking confidence, even to call for help. This is a fear

you can see in yourself as you lose confidence, this is often associated with being in hospital and especially when not spoken to well. An abrupt doctor can affect your confidence, the same as that uncaring nurse you may have on night duty. At the end of your aged-life, the chance you need to go into care may arise. You hear stories and may experience life-long friends doing this and the may hear of the detrimental consequences this experience has on their confidence. It makes you fearful. You recall one such lifelong friend absolutely hating the idea, but recognised the necessity. However, the lack of stimulation, engagement and motivation (complete isolation) stripped away any confidence they may have. They disengage with everyone and withdraw. This plays on your mind as you become more dependent. You see confidence is ubiquitously with us (or not), virtually from cradle to grave.

Social isolation can be a self-imposed consequence of a sequence of falls, to protect yourself. You think you are not safe to go out and this leads to loneliness. You feel you are becoming a burden and you lock yourself away. You stop friends visiting, but with decreasing family contact too, isolation comes quickly. The knock-on consequence is that you start losing your confidence. The cycle of loneliness can be interrupted by visitors or by getting out of the house, you realise, maybe too late how this can dramatically boosts your confidence again. This often must be organised for you when the downward cycle of loneliness is set in, and when you may not be able to see it happening.

When anxiety hits you, you become paralysed to help yourself. It is only through medication and the input of the community mental health team that the confidence lost (that results in not going out for a walk with your dog for example; not going shopping; not connecting to people generally or; not looking after your overall mental and physical well-being) can be helped. Recognising barriers to confidence loss are important. In these circumstances keeping a diary and identifying triggers for your anxiety can be worked through. Meditation and facilitated group support meetings help. Taking small incremental steps aid recovery, your re-engagement back with society and re-gaining your confidence again.

#### Unique incidental themes:

- **Being fearful of falling knocks your confidence.**
- Low confidence causes you to be frightened to call for help.
- Your walking aid gives you confidence.
- **The attitudes of others negatively affect your confidence.**
- Confidence has a life-course connection.
- **Social isolation and loneliness are linked to confidence loss.**
- **Anxiety and stress have a direct impact on confidence.**
- **Treating anxiety (with specialist interventions) boosts confidence.**

## Participant 15 - Individual interview analysis

An unexplained onset of tiredness and fatigue nine months previously triggers a health decline and level of dependency, maybe frailty, now needing statutory support to remain living at home. Confidence is lost as increasing dependency grows. There is a recognition, but not necessarily conscious thought, that frailty and confidence do exist together, as frailty presents itself, confidence declines. Losing your confidence makes you more hesitant about the things you do. It is connected to losing your independence.

Losing your independence leads to losing control, the control over your life choices. You may desire to live independently, but as frailty and ill-health (specifically linked to mobility impairment associated with now chronic leg ulcers) create a dependency on others. Aspects of control are lost, and this affects your confidence. Control also plays into a fear of falling. Your mind controls what you feel and do, and if you have had several falls, this level of control becomes limited, impaired, and you are less confident when you need to get around.

Having hope helps you look forward to the future. Re-connecting back to social events that took you out of the house, this is one thing you hope for the most. Getting out to a club regularly, to meet with others and exercise, being active, this is something you can hope for, it's a way to get you back to how you were before, before your dependency grew and your confidence started to ebb.

When in hospital, talking about your confidence to others, in the context of preparing for home, makes you think about how you will manage and cope. It's really useful.

### Unique incidental themes:

- **Frailty and ill health are connected to confidence.**
- **Control and 'getting back to normal' are linked to confidence.**
- **Social connections are important for your confidence.**
- **Talking about your confidence in hospital helps you prepare for discharge.**

## Participant 18 - Individual interview analysis

Confidence needs to be built up before you go home following a long hospital stay. To get back up on your feet after you have lost your strength (after being deconditioned) in hospital, you need to be determined.

There is a degree of acceptance, as you get older, you cannot do the things you used to, and you have not got the things around you, you used to have (loss). There is now a growing dependency on others, and this affects your confidence.

### Unique incidental themes:

- **Confidence is connected to your physical strength.**
- **Lived-loss and confidence are connected.**

### Participant 19 - Individual interview analysis

Confidence is being able to get up, to walk about and to hold you balance, and not to fall over - *to get on*. However, in addition to this practical and physical connection to confidence, confidence is particularly affected by your faith and by other people around you.

Regarding faith, this gives you confidence to carry on, even when coping with the loss of loved ones very close to you. Losing your children in your own lifetime can leave you without confidence to carry on. It leaves you low spirited, low in mood, lonely, desperate and very sad. The strong spiritual connection that faith can give, at these low points in your life, put things, the wider-world, into perspective for you. Your faith and belief allows your confidence to get on, to come back. Meeting people with the same faith is a great help to your confidence too at these times, as is having other family and friends around you, especially in later life.

The other important factor that affects your confidence, in a positive way, are associated with people around you. They may be formal carers, your family, friends or neighbours they can improve your confidence, with kindness. They can pick you up and lift your confidence. Equally, if they are unkind, and uncaring they can erode and wear away your confidence. This eroded confidence leaves you not wanting to get on, to walk, to eat, not wanting to do anything really. The unkind attitude of others can take your confidence away and leave you feeling low in mood and a little helpless. Sometimes you see that these cruel and mean people behave like that because they lack confidence themselves, this low esteem and confidence causes this behaviour.

Other things that affect your mood also affect your confidence. Having animals and pets around you helps boost your confidence, this connection to other things. Being in a familiar place, at home help your confidence too.

### Unique incidental themes:

- Confidence is being able to get up and get on.
- **Having faith (religious belief) gives you a confidence.**
- **Others around you who are kind can help your confidence.**
- **Others around you that are unkind or uncaring can erode your confidence.**
- **You can see others who have no confidence affect your confidence.**

- Pets and animals boost your confidence.
- Determination and confidence are connected.
- Being at home after being in hospital boosts your confidence.

### Participant 20 - Individual interview analysis

Confidence is something that is difficult to describe. It is a word we don't use that often, but it is useful to acknowledge and relate our recovery to.

Confidence is like riding your bike or driving a car – you don't think much about it at the time, but it is evidently there when you do. It is inbuilt, built into your body and into your mind. Mostly, you just get on with things and you don't notice it is there, it is rarely in our conscious thought – until we think about it – then you do notice its presence. Confidence is in everything you do, but often not visible or associated with every job we do. It is only when you lose your confidence you recognise it not being there.

Confidence is being in control. You need to know the rules. You need confidence to face the physical problems your body throws at you, a fall for example. The word confidence is more a mental attitude, it is something in your head. It helps you achieve your ambitions. You can gain confidence by understanding the rules. It is connected to your recovery – as you physically progress your confidence improves. It all comes together – the body, the physical thing and the head, the confidence thing. Something your physical progression is ahead of your confidence, it must catch up on your physical recovery.

#### Unique incidental themes:

- **Confidence is being in control.**
- **Confidence is a mental attitude connected to physical recovery.**
- Others help build your confidence.
- Falls, balance and confidence have a connection.
- Confidence is gained by understanding the rules.
- Confidence is unconsciously omnipresent, you only become aware of it when you lose it.

### Participant 21 - Individual interview analysis

Confidence in previous life roles, at work for example, give you an understanding of confidence later in life and helps you think about confidence and the connection with frailty. At work your confidence is high, and it grows with accomplishment, success



and positive feedback. You present this confidence in the way you present yourself, your home, your life to others.

Getting older and seeing frailty appear is not easy, you see your physical health *fritted* away by the frustration of not getting around so well and falling over. You feel it – not just feeling a *bit achy* and slowing up, but you feel it when walking, when slipping over, and banging into things. When you feel your frailty you have low confidence, you feel... it's hard to describe, *you feel buggered up*, it's frustrating.

You get so angry with yourself when you fall over. You see it all happening. Not using your stick to get around and just relying on the furniture. You fall. Despite your stick giving you that little bit of confidence, you often think it is easier to hold on to other things to get around.

Confidence is bound up in happiness and friendship – connecting to your social network brings this.

#### Unique incidental themes:

- Confidence is connected to accomplishment and success.
- Confidence is connected to increasing dependency.
- Walking aids give you confidence, if you use them.
- Confidence is bound up in happiness and friendship

#### Participant 22 - Individual interview analysis

Confidence means having will power – the will power to do things and achieve things.

Being put down by others when you are younger, by your family and friends, and having to finding your way in life affects your confidence. It knocks you back. Fighting back however, you become a stronger person, a more confidence person and you can succeed in your ambitions. You learn to rise above it, and you learn not to take notice of others. You get on that way, you achieve your goals. You may look back and see that as you took on a caring role for someone you loved, who has now become dependent on you, you need confidence to overcome the many challenges you now newly face – saying *I can do that!* is related to your confidence.

Determination, being determined – a *I'm going to do it!* spirit is connected too.

As you get older and frailer your fighting-spirit changes. Now your physical strength starts to let you down. The more lit lets you down you start to get depressed. You want to be able to do things for yourself, as you have done before, but you cannot. Even standing up out of bed is impossible. You lose your confidence and you become afraid. Not having the ability to get up out of bed is frightening. You have no confidence. You question why you have ended up in this situation, bed bound, physically disabled yourself, not able to do the simple things to help yourself, its

helpless, you see in yourself you are not improving, there is no way forward, it is so upsetting – you just cry.

**Unique incidental themes:**

- **Having a determination gives you confidence and the will to fight on.**
- **Confidence loss is connected to being afraid for the future.**
- **Confidence and depression are connected.**
- **Losing confidence and hope is emotionally upsetting.**

Age and Ageing - Accepted 7 April 2021