

Living with Physical Limitations: Exploring Adaptive Responses Among Elderly

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ABSTRACT

Mobility limitation among institutionalized elderly is a major gerontological concern, contributing to disability, psychosocial distress, and reduced quality of life. This study aimed to explore the lived experiences, psychosocial impact, and adaptive responses of older adults with mobility limitations in an institutional care setting. A descriptive phenomenological qualitative study was conducted with six elderly from a residential care institution for the elderly that aged 60 years and above. Data were obtained through in-depth semi-structured interviews and analyzed using Colaizzi's phenomenological framework. Four interconnected themes were identified: fall-related onset of mobility impairment; psychosocial powerlessness characterized by hopelessness and social isolation; adaptive responses including assistive device use and activity modification; and resilience through hope, spirituality, and desire for functional recovery. The findings demonstrate a trajectory from bodily disruption to psychosocial vulnerability and adaptive resilience within long-term care. Mobility limitation in institutionalized older adults is a multidimensional experience involving physical decline, emotional distress, and resilience processes

Keywords: Elderly, Mobility Limitation, Psychosocial Adaptation, Resilience

1. BACKGROUND

Increasing life expectancy has led to a steady rise in the proportion of older adults worldwide. In Indonesia, older adults are legally defined as individuals aged 60 years and above, as stipulated in Law No. 13 of 1998 concerning Elderly Welfare. Globally, population ageing is accelerating at an unprecedented rate. According to the World Health Organization [1] the number of people aged 60 years and older is expected to reach 1.4 billion by 2030 and 2.1 billion by 2050. Indonesia is among the countries experiencing rapid demographic ageing. The United Nations [2] projects that Indonesia's older population will continue to

grow substantially, placing the country among those with the largest elderly populations globally by 2050. This demographic transition presents significant challenges for healthcare systems, social protection, and long-term care services.

Ageing is a natural biological process characterized by progressive physiological decline. Older adults commonly experience reductions in musculoskeletal strength, joint flexibility, balance, and neuromuscular coordination, which increase the risk of functional limitations [1]. These changes often lead to decreased mobility and increased vulnerability to chronic diseases, frailty, and disability. Functional decline not only affects physical health but also has psychological and

social consequences, including loss of independence, decreased self-esteem, and social withdrawal [3].

Physical limitation, particularly impaired mobility or physical immobility, refers to a reduced ability to move independently and perform essential daily tasks [4][4], [5]. The causes of mobility impairment in older adults are multifactorial, involving intrinsic factors such as muscle weakness, gait disturbances, joint stiffness, dizziness, and chronic illness, as well as extrinsic factors including environmental hazards and inadequate social support. These limitations significantly affect the ability of older adults to perform Activities of Daily Living (ADLs), such as bathing, dressing, eating, toileting, and transferring [1], [6].

Impairment in basic daily activities often results in increased dependency on others. As physical conditions decline, older adults may struggle to maintain autonomy, leading to reduced productivity and challenges in meeting daily needs [4]. Prolonged immobility is also associated with secondary complications such as pressure injuries, muscle atrophy, contractures, and increased risk of falls [7]. Beyond physical consequences, mobility limitations can trigger emotional responses such as sadness, shame, frustration, and feelings of uselessness, particularly when individuals compare their current condition to their previous functional abilities.

Preliminary interviews conducted with older adults experiencing physical limitations revealed several recurring phenomena, including feelings of sadness due to the inability to perform usual activities, embarrassment about their current physical condition, and visible emotional distress related to decreased mobility. These experiences highlight the complex interplay between physical impairment and psychological well-being among institutionalized older adults.

Understanding the lived experiences of older adults with physical limitations is essential

to inform holistic nursing care and improve quality of life in residential settings. Therefore, this study aims to gain a deeper understanding of the experiences of older adults with physical limitations at the Social Protection Home Tresna Werdha, Garut Regency.

2. RESEARCH METHODS

This study employed a descriptive qualitative design with a phenomenological approach. A phenomenological method was selected to explore and understand the lived experiences of older adults facing physical limitations. Six older adults were purposively selected based on predetermined inclusion criteria. Six older adults were purposively selected based on predetermined inclusion criteria, with a final sample of six participants determined upon reaching data saturation.

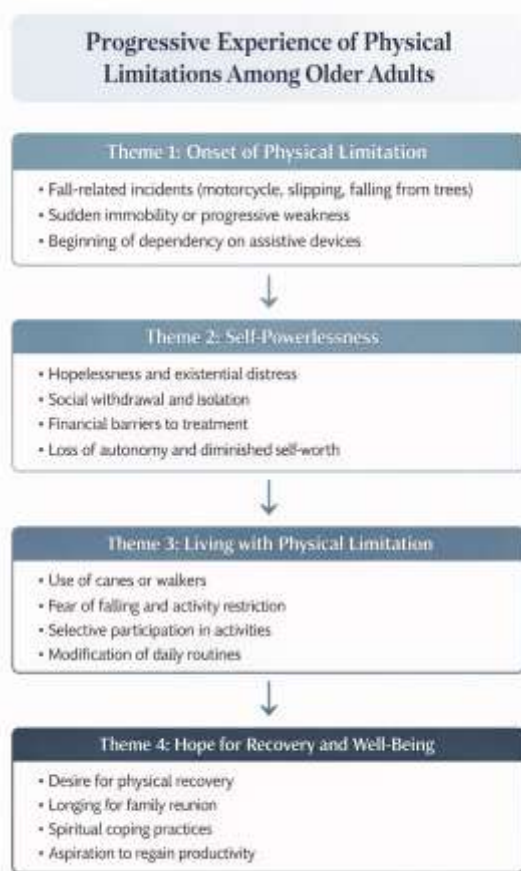
Participants were aged 60 years and above and had experienced physical limitations affecting their daily activities. Purposive sampling was used to ensure that participants had direct and meaningful experiences related to the phenomena under investigation.

Data were collected through in-depth, semi-structured interviews using an interview guide to ensure consistency while allowing flexibility for participants to elaborate on their experiences. Interviews were conducted in a private and comfortable setting to facilitate open discussion. Each interview was audio-recorded with participants' consent and supplemented with field notes to capture non-verbal expressions and contextual observations. Data were analyzed using Colaizzi's phenomenological method

3. RESULTS AND DISCUSSION

Six older adults (P1–P6) participated in this study. Analysis using Colaizzi's phenomenological approach yielded four interrelated themes describing the trajectory of living with physical limitations: (1) onset of physical limitation, (2) self-powerlessness, (3)

living with limitation, and (4) hope for recovery and well-being



Theme 1: Onset of Physical Limitation

All participants traced their physical limitations to fall-related incidents, either sudden trauma or progressive weakness following injury. Falls occurred in various contexts, including motorcycle accidents (P1), slipping during activities (P2, P3, P5), and falling from trees (P4, P6).

P1 described the abrupt change in his life after a motorcycle accident:

“I fell into a ravine with my motorcycle... after that I could not see anymore. Since then, I have had to use a cane.”

Similarly, P4 reported prolonged immobility after falling from a coconut tree:

“When I fell, I immediately could not walk. For about four years, I was unable to walk.”

For some participants, weakness progressed gradually. P3 stated:

“After I fell, my legs became weak... I could not move them as before.”

The onset of limitation was therefore characterized by unexpected bodily disruption, marking the beginning of long-term dependency on assistive devices such as canes or walkers .

All participants identified falls as the primary precipitating event leading to long-term physical limitation. This finding aligns with global evidence indicating that falls are a leading cause of injury-related disability among older adults [1]. Falls frequently result in fractures, neurological impairment, reduced confidence in mobility, and long-term dependency on assistive devices.

The narratives revealed that the onset of limitation was experienced as a sudden bodily disruption. For some participants, immobility occurred immediately after trauma, while others experienced progressive weakness. This trajectory is consistent with the disablement process model, which conceptualizes disability as beginning with pathology or injury and progressing toward functional limitation and disability [8]. The abrupt loss of mobility reported in this study underscores the importance of fall prevention strategies in institutional settings, including environmental safety modifications, balance training, and early rehabilitation interventions.

Theme 2: Self-Powerlessness

Physical decline was closely associated with emotional distress and existential suffering.

Participants expressed hopelessness, social withdrawal, and feelings of worthlessness.

P1 articulated profound despair:

*"I have no hope... just waiting for death."
"My life feels like it has fallen into a deep abyss."*

Other participants conveyed sadness and isolation. P2 shared:

"Sometimes I feel sad... at night I just sit and daydream."

P6 highlighted functional loss and grief:

"It is sad... my legs used to be strong, now they are like this."

Financial constraints further compounded feelings of helplessness. P5 remarked:

"Where would I get money for treatment?"

Social isolation also emerged as a recurrent issue. Several participants preferred staying in their rooms rather than interacting with others. As P1 explained:

"I prefer to stay in my room, close the door, and not talk to anyone."

The second theme, self-powerlessness, reflects the profound psychological consequences of functional loss. This theme reflects that physical limitation extended beyond bodily impairment to include loss of autonomy, diminished self-worth, and social disconnection.

Participants described hopelessness, diminished self-worth, and social withdrawal. These findings correspond with literature demonstrating that mobility limitations are strongly associated with depressive symptoms, loneliness, and reduced life satisfaction among older adults [1], [9].

Importantly, emotional suffering was intertwined with social and economic vulnerability. Financial barriers to treatment and perceived abandonment by family amplified feelings of worthlessness. Previous studies in long-term care settings suggest that institutionalized older adults often experience identity disruption and perceived social marginalization, particularly when family contact decreases [10]. The accounts in this study indicate that physical limitation functioned as both a biological and existential rupture, threatening autonomy and social identity.

These findings reinforce the need for integrated geriatric care models that address psychological well-being alongside physical rehabilitation. Screening for depression, structured psychosocial interventions, and peer-support activities may mitigate the trajectory from physical limitation to emotional despair.

Theme 3: Living with Physical Limitation

Despite experiencing powerlessness, participants described efforts to adapt to their condition. Adaptation was reflected in the selective participation in institutional activities, reliance on mobility aids, and modification of daily routines.

Most participants used canes regularly. P2 stated:

"Now I walk using a cane; I cannot walk normally."

Fear of falling influenced activity restriction. P3 explained:

"I am afraid when walking... I worry about falling again."

Participation in morning exercise sessions varied. P1 reported:

"Sometimes I join the morning exercise, but I need assistance with my cane."

Daily activities were performed cautiously and often with discomfort. P5 described modifying toileting activities due to pain:

"I have to lean against the wall... otherwise the pain is unbearable."

Overall, daily life in the institution was marked by limited mobility, cautious movement, and reduced engagement, reflecting a process of gradual adaptation to functional decline.

Although participants expressed feelings of powerlessness, they also demonstrated adaptive efforts. The use of canes, selective participation in exercise sessions, and modification of daily routines reflect a process of functional adjustment. This duality restriction combined with adaptation has been described in gerontological literature as resilience within vulnerability [11].

Fear of falling emerged as a critical mediator of reduced activity. Fear-induced activity restriction is well documented and may accelerate functional decline through deconditioning [12]. In this study, participants limited engagement not solely due to physical incapacity but also due to anticipatory anxiety. This suggests that interventions should include confidence-building components, such as supervised mobility training and structured group exercises tailored to ability levels.

The findings also suggest that institutional environments can either facilitate or hinder adaptation. Access to structured activities (e.g., morning exercise, spiritual sessions) provided opportunities for engagement, although participation was selective. Nursing management in long-term care facilities should therefore prioritize individualized activity planning to maintain functional capacity and prevent further decline.

Theme 4: Hope for Recovery and Well-Being

Despite significant physical and emotional challenges, hope remained central in participants' narratives. All participants expressed a desire for recovery, improved mobility, and reunion with family.

P6 stated:

"I just want to recover... to be able to walk again."

P3 expressed longing for family connection:

"I want to go home... to gather with my children and grandchildren."

Spirituality played an important role in sustaining hope. P4 described his commitment to religious practice:

"My target now is to recite half a juz in half an hour... morning and evening."

Others hoped to regain productivity. P5 shared:

"I hope I can recover and continue my drawing."

This theme highlights resilience and the preservation of meaning despite adversity. Hope functioned as a psychological resource that counterbalanced despair and dependency.

Despite adversity, hope was consistently articulated across narratives. Participants expressed desires for recovery, reunion with family, spiritual growth, and renewed productivity. This persistence of hope aligns with positive aging frameworks emphasizing meaning-making and spiritual coping as protective factors [13].

Spiritual practices, particularly religious recitation and prayer, functioned as adaptive coping mechanisms. Research indicates that spirituality can buffer psychological distress and

enhance well-being among older adults with chronic illness [14]. In this study, hope did not negate suffering but coexisted with it, serving as a counterbalancing psychological resource.

From a clinical perspective, fostering hope may be integral to comprehensive geriatric nursing care. Interventions that support spiritual expression, family connection, and meaningful activity engagement may strengthen resilience and promote quality of life.

The findings suggest a trajectory beginning with sudden physical disruption (falls), followed by emotional powerlessness, constrained daily living, and sustained hope for recovery and familial reconnection. Although functional decline triggered dependency and psychosocial distress, participants demonstrated adaptive coping mechanisms and maintained aspirations for dignity and well-being.

This study explored the lived experiences of older adults facing physical limitations in an institutional setting. Four interconnected themes emerged: onset of physical limitation, self-powerlessness, living with limitation, and hope for recovery and well-being. These findings illustrate not merely a functional decline but a multidimensional transition involving physical disruption, psychological distress, social withdrawal, adaptive processes, and sustained hope.

4. CONCLUSION

The experience of physical limitation among older adults in institutional care is a multidimensional process beginning with fall-related bodily disruption, progressing through emotional powerlessness, evolving into adaptive daily living, and sustained by hope. These findings underscore the necessity of holistic, person-centered geriatric nursing interventions that address both functional recovery and existential well-being

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