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The Culture of Falls and Fear of Falling: A Phenomenological Study

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Abstract

Purpose: This phenomenological study explored and described the lived experiences of community-dwelling older adults regarding what falls and fear of falling meant to them, and how each entity influenced self-efficacy, functional performance, and degree of engagement in occupations.

Methods: Thirty-one older adults, 58 to 94 years old, were interviewed one time at a senior center or continual care retirement community. All interviews were analyzed using QSR NUD*IST 6 software.

Results: Three main themes emerged: 1) highly fearful, and having their lives affected by the fear of falling; 2) having fallen, but rationalized their fears and modified their lives accordingly; and, 3) felt they had not fallen by their definition and remained active in place.

Conclusion: Findings suggest the importance for practitioners to listen and understand their clients' stories and perceptions of how they are selectively engaging in life's activities while maintaining a personal perception of living an active life style.

Keywords: Prevention; Health behavior; Occupation engagement; Women's health; Fear of falling

Introduction

Occupational therapy practitioners, by virtue of their profession, encourage individuals to engage in purposeful and meaningful lives with expectations that these affect the person's quality of life and are an essential cornerstone to an individual's well-being. The expectation is: throughout ones's life span individuals will seek to find a purposeful and meaningful life. However, the Administration on Aging (AOA) [1] has indicated over 52% of older adults identify some form of disability, with 28% saying they have difficulty performing at least one Activity of Daily Living (ADL), and 12.9% have difficulty completing at least one Instrumental Activity of Daily Living (IADLs). These challenges fit within the International Classification of Functioning, Disability, and Health's context of disability involving managing and/or completing daily routines and personal activity levels [2,3]. Disabling factors and barriers to one's ability to engage in life activities, at the level one desires, is a concern that must be addressed by occupational therapy practitioners. Engagement of life activities is further complicated by the addition of the aging population who experience falls and/or develop a Fear of Falling (FOF). These functional performance obstacles have yet to be clearly identified, but must be addressed as occupational therapy practitioners assist aging adults in their quest to "Living Life to Its Fullest"™ [4].

Falls occur in at least 33% of older adults in the Unites States and may be defined as "an event which results in a person coming to rest inadvertently on the ground or floor or other lower level [5]. A "lasting concern about falling that can lead an individual to avoid activities that he/she remains capable of performing" describes a fear of falling [6]. Recent studies suggest between 35-to-55% of older adults experience some degree of this pervasive fear, regardless if they have actually fallen [7-9]. A FOF exponentially increases as people age, is more prevalent with aging females, and may cause the aging female to disengage in everyday occupations even though she remains capable of performing such activities despite a lack of injury or physical problem [10,11]. Additionally, FOF creates a potentially downward cycle; as this self-imposed activity disengagement increases, the fearful aging adult becomes less mobile and weaker, which in turn, increases the risk of falling, and the downward spiral continues [12,13]. These self-imposed activity restrictions (20-to-59%) create even more limitations in their daily and personal activities, particularly those requiring lifting, bending, walking, reaching, and going outside [11-15].

Jorstand and associates' [13] systematic review made an important statement regarding the possible influence of the word "fear" and its meaning with the older adult. Specifically, how does hearing the word "fear" in relation to FOF and then its affects on their personalized sense of daily living and quality of life. Rather than use "fear" when utilizing standardized FOF assessments replacement words have been used such as "concern" or "bothered". They suggest these replacement words may jeopardize the true findings of the assessment. Particularly since it measures one construct and the replacement word may measure a different construct.

There appears to be less FOF among healthy older adults who tend to impose self-restricted engagement in risky activities (that may cause falls) without compromising daily activities [16], are engaged in leisure activities [17], and received social support from family and friends [15]. Yet, research has demonstrated there are older adults who self-restrict activities and become socially isolated due to FOF even if they have never fallen, while others who have incurred multiple falls keep engaged in their activities and social life [18]. People living with activity limitations by the very nature of self-restriction have fewer opportunities to be satisfied with life or experience happiness, which, thereby, increases the probability of a negative effect on their quality of life [19]. Occupational therapy practitioners cannot ignore the potential impact of a FOF and its debilitating affects particularly in regards self-efficacy, functional performance, and degree of

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engagement in occupations. So, what causes this disparity of activity engagement or self-imposed disengagement in their daily routines and personal activities among community-dwelling older adults?

To date, research that specifically examines the disruption of community-dwelling older adults' normal activity level that requires psychological and personal adjustments, is limited specifically towards their perspective of what falls and FOF means to them, and how and if, it impacts their self-efficacy, functional performance, and engagement in activities. In this instance, self-efficacy relates to how a person perceives personal abilities within a specific domain of activities [13]. Further, the understanding of what falls and FOF within the context of disability, defined by the International Classification of Functioning (ICF), has not been investigated. The term disability relates to managing/completing daily routine, and managing their personal activity levels [2]. It is hoped findings from this study will add to the understanding of how and what affects older adults, particularly aging females, in relationship to their continued engagement or self-disengagement from daily activities that subsequently affect their quality of life.

The current study sought to expand the understanding of the lived experiences of community-dwelling older adults, living in eastern North Carolina, to ascertain what falls and FOF meant to them, and how each entity influenced their self-efficacy, functional performance, and degree of engagement in occupations. This study adds to the occupational therapy practitioner's evidence of how falls and FOF impacts community-dwelling older adults' performance, engagement, and other pertinent issues relevant to the growing occupational therapy geriatric practice arena.

Methods

Research design

To better understand what falls and fear of falling meant to community-dwelling older adults in relation to their self-efficacy, functional performance, and degree of engagement in occupations, the authors used a qualitative phenomenological design. This approach was appropriate, as it provided detailed individual perspectives about the phenomena of lived experiences with the current levels of activities and personal perceptions of falls and FOF. Additionally, by the nature of qualitative work, this methodology allowed for exploration of themes as they developed rather than testing presumed trends, and allowed for the findings to speak for themselves. In addition this paper was derived from the data and interviews collected by two of the authors and then the themes and findings culminated by a third author not in the field, with validation interviews conducted on points discovered. A convenience sample using a homogeneous sampling that was purposive and allowed for a snowball sampling was employed. Interviewing and data collection only took place once the researchers following the approval from the University's Institutional Review Board.

Participants

Thirty-one participants between 58 and 94 of age were drawn from a rural senior center and Continual Care Retirement Community (CCRC). Those who attended the senior center were considered living at a lower socio-economic level compared to those living in the CCRC. Inclusion criteria included any English speaking individual who was 55 years or older, of any ethnicity, had a Mini-Mental State Examination Score of ≥ 21 (mild to normal cognitive level) [20], and lived independently. Participants were notified about the study through posted fliers at the senior center or CCRC, and by verbal information from employees of each site. Participants received written and verbal information about the study, and provided written consent before the interviews began. Of the 31 interviewed, less than a quarter of them were male. Their data is included in this study as it contributes to the overall understanding of FOF.

Data collection

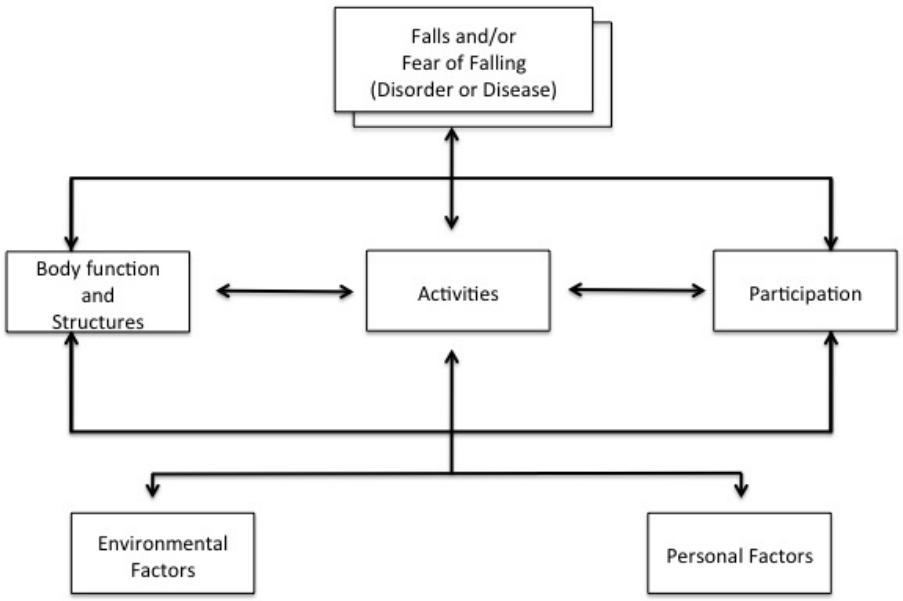
Two data sources were used in the current study, participant interviews and field notes. Each participant was interviewed face-to-face to explore the lived experiences of what falls and fear of falling meant to them. The one-time in-depth interviews followed a semistructured interview guide with open-ended questions, and took place either in the senior center or the participants' living environment, some within the actual living quarters and others within a visiting room area within the CCRC. All interviews lasted between 30-to-90 minutes depending on the responses and exchange generated between the participants and the interviewers. The interviews provided ample time for the participants to talk about their perceptions of falls and fear of falling in relation to self-efficacy, functional performance, and degree of occupation engagement. One occupational therapist performed the interviews at the senior center and an occupational therapy graduate student, working on her thesis, performed the CCRC's interviews. Both interviewers were female, and in their opening introduction explained they were interviewing several individuals, hoped to learn more about how the individual's activity levels were changing over time, and if their health conditions and mobility were changing as they aged.

All interviews were audiotaped and transcribed. Trustworthiness was supported by immediately reviewing field notes and the participant's responses within 72 hours by each interviewer. After all data were collected, the primary author reviewed all transcripts, and was blind to the socio-economic status of the participants since the setting type, senior center or CCRC, was not documented on the transcriptions.

Data analysis

Data analysis used an inductive approach, using a constant comparative process [21]. The transcribed interviews were coded by analyzing whole sentences or paragraphs. Open coding was done initially, by identifying concepts with their properties and dimensions. A qualitative computer software program [22], was used to assist in the coding and retrieval processes. Axial coding, involving re-assembling the data, relating categories to their subcategories, was then undertaken. The subcategories were integrated and refined. Analytical and conceptual memos, both written and tabular formats, were used throughout the analysis to help clarify, develop, and explore emerging themes. As themes emerged, questions were reviewed for cross-referencing to pursue these concepts and ideas within the scripted transcripts provided.

In a test of triangulation, after reading all of the transcripts, the primary author, who had not conducted the interviews, wrote out what he perceived to be the primary semi-structured questions rather than knowing what questions were queried to the participants at each setting. He then compared his generated questions to the actual questions by talking to each interviewer. The comparisons of the primary author's generated questions to the interviewers' questions were strongly viewed as reflective of the intent, and were seen as demonstrative of consistency in effort and gathering of the data. It was also noted the semi-structured questions developed by the interviewers revolved around the two primary areas identified by the ICF's context of disability:1) managing/completing daily routine; and, 2) managing their personal activity levels [2] (Figure 1).



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Levasseur, Desrosiers, J. and St-Cyr Tribble, D (2008). *Health and Quality of Life Outcome, 6*(30). doi:10.1186/1477-7525-6-30

Figure 1: International Classification of Functioning, Disability and Health (ICF) model.

Findings

The research design of this current study provided a more in-depth insight of how community-dwelling older adults perceived falls and fear of falling in relation to their everyday lives. Additionally, the culture or language used by older adults when talking about how managing and/or completing their daily lives and personal activities emerged as they shared their lived experiences. Specifically, three themes clearly emerged and included: 1) individuals who have never fallen with any fear; 2) individuals who have fallen, with no fear; and, 3) individuals with numerous falls and expressing notable fear of future falls (Figure 2). It should be noted the ingrained understanding of the ICF made it near impossible to review the data without having the knowledge of how the relationship between activity levels directly ties back to the definitions established by the ICF disability classifications (Figure 2).

Theme 1: individuals who have never fallen with no fear

As might have been expected, individuals who were identified in this area were fewer in numbers and typically physically healthier than their peers. The common statement was almost of bewilderment that one would be fearful of falling. A majority of the participants in this group expressed they had to be "*more careful*" and "*slower*" in their movements, but identified that as a natural part of aging. One individual was quite proud of his age and status of not being held back by anything that he did not want to do. "*You might not be able to do everything that you used to, but you also don't want to do some of those things anyway.*" Clearly, the comments made indicated these individuals saw themselves as engaged with their community, engaged in their daily activities of choice, and were active participants. In review of the transcripts, it was easily noted that both interviewers asked more questions that were interpreted as increased prodding for instances of falls or potential FOF when the participants self-identified they had not experienced any falls nor a FOF.

Theme 2: individuals who fallen, with no fear

Individuals who were identified within this category described their falls and often seemed to rationalize or explain away the cause behind their fall(s). They were open about falling, but quickly identified different reasons that may have caused the fall such as diabetes, high blood pressure, and/or recovering from surgery. As noted with the previous group, the researchers gathering the data would revisit the fall and prod further for instances of fear. An interesting observation was how adamant these individuals seemed, as a group, to make sure the interviewers understood that little or nothing was going to change the way they approached their lives and living styles. One might surmise this was the way they have approached their lives all along. D.G. states: "*Yes you have to make some (restrictions) – you place your own restriction on yourself…. I had been doing what I wanted to do…. Sometime you gotta do what you gotta do.*" The data gathered, if taken without the stories and insights, might allow one to conclude there was no change to their lives or activity levels; thus, not being included as an ICF concern.

Theme 3: individuals with numerous falls and expressing notable fear of future Fall

This group comprised the largest group of participants, and was noted to have multiple medical challenges with the majority indicating they had diabetes. Two specific complaint areas within this highly fearful group were identified. The verbal accounts describe these based on their perceptions of their state of being. First, those who described their predisposition as becoming "faint" and lost their balance primarily due to what was determined to be an "unstable state in their metabolism". Secondly, those who complained about the loss of sensation or tingling pain in their extremities (e.g. "*just like a thousand needles on the bottom of my feet*". The interviews and/or transcriptions, in this third theme area, were much longer in length particularly in comparison with those who had no falls and/or fears. Of note, it was very important for these

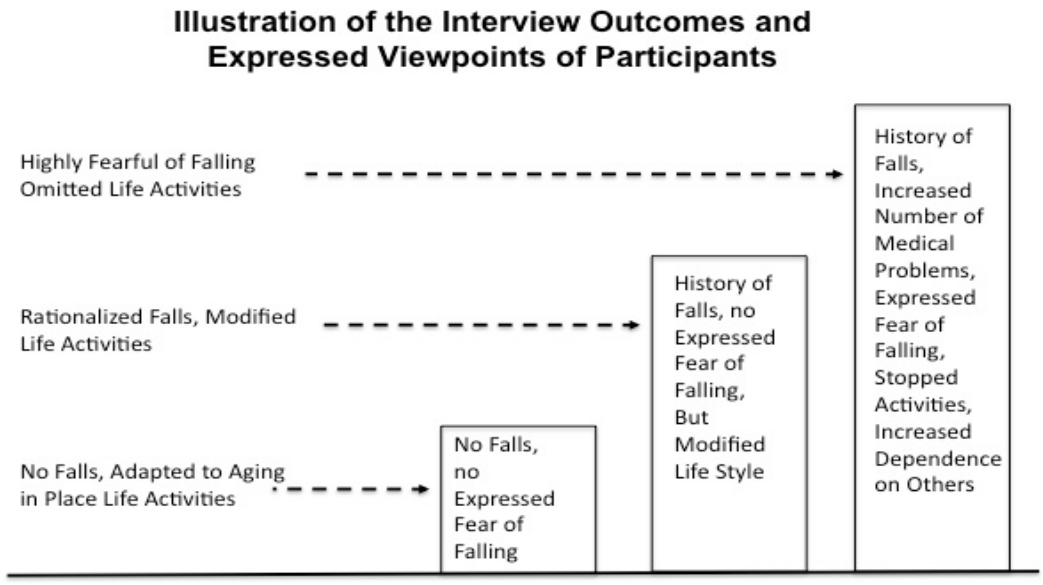

Figure 2: Illustration of the Interview Outcomes and Expressed Viewpoints of Participants.

participants to make the interviewer understand their multiple medical issues, how the associated complications affected their inability to participate in many of their life activities, and how that affected their fear of future injuries.

Many completely revamped their lifestyle or self-restricted engaging in activities that prior to their fall(s) might have been deemed as important. Individuals, in this theme area, were just as passionate about "*being safe*" and protecting themselves by withdrawing from activities as those who had not fallen and were continuing to engage in physical and leisure activities. This group clearly and easily fits under an ICF disabled category since they have made modification to their activity levels. Further, their perceptions and change in occupation engagement had a major impact on the ability to engage in their daily and personal activities which again falls within the model outlined by ICF [2,3] (Figure 1).

Culture of those who have fallen or have a fear of falling

An important finding from listening to the older adults was their unacknowledged understanding of how their perceptions of falls and FOF have been intertwined within their very essence of not only who they had become, but also how these subconscious perceptions influenced managing and/or completing their daily and personal activities. This finding may be illustrated by reflecting on the "Culture of Falls and Fear of Falling" as one listens to those who have experienced them, and the words they chose to share with the interviewers. Most of the participants had experienced at least one fall in the last five years. During the interviews, the participants were adamant in the way they distinguished between falls and stumbles, where their falls occurred, how they fell, and especially why the fall(s) occurred. Additionally, they were inclusive in describing what happened as a result of their falls, their attitude toward these falls, whether or not they had a FOF, subsequent consequences, and even what they did to prevent falls from happening.

Notably, all of the participants made a distinction between falls, actually landing on the ground, and stumbles/loss of balance, and when they almost fell but did not actually land on the ground. The participants did not consider they had fallen if they had only stumbled or lost their balance. Perceptions that a fall had not occurred were also evident when participants talked about situations when they were sitting or lying down. C.P. said, "*I'll get—I'll lose my balance and "fall" into that couch or this chair or that chair, or I may grab something.*" B.B. stated, "*I wouldn't say many falls. More wobbling kinds of situations.*" M.T. also referred to at times feeling "a little bit wobbly." M.B. (II) said, "*I slid off the bed two times in a year—I didn't fall off, I just slid off. It's not what I'd call falling.*" It was as if those incidents were perfectly acceptable, and possibly would not have been reported in a standardized fall or fear of falling assessment.

The participants, who had fallen, spoke about where their falls had occurred; and, the majority had fallen in their residence. C.E. tripped over boxes and fell off her toilet onto a set of bathroom scales in two different falls: "*Ooh, that was awful. My knees still bother me.*" Several participants had fallen in the bathroom, often when rising from the toilet. D.G. slipped while in his shower stall: "*My foot slipped. I fell in the wall, and when I hit the wall either with my cane or my elbow, I fell down.*"

Almost as if they were caught by surprise, several expressed how sometimes the fall came about so fast they had no time to prepare and no warning it was going to happen. B.F. said, "*I was up and I was down. There was nothing in between.*" C.P. had a similar experience: "*I never had that sensation when I had no legs at all. I couldn't stop. I couldn't do anything. I just had to fall.*" M.B. said that she had the "*instinct to turn and go, but it was too fast. I just fell before I even knew it.*" B.B. did the same thing: "*I turned around—I thought I heard the telephone ring—and I turned around and fell straight on my back.*" A concern that should be raised, is that at face value or without truly "listening" to what is being said by these participants, the inexperienced practitioner could interpret these statements as being individuals who were undaunted and revitalized individuals without a handicapping condition; yet clearly, they fall within the constraints of the ICF as an individual with impairments.

Discussion

The purpose of this qualitative study was to gain an understanding

and possible insight of the lived experiences of community-dwelling older adults, more specifically aging females living in eastern North Carolina, in relation to what falls and FOF meant to them, and how each entity influenced their self-efficacy, functional performance, and degree of engagement in occupations. The significance of this study is most relevant to occupational therapy practitioners when the possible insight gained from the findings are applied to understanding how older adults' perceptions impacted their lives, and what or how they identified their level of independence. Notably, their views affected how they have managed and/or completed their daily routines and participated in personal activity levels. Three categories emerged from the study with an imposing factor that challenges the practitioner to investigate, at a deeper level, in establishing actual abilities versus their perceived sense of independence. The discovery of how, often times, the subconscious culture of the way older adults viewed their self-efficacy, functional performance, and degree of occupation engagement should not be discounted by practitioners during the evaluation and treatment process of ensuring their older clients are "Living their lives to Its Fullest™" [4]. This finding demonstrates the need for occupational therapy practitioners to not rely on just standardized fall assessments, but also ask probing questions regarding their fall history, possible fear of falling, and ramifications of each entity. Fear is an impactful word and the word alone brings different meaning to different individuals, all of which affect each us on our own level [13].

A strength of the current study's findings provides a unique and informative process to provide occupational therapy practitioners insights on client-centered points of view rather than assumptions made surrounding their falls and possible FOF. The voices of the aging women resonate with aging individuals faced with changing physical challenges.. These voices clearly point to the modifications they have made in their lives, which in turn, corresponded to the ICF's disability categories, daily and personal activities [2,3]. In addition, since the primary author was a non-data collector, his views were less biased, from the onset, as compared to the two of the authors who interviewed and had direct contact with the participants. The objectivity achieved resulted in the notion of resilience of the participants to remain engaged in their daily and personal activities rather than being resigned to the aging process and taking on a disability role since they had incurred a fall and/or had a fear of falling.

This method of having third author conduct the review for themes speaks to the intensive and rigorous approach that was taken in moving bias aside and thus allow for the true emersion of themes and identifications of the findings that were not sought, but discovered through this process.

Categorically, there were different levels of health issues and multiplicity of health problems that included cancer, heart problems, diabetes, high blood pressure and cholesterol, arthritis, Alzheimer's disease, Parkinson's disease, hip and knee replacements, sleep apnea, chronic obstructive pulmonary disease, incontinence, and depression. However, most participants had a positive outlook on life, tended to minimize health problems and falls, and viewed themselves as independent, but with limitations. Of concern to the researchers was the level those interviewed would essentially deny their lives had changed or had to be modified as a result of falling or having a stumble or loss of balance. They also did not identify they had a FOF, rather they would state "one has to be aware of what you are doing or you just go down." Practitioners should recognize how their older adult clientele view their falls and FOF in relation to occupation engagement, and how these perceptions may influence their motivation to engage in daily and personal activities during therapy and once they return to their homes.

The aging women who dismissed their falls may be at a higher fall risk since they may fail to incorporate precautions in their daily lives and thus place themselves in a higher state of risk for a fall. Yet, on the other hand, these older female adults may remain more active, maintain their strength, and have a higher level of self-efficacy than those who stopped engaging in activities for fearing another fall would happen. Conversely, those who were "scared to death" as C.A. emphatically verbalized two times in a loud voice, may also be at a higher fall risk since this group of participants chose to engage in less daily and personal activities, thereby becoming physically weaker, so they would not fall. As noted in Figure 2, individuals who had a history of falls accompanied by an increased number of medical issues, expressed greater concerns about their FOF. D.G. said: "You always have a fear. Makes you a believer". Another participant felt as if her fall affected her attitude. B.B. stated he "did not have a heavy fear of falling," he was just "super-cautious." F.D. said that he had a FOF, but "it doesn't restrict me." "Ooh, that was awful" M.B. said that she had a FOF "'cause I know I can fall. Just about every time I move I think about falling." These comments demonstrate the need for occupational therapy practitioners to ask in-depth questions regarding how their older clients view falls and fear of falling, particularly concerning their ability to manage and/or complete their daily and personal activities.

Having traits of "purpose, perseverance, equanimity, self-reliance, and existential aloneness" [23] adds to the notion of resilience among older adults in regards to their self-efficacy and occupation engagement. Purpose can mean having something to do; an occupation. All of the participants had a physical and/or social activity and/or a volunteer job, and, therefore, had purpose to their lives. Perseverance is the ability to keep going, despite obstacles in the path. Self-reliance is a "belief in one's personal strengths and capabilities" [23]. Many of the participants viewed themselves as capable individuals who persevered and managed their daily routines independently regardless of the aging process, yet upon closer examination they were dependent at some level of assistance to actually meet or achieve their needs. This same sense of adjustment occurred when examining the data in relation to successful aging.

Successful aging can be defined as "the enjoyment of health and vigor of the mind, body, and spirit into middle age and beyond. For many, it is also the freedom from impairment, and the ability to live independently"[24]. Participating in activities without of disease and disability were indicative of successful aging, as were having close personal contacts and freedom from depression [24]. Many participants embodied the spirit of successful aging, as demonstrated by being of strong mind and spirit, which to a certain extent overcame the debilitations in their bodies. A majority participated in some physical activity, and all participated socially, although some needed help with morning ADLs. All of the participants had at least one close personal contact, and no more than two were clinically depressed. Far less than a third of the participants declared an outright fear of falling, and many of the participants seemed to shrug off the falls they had experienced. In addition, many of the participants, despite having had a fall, were not recurrent fallers (experiencing two or more falls in a six month time frame). Mobility aids allowed the participants to experience the freedom of independence, and were intrinsic to the participants' ability to find a modified life style. Listening to the client's story becomes critically important to the practitioner as the level of desired independence can be determined specifically to self-satisfaction as well as performance capabilities [25-27].

Limitations

This study relied on two separate interviewers and their consistent collection of data accomplished through multiple interviews and then subsequent transcription of the data. It also relied on gathering perceptions of the participants and asking for clarification, while not pushing personal agendas or bias to the forefront. The interviewers did not observe participants' performance on any specific balance, gait, or performance assessments or psychological screenings. The study was performed in two eastern North Carolina settings, and therefore, results may not be transferrable to the entire population of community-dwelling older adults.

Future Research

This study adds to the body of literature regarding falls and FOF by investigating the experiences of community-dwelling older adults who attended a rural senior center or lived in at a CCRC. It provides a snapshot of what life is like at these two community settings, which helps explicate falling and the FOF, at these venues. Future research opportunities are endless in learning more about older adult perceptions of falls and fear of falling in relation to self-efficacy, functional performance, and occupation engagement. Practitioners could also expand the knowledge base on the ramifications of falls and fear of falling among specific health impairment populations such as stroke or Parkinson's disease. Learning about these experiences may lead occupational therapy practitioners to better able assist older adults with wellness and fall prevention programs that emphasize the identified issues, such as problems with balance, using furniture and other unsafe items for assistance, cognitive insufficiencies, vision deficits, lack of physical activity, and possible lack of motivation to engage in activities due to a FOF.

Conclusion

Findings suggest the importance for practitioners to listen and understand their clients' stories and perceptions of how they are selectively engaging in life's activities while maintaining a personal perception of living an active life style. It was apparent the participants, often times, dismissed their falls and/or FOF when describing how they managed or completed their daily and personal activities. Thus, it is imperative for occupational therapy practitioners to not only rely on standardized fall and fear of falling assessments, but also determine how or if their older clients are self-restricting their activities due to the aging process and/or protect themselves from fall-related injuries. By asking in-depth questions, whether a person has fallen or has a FOF, practitioners should become aware of how occupation disengagement may place their older clients at a higher fall risk, develop a FOF, and affect their self-efficacy and ability to manage and/or complete daily and personal activities.

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