FEAR OF FALLING: THE EXPERIENCE OF ELDERLY INDIVIDUALS WHO HAVE PREVIOUSLY FALLEN

By

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Fear of Falling: The Experience of Elderly Individuals Who Have Previously Fallen

Fear of falling resulting from a previous fall has serious health implications for elderly individuals who live in the community. This fear has been linked to activity restriction, poor physical health, increased dependence, and lifestyle changes. Previous research on fear of falling has described it in relation to other outcomes of a fall and not as a discrete entity. None of the studies included the individual’s perspective. Therefore, the purpose of this study was to describe the meaning of the experience of fear of falling from the perspective’s of elderly individuals who have previously fallen.

The phenomenological method was used to gain an understanding of the subjective experience of the nine elderly community-dwelling individuals who participated in the study. All of the participants had fallen more than once and all had sustained an injury from a fall. In the course of two or three interviews, each participant and the researcher constructed an account of the participant’s experience of the fear of falling.
Using content analysis the data was conceptualized into themes and concepts reflective of the participants’ perspectives. The presentation of this descriptive data was organized into two major themes which represented a process of adjustment: making meaning of the experience of the fear of falling and integrating the meaning of the experience into daily living.

The findings revealed that fear of falling threatened the individual’s physical and psychological survival. In response a process of adjustment was initiated in which the individual used behavioural and cognitive activities that sought to maintain control and were self-enhancing.

The participants’ accounts of their fear of falling highlight the importance of determining the client’s perspective in order to understand and work with elderly individuals who fall and are afraid of falling again. In light of the research findings implications for nursing practice, nursing education, and nursing research are discussed.
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CHAPTER ONE
Introduction

Introduction and Background to the Problem

In Canada, approximately 11% of the population is over the age of 65; and, of these, 95% choose to live in their own homes (Mackus & Millette, 1987). The projection is that those over 65 years of age will represent approximately 20% of the total population by the year 2001 (Stats Canada, 1988). This demographic change will have an impact on the services that community nurses provide for individuals living in the community.

In the community-dwelling elderly population, falls are a common problem and can have serious consequences for the individual. It is estimated that 1/3 of this population will experience one or more falls a year (Campbell, Reinken, & Allan, 1981; Perry, 1982; Prudham & Evans, 1981; Sorock, 1988). Approximately 5 to 15% will sustain a serious injury which requires health care intervention (Tinetti, Richman, & Powell, 1990). Many researchers report that physical trauma can lead to loss of mobility and function (Brummel-Smith, 1989; Sorock 1988; Tinetti,
Speechley, & Ginter, 1988; Tinetti et al., 1990). It is also reported that some individuals may restrict their activities as a way of coping (Speechley & Tinetti, 1990). Lack of activity can lead to decreased strength and independence and may result in an increased risk for falling (Brummel-Smith, 1989).

The literature also describes "psychological trauma" (Tinetti et al., 1990, p. 239) occurring as a result of a fall in the elderly individual who lives at home. Over 50% of the studies on the community-based elderly which were reviewed included comments by the researchers about fear of falling. Fear of falling was linked to activity restriction (Speechley & Tinetti, 1989), poor physical health, reduced mobility, increased dependence (Downton & Andrews, 1990; Prudham & Evans, 1981; Vellas, Cayla, Bocquet, de Pemille, & Alvarede, 1987; Walker & Howland, 1990), lifestyle changes (Prudham & Evans, 1981), and feelings of boredom and depression (Vellas et al., 1987). These pose serious health problems for the elderly and may threaten their ability to function independently in their own homes.

In most of the studies using the community
dwelling elderly as the sample, the association between fear of falling, function, mobility, and independence has been found retrospectively; and, therefore, no assumption can be made about whether the fear preceded or followed the fall event. In addition, those studies which were prospective in nature did not consistently define fear of falling or utilize a standard method of assessing the fear. Methods of sampling were poorly described in some of the studies (Tideiksaar & Silverton, 1989; Walker & Howland, 1990). In others, small sample size and lack of randomization prevented the generalizability of the results to other target populations (Tideiksaar & Silverton, 1989; Tinetti et al., 1988). Nonetheless, the range of reported estimates of fear of falling in these studies indicated that this phenomenon is a health problem that warrants further research (Downton & Andrews, 1990; Tideiksaar & Silverton, 1989; Walker & Howland, 1990).

The literature on falls in the elderly population has identified that fear of falling has serious consequences for the individual. The fear that individuals feel following a fall has been linked to changes in their ability to cope with activities of
daily living (Brummel-Smith, 1989). Some investigators have suggested that fear of falling contributed to a loss of confidence and self esteem (Brummel-Smith, 1989; Tinetti et al., 1990). Restriction of activities and social isolation have been described by researchers in association with fear of falling (Downton & Andrews, 1990). Coping with the fear of falling by decreasing function has the potential to compromise an individual's ability to maintain an independent lifestyle in the community.

As increasing numbers of elderly individuals choose to remain in their own homes as they grow older, it seems likely that falls and fear of falling will pose significant health concerns for this population. Community health nurses will be required to assist these individuals towards maintaining their self care and independent lifestyle. To do this will require that nurses have a broad knowledge base that considers the client's experience from the client's perspective. An individualized care plan that has the greatest potential for success is one in which the nurse's perspective is congruent with that of the client. Therefore, it is important for community nurses, in
order to provide effective care, to understand the meaning of fear of falling as experienced by the individual who has previously fallen. Very little research has been done that describes fear of falling and no research has been done that examines the subjective experience of this fear from the perspective of an individual who has previously fallen. In order to provide nurses with insight about the experience of fear of falling, the proposed research has relevance.

The Framework

The framework for a research study provides the researcher with a perspective from which to view the problem (Woods & Catanzaro, 1988). The framework chosen for this study is the life-span construct model as described by Whitbourne (1985). This model is the result of a re-evaluation of three traditional models of adaptation: the life events model (Hultsch & Plemons, 1979), the cognitive appraisal model (Lazarus, 1966), and the subjective well-being model (Campbell, 1980). Each of these models is concerned with researching individuals at varying ages across the life-span and each emphasizes specific features of the adaptation process. However, all concur that the
fundamental focus of adaptation is the preservation of the physical and psychological well-being of the individual and that this outcome can function as a motivational force to facilitate adaptation (Whitbourne, 1985).

The basic assumption of the life events model of adaptation (Hultsch & Plemons, 1979) is that any type of change brought about by a life event disrupts the normal state or homeostasis of an individual. This model discounts human behaviour that seeks disequilibrium and change. The weaknesses of this model include the lack of consideration for the subjective meaning an individual attaches to an event and the negative connotations attached to change. The major contribution of this model is that it dimensionalizes the qualities of events that create stress (Holmes & Rahe, 1967) and the characteristics of the individuals that mediate the stress (George, 1980; Hinkle, 1974). The cognitive appraisal model (Lazarus, 1966) incorporates the individual's interpretation of an event and the appropriateness of the coping strategy in terms of that interpretation (Whitbourne, 1985). A weakness of this model is the lack of clarity in
differentiating between the differences and similarities of the various coping mechanisms in response to positive or negative emotional experiences.

The subjective well-being model supports the premise that the evaluation of a situation is a subjective judgemental process (Whitbourne, 1985). Andrews and Whithey (1976) found evidence of this process in the feedback loop which was created by an initial evaluation of a situation, to the coping behaviour, and to a re-evaluation of the situation. A similar feedback mechanism has been proposed in the cognitive appraisal model (Lazarus, 1966). The weakness of this model is the lack of consideration for changes that may occur in the characteristics of the individual or the environment as a means of coping.

The life-span construct model draws on the strengths of each of the above models. Its underlying premise is that the individual's cognitive and emotional construction of the life-span determines how the individual develops through a lifetime of experiences. This model offers an integrated approach to understanding an individual's ability to adapt to change. It focuses on the ways in which physical,
psychological, and social functioning over an individual's life course influence adaptation to stressful life events and activities of daily living (Whitbourne, 1985).

The primary source and content of the life-span construct is identity which defines the individual's sense of self. It is shaped by the individual's physical, psychological, and social qualities. Other influences include the individual's value system as it relates to family, work, self development, age norms, and involvement in the social welfare of the community (Whitbourne, 1985). Within the life-span construct, there are two structural components: the scenario and the life story. The scenario consists of expectations about the future which have been identified by identity as important, and the life story is an incorporation of past events into an organized sequence which provides a sense of continuity.

The life-span construct model of adaptation proposes that coping strategies can vary depending on whether an event is consistent or inconsistent with an individual's scenario. An individual's perception of the environment may change or the individual may
directly change the environment. Perceiving the environment in a different way is a mechanism to protect the self-esteem and requires an appraisal process. Protection of the self-esteem may involve a restructuring of identity which involves changing the estimation of one’s capacities to be congruent with actual abilities. It may also involve distorting the meaning of the event.

The life-span construct model proposed by Whitbourne (1985) provides a way of viewing the individual from a broad perspective. It incorporates the subjective appraisal process with the individuals’ perceptions about past, present, and future events. The model recognizes the influence of physical, social, and psychological qualities on an individual’s unique conception of the life course. Therefore, the life-span construct model would seem to be a useful framework for understanding the meaning of the fear of falling from the elderly individual’s perspective. It would direct one to consider a variety of coping strategies and would facilitate an understanding of the thinking, feeling, and behaviours of those who live with a fear of falling. In addition, this framework
will direct nurses to collect and examine data from a broad perspective when planning care for individuals who have a fear of falling.

The goal of community nursing is to promote self care and independence. This goal assumes that individuals are active participants in their care and have the potential for growth and development. This is consistent with the basic premise of the life-span construct model which proposes that the potential for change exists only within the individual; and, therefore, it is an appropriate model to guide this study.

Statement of the Problem

Falls have been documented as a common problem in the elderly population living in the community. Fear of subsequent falling may have serious consequences for the individual and may contribute to restrictions in activity and lifestyle changes. These consequences may compromise an individual's ability to function independently. Little is known about the experience of the fear of falling from the individual's perspective and the resultant changes in behaviour and lifestyle. Understanding the meaning of this experience will
enhance the community nurse's ability to plan and provide care that meets the individual's needs.

**Purpose of the Study**

The purpose of this study is to describe the meaning of fear of falling and its impact on the activities of daily living from the perspective of an elderly individual living in the community who has previously fallen.

**Research Question**

What is the meaning of the experience of the fear of falling for the elderly individual living in the community who has previously fallen?

**Definition of Terms**

**Fall:** An untoward event in which the individual comes to rest unintentionally on the ground (Morris & Issacs, 1980).

**Fear:** A normal response to active or imagined threats, comprised of an outer behavioral experience, an inner feeling, and accompanying physiological changes (Bhala, O'Donnell, & Thoppil, 1982).

**Significance for Nursing**

Nursing's goal is to understand clients in order to know how to care for them more effectively. This
study has practical significance for nurses caring for elderly clients who are afraid of falling. It is an attempt to describe the phenomenon and the human experience of living it. Nurses who have a fuller awareness of the interpretation of this experience from the perspective of the individual will be able to provide care that better meets his/her needs. Understanding the perceptions of the fear of falling will enable the nurse to assist individuals in coping with these feelings.

The notion that clients and health care professionals may not share the same perspective in regard to the fall event has significant implications for health care. The focus of this study is the client, however it is hoped that a better understanding of the client’s perspective will assist nurses in planning care. It is important for nurses to attend to their clients’ interpretations so that care can be planned that is congruent with the individuals’ needs.

As the number of elderly people who live in their own homes continues to grow, community nurses will assume more expanded roles as primary care givers. There is a greater need for them to understand the
clients' perspectives and the impact of these perspectives on the determination of patient behaviour.

**Introduction to the Methodology**

Phenomenology is the research design selected for this study. Phenomenology is the appropriate approach when the goal of the research is to understand human experience from the individual's perspective (Knaack, 1984). This method attempts to describe the human experience as it is lived (Oiler, 1982). The perceived world is examined in order to describe the lived experience. The researcher becomes immersed in the phenomenon and enters the world of the participants. The researcher must bracket or set aside any thoughts or biases previously formulated in order to accurately describe the perceived world (Oiler, 1982). Elaboration of the perceived world enhances our understanding of the experience under investigation (Oiler, 1986). This method is well suited to this study as the purpose is to understand the meaning of fear of falling from the perspective of the individual.

Phenomenology is appropriate when little is known about the phenomenon (Oiler, 1986). The inductive and
descriptive methods used in this approach impart an understanding of the phenomenon.

Additional support for using this approach is its relationship to the nursing profession which bases its care on a holistic perspective (Oiler, 1982). A goal of nursing is to understand the experience of the individual and to provide care which takes it into account. Nursing values the individual and encourages individuals to participate in their care. This study will provide a holistic view of individuals who have a fear of falling and their care needs; and, as a result, nurses will be better able to support and nurture them.

Methodological Issues

Phenomenology is the qualitative research method used for this study. Qualitative research assumes that there is value in understanding the inner experience and outer behaviour of a subject as a way to enhance the comprehension of human behaviour (Rist, 1979). This is in sharp contrast to the quantitative method which applies an empirical standard to social phenomena. Therefore, the criteria for evaluating a qualitative study are different than those used for a quantitative study. To ensure scientific rigor in a
qualitative study, Guba and Lincoln (1981) have proposed four criteria against which a study is measured. These include the "truth value, applicability, consistency, and neutrality" (p. 103-104).

The truth value of a qualitative study is "in the discovery of human phenomena or experiences as they are lived and perceived by subjects" (Sandelowski, 1986, p. 30). Credibility is the criterion against which the truth value is evaluated. Credibility exists when the descriptions and interpretations of the data are recognizable by those having had the experience as well as those who read the study. The truth value represents the internal validity in a qualitative study (Sandelowski, 1986).

Applicability in a qualitative study refers to the criterion of "fittingness" (Sandelowski, 1986, p. 32). This criterion is met when the findings fit into contexts outside the research situation and when the audience views the findings as meaningful and applicable in terms of their own experiences (Sandelowski, 1986). In a quantitative study, applicability is analogous to external validity.
Consistency is the criterion which determines a study's reliability (Sandelowski, 1986). In qualitative research the concept of auditability relates to the consistency of the findings and is present when another researcher after examining the data, reaches the same conclusions as the investigators of the study. Guba and Lincoln (1981) refer to this as the decision trail.

The fourth criterion is neutrality which refers to the "freedom from bias in the research process and product" (Sandelowski, 1986, p. 33). In qualitative research, confirmability is the criterion of neutrality; and, in quantitative research, it is objectivity. Confirmability is achieved when auditability, truth value, and applicability are established.

**Assumptions**

1. Fear of falling is a significant experience in the life of an elderly individual who has already experienced a fall.

2. Individuals who participate in this study will have fallen and be able to recount and articulate their feelings about their fear of falling again.
3. Understanding the participants' subjective experience of fear of falling enables a greater depth of comprehension of human behaviour.

Limitations

Only the perspectives of the individual participants in this study were included; and, therefore, the findings are not generalizable to other groups; however, knowledge of individual experience adds to our understanding of human behaviour.

Summary

Fear of falling has serious implications for elderly individuals, but little information exists which describes the experience of this phenomenon from the individual's perspective. This chapter has described the problem which provides the rationale for the study. It has outlined the framework, methodology, assumptions and limitations. Chapter Two presents a review of the literature relevant to this study. Chapter Three describes the methodology and Chapter Four presents the findings and their interpretation. Chapter Five presents a discussion of the findings in relation to relevant literature. The summary and implications for nursing are presented in Chapter Six.
CHAPTER TWO

Literature Review

Introduction

The purpose of a review of the literature is to provide a description and analysis of the current state of knowledge about the subject under investigation. To gain a broad perspective about the subject, the literature review selected includes information on fear and specifically fear of falling. It is organized into three sections: (1) fear, (2) related phenomena, and (3) fear of falling.

Fear

A clear scientific definition of fear has not been identified in the literature, but rather a variety of definitions have been found relating to specific fearful stimuli (Bamber, 1974; Key, 1986; Wolpe & Lang, 1964). There is consensus, however, among the researchers that fear is an emotional response to a tangible stimulus (Rachman, 1978), concrete or clearly in-focus objects (Key, 1986), and specific stimuli (Geer, 1965).

Izard (1972) has described fear as one of the fundamental emotions that can be experienced as a
discrete entity. Three components characterize the fundamental emotions and distinguish them from other complex emotions. These include an innate nervous system function, a distinct neuromuscular-expressive pattern, and a distinct subjective quality. Rachman (1978) has described the components of fear similarly and describes them as the subjective experience of apprehension, associated psychophysiological changes, and attempts to avoid or escape from certain situations. Fear has been further differentiated into acute and chronic fear by Rachman (1978) and Gellhorn (1965). They describe acute fear as more intense and sudden in onset and associate chronic fear with anxiety.

Izard (1971) believes that, almost immediately, the initial emotion of fear elicits other emotions that interact with it. The combination of fear with other emotions does not change its essential components, but the observable behaviour of the combinations may differ. For example, fear in combination with guilt yields only avoidance or withdrawal. Fear in combination with interest yields alternating approach and avoidance behaviours (Izard, 1972).
Difficulties often arise in studying fear because there is a lack of correspondence between the three main components (Rachman, 1978). For example, an elderly individual who is intensely apprehensive about falling may express a fear of falling, experience physiological symptoms of anxiety, but may not make any attempt to avoid the situation causing the fear. Rachman (1978) believes that although the three components may not correspond they do exist. Therefore it is helpful in fear research, to specify which component is being reported.

The importance of fear in any person's life depends to a large extent on its intensity, duration, and frequency. The subjective component is essential to any conception of fear (Rachman, 1978). Therefore, it seems reasonable that in order to understand fear a subjective description by the individual is required.

Several researchers have linked the experience of fear to an individual's ability to control the outcome of the situation. Rachman (1972) posited that the ability to control a potentially threatening situation decreases the possibility of fear. Bandura's theory (1986) of behavioural change suggests that fear is
mediated by changes in the perceived self-efficacy which equates to an individual’s sense of controllability. The greater the perception of control, the less likely that the individual will experience fear. This concept is also prominent in Seligman’s theory (1975) of personal helplessness. Seligman (1975) states that the expectation of uncontrollability "produces fear for as long as the subject is uncertain of the uncontrollability of the outcome" (p. 56). The sense of controllability is related to predictability, and according to this theory, individuals prefer predictable events. Both of these theories have implications for nurses caring for individuals who have a fear of falling. The more information that an individual has about a fearful situation, the warning signs, and the probable outcome, the greater the likelihood of finding ways to prevent it or of reducing its consequences.

Concern about ways to modify fear has prompted researchers to develop scales for describing and measuring the range and intensity of fears. Most studies have been conducted on children, adolescents, college students, and psychiatric patients (Bamber,
Kirkpatrick (1984) conducted a study on a sample of 545 men and women between the ages of 15 and 89 years for the purpose of determining the presence of common intense fears among adults. Subjects completed a 133-item self-administered questionnaire. Fear of death of a loved one was the overall highest fear among both men and women. Kirkpatrick’s (1984) concluding remarks are relevant for the study reported here. He stated that the findings showed that over the lifespan childhood fears mostly diminished by adulthood through a process of adaptation. A possible explanation for adaptation may be that an individual’s identity has been restructured in response to the stressful event. Kirkpatrick (1984) also found that cultural and environmental factors have a significant value in explaining adult fears. In the life-span construct model, these factors are considered to influence and be an integral part of an individual’s adaptation.

Croake, Myers, and Singh (1988) utilized a life-span approach to study the fears expressed by elderly men and women. A total of 66 elderly adults completed a 121-item scale. The results indicated that older
women expressed greater fearfulness than men, the
greatest fears of both men and women were aging and
sickness, and that these fears intensified over the
lifespan. The researchers indicated the need for
further research on patterns of adult fears with larger
samples in order to generalize the results.

In summary, fear is a complex phenomenon and
studies to date have been fraught with methodological
issues. These include lack of clear definition,
instruments which have not been adequately tested to
establish reliability and validity, and lack of a clear
theoretical framework to guide the studies (Key, 1986).
Use of checklists to assess fear is common, but some
researchers feel they are an inadequate way to describe
the experience of fear (Key, 1986; Rachman, 1972).
Several researchers have concluded that the subjective
component is essential to any conception of fear
(Kercher et al., 1988; Key, 1986; Rachman, 1972). Key
(1986) suggests that, because the study of fear is at a
preliminary stage, "soft" techniques of open-ended
questionnaires and unstructured interviews are the most
suitable techniques. He also recommends that it may be
useful to identify those fears that are unique to the
population being studied.

Related Phenomena

Phenomena which are closely linked to fear include worry, concern, anxiety, helplessness, and phobias. Within the literature these terms are used frequently, interchangeably, and without precise definition.

Anxiety has been investigated extensively. Some researchers have concerned themselves with defining this concept in order to measure it. According to Izard (1971), anxiety includes fear and two or more of the fundamental emotions of distress, anger, shame, and the positive emotion of interest-excitement. Sarason's (1966) analysis of anxiety concluded that the anxiety experience involves the fundamental emotions of fear, shame or guilt, distress, and anger. Other researchers have described anxiety as complex and incorporating fear (Epstein, 1972; Levitt, 1967; Spielberger, 1972). Clearly, there is consensus that anxiety is not unipolar, unidimensional, or unifactoral in nature (Izard, 1971).

May (1950) defined anxiety as diffuse apprehension, differing from fear in its vagueness and objectlessness. He further described it as a state
associated with feelings of helplessness and a threat to an individual's self-concept. This definition would seem to involve a cognitive component.

Covington (1986) equated anxiety to despair and helplessness which relates to a realization that the individual is personally incompetent to alter the events. This position supports the notion that it is the lack of controllability that causes anxiety. An individual's sense of worth is threatened when there is a loss of control.

Seligman's theory (1975) of personal helplessness is compatible with this interpretation. Individuals perceive themselves as unable to complete a task even where the event is controllable. This perception may produce both anxiety and depression.

Carver and Scheier (1986) proposed that anxiety arose when individuals had some reason for being concerned about their well-being. They found that concern is based on an individual's perception and cognitive processing of information that either physical or psychological harm is possible.

Garber, Miller, and Abramson (1980) distinguished between neurotic and realistic anxiety. Realistic
anxiety or fear is caused by the perception of real or anticipated danger while neurotic anxiety is influenced by hereditary factors. A view which stresses the importance of environmental influences in the development of anxiety derives from the Neo-Freudian school. This view posits that anxiety is socially produced and, when present, reduces the efficiency of the individual in meeting basic needs, disturbs interpersonal relations, and produces confusion in thinking (Garber, Miller, & Abramson, 1980).

Janis (1982) postulated that worrying begins as soon as an individual perceives signs of impending personal danger. Anticipation of the stressful event and the accompanying period of worrying decreases the intensity of fear. Lack of preparation for the stressful event can cause feelings of helplessness (Janis, 1982). Miller (1979) linked worries and brooding together as a reaction by an individual who is not in any physical danger but who cognitively perceives an unrealistic fear. In his analysis of psychological well-being, Bradburn (1969) related personal worries to an individual’s assessment of bodily symptoms associated with psychological
difficulties and anxiety.

Phobias are a special kind of fear (Bhala, O'Donnell & Thoppil, 1982) and are out of proportion to the demands of the situation, cannot be explained or reasoned away, are beyond voluntary control, and can lead to avoidance of the feared situation (Marks, 1969). Phobias may be a result of classical conditioning processes through association (Bhala, O'Donnell, & Thoppil, 1982).

There is agreement among the researchers that anxiety arises from stimuli that are less concrete than the stimuli that elicit fear. Key (1986) stated that anxiety is "an emotional reaction when the object or situation is vague or not clearly in focus" (p. 54-55). Geer (1965) considered anxiety to be a "response to a more general or pervasive stimulus" (p. 45). Croake, Myers, and Singh (1988) believed anxiety to be a response to a menacing stimulus not specifically delineated.

Anxiety, worry, concern, and helplessness are combinations of interacting fundamental emotions (Izard, 1972). The emotional processes are influenced by innate and sociocultural factors, learning, and
individualized experiences. Izard (1972) further stated that these emotional processes direct and affect the cognition and behaviour of an individual. However, among the theorists there is ongoing debate about the relationship between emotion and behaviour, and cognition and behaviour. The literature is unclear about whether emotion or cognition has the greater influence on our thoughts and actions.

From a review of the literature it is evident that distinguishing between fear and other emotions is difficult. How these emotions affect an individual’s behaviour has not been clearly described. In addition, descriptions of the related phenomena from the perspective of the individual are absent from the literature. Further study is needed based on subjective interpretation of fear in order to differentiate it from the various related phenomena.

Fear of Falling

A review of the literature on falls revealed a paucity of information specific to fear of falling. Many studies implied that fear of falling was a consequence of a fall, but few were directly concerned with its description or measurement (Nelson & Amin,

Nelson and Amin (1990) reviewed eight hospital and community-based studies. Common throughout these studies were the references to the psychological consequences of the fall event. The consequences were described as fear of falling which resulted in restricted mobility and inactivity which led to further social isolation and physical decline. These references to the psychological consequences of a fall are supported by two recent studies. Galloway (1991) in a study of community-dwelling elderly women who were hospitalized for a fall, found that fear and worry about falling again altered their lifestyle. They were more cautious, more dependent on others, and less active. Ursic (1991) studied elderly women who had fractured a hip as a result of a fall. Her findings supported the notion that fear of falling again and the loss of energy and stamina contributed to altered perceptions of self. These women were unable initially to return to their pre-hip fracture activity level, and they were plagued with anxiety about the future. Both
of these researchers (Galloway, 1991; Ursic, 1991) identified the psychological trauma of the fall as diminishing the women's sense of control.

No institution-based studies were identified in the literature that specifically sought to investigate the fear of falling. A few community-based studies attempted to quantify and describe fear of falling.

Tinetti et al. (1988) conducted a one year prospective study with a sample of 336 persons 75 years of age or older who were living at home. The purpose of this study was to identify risk factors for falling. As part of the assessment process, subjects were "asked about falls occurring during the previous two years, recent mobility, fear of falling, dizziness, unsteadiness, and musculoskeletal symptoms" (Tinetti et al., 1988, p. 1702). The results indicated that, of the 108 subjects who fell, 48% said they were afraid of falling and, of those, 26% avoided activities because of their fear of falling. The method for assessing the fear was unclear and no standardized tool was described. No definition of fear was included. Fear of falling was not studied as a discrete entity but as one of the intrinsic factors. How fear of falling
related to the other factors including age, sex, health, postural hypotension, depression, and living situation was not described.

A study by Tideiksaar and Silverton (1989) sought to determine the presence of psychological characteristics that may place a person who has fallen at continued risk. Twenty-two individuals over the age of 65 who had fallen and were living in the community were assessed for their fall under-reporting, denial of functional limitations, and fear of falling. The researchers reported that fear of falling or "fallaphobia" was found in 55% of the sample (Tideiksaar & Silverton, 1989, p. 82). The subjects described the fear as panic attacks, accompanied by sudden intense apprehension, coupled with dizziness or heart palpitations, and found that the intensity of their feelings related to the length of time that they lay on the ground following the fall. The limitations of this study include the small poorly-defined sample and the retrospective nature of the study.

In a sample of 115 subjects aged 62 years of age or older who were living in a seniors' apartment complex, fear of falling (25%) was found to be the
greatest fear when compared with other common fears including fear of robbery, fear of forgetting an important appointment, fear of financial difficulties, and fear of losing a cherished item (Walker & Howland, 1990). The results of this study showed that falls are frequent and fear of falling prevalent among this sample. The researchers suggest that interventions intended to increase knowledge about falls and promote behavioural change should focus on the individual’s sense of personal control in order for the interventions to be more successful (Walker & Howland, 1990). It might be assumed that the type of living situation described in this study would provide a sense of security; and, therefore, the fear of robbery and losing a cherished item would have less importance for those individuals in the study. As well, it is difficult to compare fear of falling, which the researchers found was associated with limited mobility, reduced social interaction, and compromised quality of life, to fear of financial difficulties.

Downton and Andrews (1990) carried out a retrospective study of 203 fallers and non-fallers over 75 years of age for the purpose of describing factors
associated with falls. They assessed dependency, depression, cognitive function, anxiety, and drug use with a variety of standardized questionnaires. Fear of falling was assessed by asking the question: Do you limit your activity because of fear of falling? The results indicated that over half of those who had fallen in the previous 12 months and a third of those who had not fallen limited their activity due to a fear of falling (Downton & Andrews, 1990). The results also showed that subjective dizziness and fear of falling were associated with higher dependency, an increased number of physical symptoms, greater drug consumption, and higher scores for anxiety and depression. The researchers subdivided the sample several ways including inside fallers and outside fallers but found that all groups were equally anxious and depressed. They concluded that "fear of falling is itself a substantial problem for elderly people" (Downton & Andrews, 1990, p. 97).

One study was reported in the literature that described the development of a tool to measure fear of falling and its effect on functional decline. Tinetti et al. (1990) developed the Falls Efficacy Scale (FES)
based on the operational definition of this fear as "low perceived self-efficacy at avoiding falls during essential, non-hazardous activities of daily living" (p. 239). The self-efficacy concept is based on Bandura's (1986) theoretical assumption that cognition processes underlie emotions. The article describing Tinetti et al.'s. (1990) work reports on preliminary psychometric data associated with the development of the FES.

Although the study by Tinetti et al. (1990) is quantitative and the tool has had insufficient testing, some of the early results are relevant for the research reported here. The FES score was associated with difficulty getting up after a fall, anxiety trait, general fear, and balance and gait. The researchers further stated that self-efficacy was shown to be influenced not only by relevant skills, but also by past experience, vicarious learning, and social contact. As well, the association between the FES and anxiety trait suggests the influence of hereditary factors. While this study did address fear of falling, there is still a lack of information from the perspectives of individuals who live with this fear on
a daily basis.

To date the experience of fear of falling has not been examined from the individual’s perspective. No studies have been found that confirm and describe the fear associated with falling.

Summary

In this chapter the literature was reviewed that was relevant to the study and included research on fear, related phenomena, and fear of falling. The research on fear and related phenomena focused on the identification of the stimuli causing the fear and the physiological response to this fear. The researchers acknowledged that a subjective component was essential to the conception of fear, and they referred to a relationship between fear, cognition, and behaviour; however, there was a dearth of information on these relationships. In the research on falls, fear of falling has been identified as a serious problem for the elderly; however, the research has been limited to attempts to demonstrate a relationship between functional ability and fear. Missing from the research is a description of the experience of fear of falling from the individual’s perspective, the meaning the
phenomenon has for the individual, and the effect it has on cognition and behaviour. The following chapter describes the methodology which guided this study.
CHAPTER THREE

Methodology

Introduction

The phenomenological method was used for this study to gain an understanding of the experience of fear of falling from the perspectives of elderly individuals who had previously fallen. This chapter describes how the research data were obtained and is presented under the following topics: the selection of participants, data collection, data analysis, and ethical considerations.

Procedure

Selection Criteria

The selection criteria were purposefully developed in order to ensure that the sample was knowledgeable about the experience under investigation and able to provide descriptions that would increase the researcher's understanding. The following is a description of the selection criteria, the procedure for recruitment, and the characteristics of the participants.

The criteria for inclusion described each individual in the following way:
1. Seventy-five years of age or older.
2. Lives independently in a non-institutional setting.
3. Resides in the Capital Regional District.
4. Has fallen at least once within the last six months.
5. Has the ability to recount and describe his/her fear of falling.

The rationale for these criteria will be discussed briefly. The age specification was set to ensure that the descriptions were obtained from an elderly population. The purpose of this study was to understand the experience under investigation from the perspective of those living in the community; therefore, the institutionalized elderly were excluded. Because the researcher resided in the CRD, the residence requirement was set to ensure ease of access to the participants by the researcher. To ensure vivid recall of the fall event and the subsequent fear of falling again, it was specified that at least one fall had occurred within the last six months. The ability to recount and describe fear of falling was specified in order to exclude those individuals whose memory or
mental status would make it difficult to obtain accurate descriptions of the event. Because the researcher was fluent in English only, it was necessary that the participants were able to converse in this language to ensure and facilitate understanding between them.

**Selection and Recruitment**

This study was concerned with understanding the fear of falling experienced by an elderly individual following a fall. Participants in a qualitative study are selected because they are knowledgeable about the phenomenon under investigation and can engage in cooperative dialogue with the researcher (Knaack, 1984). A planned procedure for the recruitment of the participants was followed. Initially, approval for the research in terms of protection of human rights was obtained from the University of British Columbia Behavioural Sciences Screening Committee for Research and Other Subjects Involving Human Subjects. Permission to recruit participants through Long Term Care (LTC) and Home Nursing Care (HNC) was obtained in writing from the Capital Regional District’s Care Programs (CRD).
Participants were identified from the caseloads of community health nurses working in the LTC and HNC divisions of the CRD's Care Programs. A verbal explanation of the study and selection criteria were given to the nurses. Potential participants who met the selection criteria were approached by the nurses to determine their interest in the study. The community health nurses reviewed the letter of information (Appendix A) with the potential participants. Participants who acknowledged that they had a fear of falling and were willing to take part in the study gave permission to the community health nurses for the researcher to contact them. Names of these individuals were given to the researcher. Initial contact by the researcher and further explanation was done by telephone. A home visit for the first interview was arranged with those individuals who agreed to participate. A consent form was signed at this time. (Appendix B)

As is typical in a qualitative design, subject selection is complete when the phenomena being studied cannot be illuminated any further. Therefore sample size is not predetermined (Sandelowski, 1986). In this
study several individuals were approached by the researcher and declined to participate. The initial sample size was eight, but was enlarged by one when the quality of the data was determined to be inadequate. The sample included six women and three men whose ages ranged from 75 to 91. Their mean age was 84. All of the participants had fallen more than once, and all had sustained some kind of injury as a result of a fall. A more complete description of the participants will be presented in Chapter Four.

Data collection

In a qualitative study, knowledge and understanding are developed through experiences that are shared and understood by the participant and the researcher (Rist, 1979). To facilitate an understanding of the experience from the individual's perspective, the researcher uses the technique of "bracketing" which involves consciously setting aside any preconceptions about the phenomenon under study (Knaack, 1984, p. 111). Using the strategy of in-depth interviewing, the researcher actively engages in the interactive process and enters into the world of the individuals whose experiences are under study (Oiler,
This method of data collection allows the researcher to get close to the data and be immersed in the phenomena before attempting to interpret them. In addition, the researcher actively listens for key words and statements and verbally reflects them to the participants in order to facilitate further descriptions (Omery, 1983; Knaack, 1984). The accuracy of the description is enhanced by verification of the meaning with the participant.

A set of trigger questions (Appendix C) was used by the researcher to guide the initial interviews and as a means of eliciting rich descriptions of the human experience without telling the participants what to say (Knaack, 1984). In addition, the researcher asked questions based on the experiences described by the participants. In this way "the researcher 'takes on the role of the other..' and seeks to understand 'the definition of the situation' from within the framework of the participants" (Rist, 1979, p. 20). Subsequent interviews with the participants were based on questions which arose from the analysis of the initial interviews.

All interviews were conducted by the researcher in
the participants' homes. They were each 50 to 90 minutes long, tape recorded, and transcribed verbatim. Written notes were made to record conversations not tape recorded, phone calls, and descriptions of the participants' non-verbal communication. Each participant was interviewed once and six were interviewed twice. Second interviews were unable to be completed with two of the women because they died during the study and the third woman moved to a Long Term Care facility. Two of the participants were interviewed a third time for purposes of validation of the data.

Data Analysis

The process of data analysis occurred concurrently with data collection which allowed validation of emerging themes and concepts with the participants. In addition, data reduction during the collection stage assisted in decreasing the quantity of the data being generated.

Giorgi's (1985) method of analyzing data in a phenomenological investigation guided this process. Each transcript was read in its entirety "to get a sense of the whole" (Omery, 1983. p. 57). The
transcript was read slowly a second time for the purpose of identifying common statements or ideas and identifying "meaning units" (Giorgi, 1985). Identification of patterns of meaning or themes was achieved through constant analysis which involved inferring, questioning, and modifying the data. The emerging themes were compared by relating them to each other and to the whole.

The third step was the transformation of the participant's everyday language into language or concepts of science. This step was facilitated by a process of reflection and imaginative variation. Integration and synthesizing of the participants' perceptions comprised the total description.

Throughout the data collection and analysis the researcher validated and clarified the themes through ongoing review and reflection of the data. To ensure that the descriptions were recognizable by the participants as representative of their experience, the researcher sought confirmation with each participant. Sandelowski (1986) has stated that the credibility of a study is established when the descriptions of the experience are immediately recognized by those who have
had the experience.

Auditability of this study was established by the researcher through the clear articulation of the "decision trail" (Sandelowski, 1986, p. 33). A clear decision trail describes and justifies what was done and why. For this study, the analysis and conclusions were reviewed by the researcher and thesis committee on an ongoing basis to verify the progression of events of the study and their logic (Sandelowski, 1986).

Ethical Considerations

The approval of the UBC Behavioural Sciences Screening Committee for Research and Other Studies Involving Human Subjects was obtained prior to data collection. The standards as approved by the Committee were followed throughout the study.

Participation in this study was voluntary. All participants were given both a verbal and written explanation of the purpose of the study, the time commitment required, and the nature of their involvement. (Appendix A) A written consent was obtained prior to the first interview. (Appendix B) The participants were given a copy of the consent form which advised them of their right to decline to
participate or to withdraw from the study, and identified that the study would not pose any threat to their present or future health care needs.

Confidentiality was ensured through coding of the transcripts and the participants' identification was known only to the researcher. No personal identification of the participants was included in the thesis. The data on the tapes was known only to the researcher, thesis committee, and typist. All recorded information on the tapes was destroyed at the completion of the study.

A brief summary of the findings of the research was made available to participants at their request.

Summary

In this chapter the design and methodology of the study were outlined and included a discussion of the selection of the participants, data collection, data analysis, and ethical considerations. The participants' accounts of their fear of falling and their explanations for their behaviours will be presented in the following chapter.
CHAPTER FOUR

Characteristics of the Participants and Their Accounts

Introduction

This chapter presents the characteristics of the participants and their accounts related to their fear of falling again. These accounts were generated from questions which reflected the framework of the study: the lifespan perspective. During the interview process, meanings were formulated from the participants’ accounts. The meanings were then clustered into emerging themes through the process of constant comparative analysis of individual explanations. Together the themes represent the essential structure of the phenomena of fear of falling again.

Out of these themes there were two underlying concepts which recurred and were evident throughout the participants’ accounts: control and self-enhancement. The importance of these two concepts will be discussed in the following chapter in relation to the present findings and current research.

The findings are presented as two major interrelated themes. Each theme arises from the
participant’s fear of falling and represents a process of adjustment. The first theme, making meaning of the experience, describes the way participants made sense of their fearfulness. This theme is comprised of three elements: linking fearfulness to falling, recognizing other fears, and appraising self. Together these represent the ways in which the participants sought to understand and interpret their fear of another fall. The second major theme, integrating the meaning of the experience into daily living, describes the way the participants sought to restore balance into their lives. There were two elements within this theme. The first, reordering behaviour, includes the behavioural coping strategies which the participants implemented in order to control their risk of falling again: altering mobility, changing activities, following routines, and accepting help. The second, preserving identity, represents the participants’ efforts at maintaining a consistent sense of self. Two introspective processes are described: favourable comparison to others and solitary reflecting. The individual’s identity was also influenced by the reordered behaviours.
Characteristics of the Participants

The individuals in this study represented the frail community-dwelling elderly. They all had one or more chronic health problems including osteoporosis, osteoarthritis, Parkinson's disease, hypothyroidism, cataracts, diabetes, cancer, and peripheral vascular disease. Two of the men had suffered a cerebral vascular accident and all of the participants experienced decreased visual acuity and hearing.

The participants exhibited varying degrees of mobility. Two individuals used a cane, three required a walker, one depended on human assistance at all times, one needed human assistance only when outside, and one was confined to a wheelchair. One of the men did not use any walking aides, and as a result he often fell; however, he still drove his car occasionally.

Socially the participants were isolated. One woman had not been outside her apartment for over a year and several of the other women had been out only three or four times in the last year for doctor's appointments or special family affairs. Only one participant regularly left his home to engage in a social activity. The other two men left their homes
several times monthly for grocery shopping and doing small errands. One of the men was always accompanied by a neighbour.

The living arrangements of the participants varied: seven lived alone either in an apartment or their own home, and two shared a home with an adult child who was absent from the home during the day. All of the participants were widowed. Eight had homemaker assistance which ranged from once every two weeks to 24 hour care. They received help with cleaning, laundry, personal care, and meal preparation. All had help with grocery shopping which indicated their difficulty in mobilizing outside the home. Seven of the participants had raised children, and for them the family provided another avenue of support. Three used a medic-alert system.

Falling was a recent event for most of the participants. Three had experienced their first fall within the last four years, and six began falling within the last two years. All participants reported falling at least once within the last six months. The participants all had fallen frequently: six had fallen three times, two had fallen twice, and one reported
falling many times. Of the nine participants in this study four described near falls, stumbles, and trips which they had not perceived as falls because they had not landed on the ground. A variety of physical injuries resulted from their falls. Six participants suffered fractures ranging from a fractured hip to "cracked" ribs. The other participants sustained bruising and lacerations. Six required hospitalization and rehabilitation before returning home. All of the participants suffered the psychological consequence of fear of falling which they attributed directly to their falls.

The Accounts of the Participants

The participants’ accounts of their fear of falling again are presented in this chapter. The verbatim comments made by the participants are included and help to illustrate the researcher’s interpretation and conceptualization of these accounts.

Making Meaning of the Experience

The first major theme, making meaning of the experience, represents the efforts of the participants to make sense of their feelings about fear of falling again. Making meaning is a highly individual process;
and, therefore, the participants' interpretations reflected differing perspectives. The data are presented in relation to the three elements which comprise the theme of making meaning: linking fearfulness to falling, recognizing other fears, and appraising self.

Linking Fearfulness to Falling. The interview discussions began with the participants telling their stories about their falls which they described in detail. Emerging from these discussions were the reasons why the participants felt afraid. In recalling their falls the participants denied feeling afraid at the time of the fall and attributed this to the unexpectedness and suddenness of the event:

Well, that is just the way it is, something happens, you don't know what to do or how to stop it or anything, you just, it didn't last long. It was only less than a second. During that time I lost all tension in my muscles and so I just fell. That's all, I wasn't afraid at the time.

The onset of the fear of falling varied among the participants and was attributed to the severity of their injuries and the number of falls they had
experienced. Some of the participants related their fear of falling to problems associated with their chronic illnesses. They were worried about their physical health and this seemed to accelerate their fear of falling. One man described the change in his feelings about falling following a recent stroke which had left him with marked weakness on one side:

Recently I have been more concerned. I wasn't concerned at most of my earlier falls of a year or two ago, but now, I am cautious and conscious about it. I know if I fall, I'm going to get hurt. There is not much doubt about it, so I give it much more serious consideration since my stroke.

For some of the participants feeling afraid of another fall related to their feelings of helplessness following the fall. These feelings were confirmed if they were unable to help themselves up or if they needed hospitalization. Help was often required from family, friends, neighbours, and even strangers "and ah.. the milkman had to come and lift me up", "yes, I didn't move at all and they came", and "Bob came over and the woman downstairs heard it."
For all of the participants, the worry about becoming a burden to others exaggerated their fear about falling again. Relying on others confirmed their declining abilities and was in sharp contrast to their self-image:

I've always been able to do for myself. It seems like I've lost the ability to deal with myself. Because it's not that I hate, I shouldn't say that, I don't like to put people out of their way. Falling had an impact on the way they felt about mobilizing. Their fearfulness ranged from feeling "terrified" to feeling "anxious." As a result they moved with a foreboding sense of caution. One woman described the tenseness she felt:

I get panicky. That's why I say, that you got to, don't tense up. If you tense yourself up you've got more danger going down than if you just relax and go the other direction. Getting tensed up and afraid, uh, is one sure way of going down and ..that's me.

Some of the factors which had an impact on the feelings of two of the participants were the expectation that falling was common to growing older and the influence
of a lifelong pattern of falling:

You know, sure you stumble a bit at times, especially when you get older.

I’ve been falling all my life. They were nothing in my life. I didn’t expect to be injured in any way and I never was really. It’s the same now except I am conscious of falling again.

For these two participants, a fall confirmed their expectation and adapting to their fearfulness was less difficult.

In making sense of their fear of falling again, the participants were afraid of another fall because they feared its consequences, "You can’t stop it and you know what the possibilities are." Thinking about falling again triggered thoughts about their other fears.

Recognizing Other Fears. The participants described other fears related to the consequences which they perceived would result from another fall: fear of fracturing a hip, fear of hospitalization and placement, and fear of mental deterioration. Together these were believed to be the reasons for feeling
afraid of another fall.

Breaking a hip was their greatest fear and was believed to be an event from which there might not be any recovery. It was perceived as an event which was highly probable should they fall again. They also believed that it would confirm their decline:

I would be scared to death I would break my hip and I'd be back in the hospital and, uh I don't think I could take it. I think that would be the last thing I could take. That would be the final of me because I just couldn’t take it. I couldn’t fight it.

The fear of fracturing a hip was reinforced by physicians, nurses, and friends:

I hear if from everybody. Nurses at the hospital, you know, you are lucky you didn’t break a hip. You are lucky you didn’t break a hip. Really, I'm scared stiff.

The participants acknowledged that a fracture would mean hospitalization. The meaning of hospitalization for the participants was based on their past and present experiences with hospitals. They recalled being "looked after", "the lack of privacy", 

and the "impersonal care." Hospitalization meant they were dependent on others and less able to control their lives. A loss of identity was a concern for several of the participants:

The trouble with the hospital as far as I am concerned right now, is the nurses generally speaking don’t know you because they’re only there one day and you never see them again.

Many of the participants had been cared for in units or rooms where other patients were disoriented and confused and this contributed to their negative feelings about hospitals. This exposure also contributed to their fear that their own mental deterioration would accompany another fall, and this increased their fear of falling again. They perceived that being confused would make them dependent and powerless. One woman had cared for her confused husband, and she worried that she might be similar:

If I wasn’t here to care for him, you know, it was a handful. He didn’t know anybody. I know what he was like and I know what my brother was like, so God help me if I’m in the same position they are. So, uh, I’m very careful not to fall again.
The participants believed that being hospitalized for a fall would ultimately result in permanent placement, and they worried about the loss of their home. "Home" symbolized who they were; they had more control, independence, and privacy in their home:

It's mine. It's my front door. It's mine. I don't have to answer to anybody. If you understand what I mean. That's important to me. I don't have to answer to anybody.

Placement would mean that the participants' activities would be regulated by others, and this would mean a loss of decision-making. They perceived that they would have less control over their lives. Thinking about permanent placement caused them to worry more about falling again.

Other individuals worried about being abandoned by family and friends if they lived in a facility. They feared the loss of meaningful relationships and imagined an uncertain future. Anxiety about falling again increased for some of the participants when family members threatened to institutionalize them if they fell:

"You know mother if you have another accident and
have to go to the hospital you won't be coming home when you come out of the hospital." I thought that was a little bit rough.

The participants also worried that their identity would be lost in the institution. One woman’s negative experience with a friend increased her anxiety:

She [her friend] opened her purse one day there and showed it to me, I said, "Don't you know what she is showing you?" That they took everything from her, her identity card. She has nothing in there. I would be like that. They would come and try to get my purse, they would have a fight! I said, "That is your privacy. That is your identity."

In making meaning of the experience of the fear of falling again, the participants were afraid because of the perceived consequences of another fall. They perceived that another fall could result in a fracture, hospitalization, placement, and mental deterioration. These were significant concerns for them and threatened not only their physical survival but also their perception of themselves. Through a process of
appraisal, the participants thought about themselves as they tried to find meaning in their fear of falling again.

**Appraising Self.** Falling and the fear of falling again represented a threat to the participants' self-perceptions because it altered how they felt about themselves. It triggered a process of self-appraisal as a way of making meaning of their fear:

But when I started falling, and I couldn't give you a good reason for falling. I had to turn around and look at myself. Look at things differently. Yes I feel differently.

When the participants were asked to describe the effect of their fearfulness on their lives, they all recalled images of themselves as independent, competent, and confident individuals. Since falling they viewed themselves as more dependent and less able to carry out their daily activities independently. The most common feeling expressed by the participants as a result of their falls was the loss of confidence in mobilizing. The loss of confidence increased their fear of falling again:
Well I think the main loss of confidence was in the actual physical side of the thing, you know. That's what I'm not confident about anymore. I don't feel confident that I cannot fall sometime. Feelings of uselessness and unreliability were also described by the participants. Declining abilities and the reliance on others had an impact on their self-image:

It hurts yourself. It hurts your self-image. It doesn't physically hurt you, you know what I mean. It's a mental state. It's sort of you are no darn good.

One man related his fearfulness to the feeling that falling meant he was losing the ability to control his activities:

I suppose I was losing control. I can never go out anymore up to the park.

The fear of another fall seemed to expose their feelings of vulnerability, and they reflected on growing older. Aging and the associated losses of strength and stamina were a focus of their attention since falling:
Before those falls I used to be able to go, go, go, but now I can't. I must be old. Too tired to go.

Thoughts about the future were triggered by their thoughts of what might happen should they fall again and this increased their fear:

I'd never thought what I would be like, because I never thought I'd live this long, for one thing. And I've often said, "I hope I don't live to be old and crippled." But I did. You don't have any say.

This woman had been confined to her apartment for almost a year because of her fear of falling again.

Fear of falling again represented a threat to the participants, both physically and psychologically. In response to this threat, a process of adjustment occurred. The participants attempted to make sense of the meaning of their fear within the context of the fall event, their other fears, and their self-perceptions. The way in which the participants made sense of their fearfulness represented the first theme of the adjustment process, making meaning. Making meaning was a way for the participants to understand,
predict, and control their situation. Finding meaning in their experience initiated efforts at planning for the future as a means of control. In an attempt to integrate the meaning of the experience of fear of falling again, they developed adaptive strategies.

**Integrating the Meaning of the Experience**

The second major theme is integrating the meaning of the experience of fear of falling into daily living. It represents the efforts of the participants to adapt to their fearfulness. Because the fear of falling threatened the physical and psychological survival of the participants, they dealt with their fear on two levels: behaviourally and cognitively. They reordered their behaviour in order to decrease the risk of falling again and as a way to attend to the problems associated with living daily with the fear of falling again. The reordered behaviours centred around their ability to gain control over their fear of falling again and over their lives. The changes they made to their behaviours also influenced their perceptions of themselves: the changes helped to enhance their identity. Preserving their identity was a cognitive, introspective process which was aided by self-enhancing
efforts and the reordered behaviours.

Reordering Behaviour. Reordered behaviours were the observable changes that the participants made in order to cope with their fear of falling again. These changes included altering mobility, changing activities, following routines, and accepting help. Their primary purpose was to limit the threat of another fall and to maintain control over their independent lifestyle. All of the participants acknowledged that they needed to make changes in their activities:

You have to accept that. If you accept that, you can never, I know I can't go on. I can't do what I was doing before.

Fear of falling was a pervasive feeling which affected all aspects of the participants' lives and altering mobility was the most common strategy used by the participants as a way to reduce their fear. The way they mobilized since falling reflected a conscious awareness of the need to be cautious and careful. Their movements lacked spontaneity and instead were deliberate and calculated:
I’m awfully careful now, how I walk over things. I’m always conscious you know. Don’t forget for a moment.

That’s with me, I’m not automatic anymore.

But I do consider, think all the time of not falling again.

The participants changed the way they walked in order to prevent another fall:

I don’t walk the way I used to walk at all, yes, well they [referring to her legs] are stiff because I walk like that, not because my legs are stiff. There’s nothing wrong with my legs. I walk and I, uh, if I’m going to make it or if I’m going to fall, because specially I’m more scared since the last fall because it happened so fast.

Another participant gave this account of how he walked in order to be as safe as possible when he was outside. He ignored the risks associated with walking in this way:

I walk with my head down looking for obstructions on the pavement. That’s the one thing that keeps
me out of trouble. I don’t like walking bent down like this, but this is the only way to go.

Verbal reminders, visual cuing, and mentally rehearsing their planned movements were ways in which the participants felt more secure in mobilizing. Using walking aides, including canes and walkers, to assist their mobility also increased their sense of security. Since falling and becoming afraid of another fall, seven of the participants used a walking aide; the others steadied themselves on furniture and the walls of their home:

Oh yes, yes, because you walk in there and it’s more, it’s on wheels, you see and you feel more secure.

Accepting the need for a walking aide was more difficult for two of the men because it was inconsistent with their self-image. For these two participants, the importance of their image was stronger than the issue of personal safety. Both men fell frequently and were at high risk for a serious injury.

Six of the nine participants were afraid of falling and being alone if they fell. They felt unable
to go out of their homes unless accompanied by family or friend. Being with someone helped them to feel safe and secure, but also made them feel less independent. As a result they altered their mobility pattern:

I'm afraid that if I go out by myself, I might drop on the street. So I usually wait for my daughter and my granddaughter or this lady that, this lady I don't know. I don't go out very often.

The participants believed that the freedom to remain in their own homes depended on their ability to safely mobilize. This was a strong motivator because the loss of their home was perceived to be the ultimate loss which would signal the end of their independent life. One woman who used a walker and was crippled with osteoporosis struggled to walk safely to the washroom. Maintaining control over her bodily functions gave her a feeling of independence and she interpreted it as evidence that she was able to remain at home:

I keep saying, please God, you know, let me get around properly in this [walker]. Please God let me be able to go to the bathroom, and every time I
go in that bathroom now it’s almost like I hate going in because I’ve fallen in there so much, you see.

This woman was afraid of falling each time she mobilized, but her desire to be independent and in her own home motivated her to ambulate very cautiously, slowly, and with her walker.

Thus, to reduce their fear of falling again the participants altered their pattern of mobility by increasing the care and caution with which they moved. Changing their mobility helped to increase their feelings of security and independence, and gave them a sense of control over their activities.

Changing their activities was the second most common strategy employed by the participants as a way to reduce their fear of falling. Because of their lack of confidence in mobilizing, the participants chose to restrict their activities outside the home:

I put it off and put it off [going uptown]. So I haven’t gone yet.

Activities outside their homes were perceived to be more unpredictable and more difficult to control. Thus, the participants felt safer ambulating within
their homes in familiar surroundings.

For some of the participants restricting their activities represented significant losses to them, and they had difficulty reconciling the need to be safe with the need to accomplish meaningful activities. One woman remained positive about the changes even though she was saddened by them:

I feel different because I can’t do nothing [without help]. But before I used to do everything for myself. My own washing, and, but now, that is the difference in me. I can’t be the same. I, uh, but I, I’m still happy the way I am, except I would like to be able to move about more.

Restricting their activities to their own homes helped to reduce their fear of falling again but also isolated them from family and friends. The loss of contact with friends was more difficult for those without children. For one woman this loss reinforced her own aging and she expressed a feeling of hopelessness:

Uh, I’m alone too much. My friends come, but they live away out and they’ve got other things to do, and they get sick. I have one friend that I’m
very close to and now she has had her breast off and then a bad shake, so she can't come any more. You see, my friends are getting old along with me and they are wearied out the same as I am.

To cope with the social isolation, the participants kept in contact with friends and family by phone. They also spent long hours occupied in solitary activities like reading, watching television, listening to the radio, and contemplation.

The participants planned daily activities that were within their capabilities. Successful completion of simple tasks like getting dressed gave them a sense of control and independence over their lives. These feelings helped to reduce the lack of confidence one woman felt:

It gives you confidence in yourself. Your confidence gets destroyed when you continually try to do stuff and continually fail, well you really think you are a failure. Where if you do something, and you do it, you feel a little bit, maybe it's silly, but you feel a sense of pride.

Feeling more confident also had an impact on their feelings about themselves.
Falling and feeling afraid of another fall seemed to accelerate the process of narrowing their interests. The participants concentrated on activities that were simple, attainable, and that would meet their basic needs:

No, I live from day to day. I think that’s the best way to be for me. You know, I don’t, I know there’s no future to speak of and so I just do what is necessary every day.

The participants restricted their activities to reduce their fear of falling again. The activities that they selected were ones which helped them meet their basic needs, presented the least risk of falling, and gave them a sense of control. They were able to make choices about their activities. Making decisions helped to maintain their feelings of self-worth.

Another strategy used by the participants was to ritualize their daily routines. Routines were repetitive patterns of behaviour that helped to ensure predictability and increased their sense of safety and security. In this way routines helped to decrease their fear of falling again.

The degree of rigidity in their routines varied
among the participants and was related to their previous patterns of behaviour. For those whose previous patterns of daily activities had been unstructured and spontaneous the fear of falling again prompted them to develop predictable patterns of activities. For those who had always relied on predictability their routines became very rigid:

Oh, I’ve always followed a routine since my wife died, but now I am very conscious of doing the same thing every day. It’s better that way and I’m not so likely to fall.

Another factor which influenced the rigidity of their routines was the participants belief in the value of routines. One man felt that his daily routine of "keeping house" gave him a purpose:

Yes, I think if you are going to be interested in life at all, you have to have a routine. You know, it’s really better for you. To do something whether it is interesting or not, if it is worthwhile. I think that’s, I think it’s worthwhile to keep the house clean.

Following familiar routines helped to reduce the lack of confidence they felt because they were afraid
of falling again. The participants felt a sense of reassurance when they were able to accomplish their daily routines. Routines also helped them to cope with their limited energy and stamina. They were the easiest way to get things done and conserved their limited energy resources:

My whole day is a series of routines. Sort of those practice kinds of events. Well, uh, my routine, even if you have your full faculties, you go through a routine, you may not be thinking of it, but it is a routine, and you go through that because it is the easiest way to get things done.

Unexpected interruptions to their daily routines caused the participants to feel anxious and less able to cope. As a result their fear of falling again escalated. One woman gave this account of how company caused a disruption to her usual routine:

And of course, when there is more than one person that comes, I get a little tense. More than one person at a time with me, is too much, and they had gone and I was going to go out to the kitchen and I didn’t have my walker, I always have my walker, and I fell on my back.
Living by a series of routines was a way for the participants to maintain a sense of control and predictability over their lives. Being able to accomplish familiar tasks gave them a sense of competence. Worrying about falling again was reduced by the regularity of their behaviour. These behaviours also assisted the participants in striving toward a positive sense of self.

The fear of falling again resulted in the participants limiting their activities. Restricted activities threatened their ability to live independently. In order to further reduce their fear of falling and maintain control over their independence, the participants accepted help with some of the tasks of daily living.

All of the participants struggled with their need for assistance and their desire to remain independent. Accepting help was perceived as a way for them to continue to live in their own homes:

You have to, you have to accept things. That's all there is to it. There are a lot of things among other things, just like you have to accept being helped. When you've been a person that's
been independent as blazes and all of a sudden you have to ask everybody for help, it hurts. But, uh, finally you get to accept it that they have to help you and you shut up and take it, you know, and be glad that people are as kind as they are. Factors which affected their ability to accept help were their self-image and their health. Of the nine participants, the men had the greatest difficulty accepting help. They had the least amount of help and lived at the greatest risk for falling again. One man resisted suggestions from his family to have increased homemaker help:

I don't discount their suggestions that I have the help, but, uh, I suppose that I, I suppose if I were really honest about it, I feel that it is, uh, uh, false pride.

Reconciling the need for help was easier for some of the participants because they were able to find new challenges in their changed lifestyle. Teaching her homemaker new skills was a way for one woman to manage her household tasks but also enhanced her self perceptions:

Oh yes, I have to, I have to more or less teach
her what to do because she's not used to our ways. She's not used to our cooking. I have to show her what to do in the cooking. I guess I still have my brains in spite of all.

Accepting help meant that the participants had to change their previous practices. Some of the participants found they had to lower their standards and others found they had to give up activities which they enjoyed. Fear of falling again and unsteadiness meant that many of the participants needed help with personal care:

I have to have help bathing and I like to have a bath more than a shower and so instead of a bath I...soaking, soak out the aches and pains. Now I have a shower, but I have help with that.

Accepting formal help on a regular basis became part of the daily routine for some of the participants and provided a measure of security for them. Fear of falling and the consequences of another fall were reduced because the homemakers were able to do tasks which the participants were unable to do. Their fear of falling was also reduced because they knew that their homemakers would help them if they fell:
I was helpless on both my knees. I’ve got arthritis in this knee, but anyhow, I thought well it can’t be very far from 9 o’clock. So that’s what I had to do, just wait until she [homemaker] came, and she got me up you see into a chair. She helped me and I got over it. I would have been in worse shape to wait for my son.

Family and friends also provided some assistance, but the participants felt less able to direct and control this type of help. They accepted as little help as possible to avoid being a burden.

Accepting help was a strategy the participants used in varying amounts to assist with their activities of daily living. Only those tasks which provided the greatest risk of falling and which were unmanageable for the participants were the ones relinquished to someone else. Being able to make decisions about the kind of assistance which was accepted helped them to feel control over their lives.

Reordering behaviour was one way that the participants integrated the meaning of the experience of fear of falling into their daily lives. Making behavioural changes to their mobility and activities
were efforts directed toward their physical survival. These changes decreased the risk of falling again and helped the participants manage the problems of living with the fear of falling. The reordered behaviours also affected their perceptions and feelings about themselves. They felt a greater sense of control over their independence, and in this way the behaviours helped to maintain their psychological survival.

**Preserving Identity.** The second strategy that the participants used to integrate the meaning of the experience of fear of falling into their daily lives was through a process of cognitive adaptation. Feeling afraid of falling again created a stressful environment for the participants and threatened their self perceptions. In response they used strategies which would preserve their identity and enhance their sense of self in terms of their altered circumstances. The two major strategies they used to help them in this process were comparing themselves to others and solitary reflecting.

Feeling afraid of falling again conjured up feelings of loss of confidence and self-worth. These feelings affected the participants identity: they
threatened the maintenance of an integrated sense of self. Comparing themselves to others was a conscious cognitive process to foster feelings of value and worth.

All of the participants had either direct or indirect knowledge of others who had sustained fractures, been hospitalized, or permanently placed in long term care institutions as a result of a fall. They described reasons why they felt lucky as they appraised their present situations in comparison to other individuals.

Falling and fracturing a bone was something that the participants feared. Having survived a fall without sustaining a serious injury helped one woman feel positive:

I feel fortunate about the strength of my bones, more than anything because the falls I have had, some of them have been quite severe, and yet I haven’t hurt my bones at all.

For those who had sustained a fracture, they felt lucky because they had been able to recover and continue living in their own home. They credited their recovery to positive personal lifestyle choices, for example
eating well and keeping active.

Comparing themselves to those in poor health was common. It was a strategy which allowed the participants to view themselves favourably and in this way they enhanced their sense of identity:

Well I know lots of people in worse shape, so I think I'm doing pretty good. I must be doing something right and that helps, helps you, uh, your feelings.

The participants also compared themselves with others in the same age group. Although their social identity had changed with aging and their present circumstances, they were able to view their longevity as unequivocal evidence of their personal strengths:

I have been really lucky. Next month I'll be 88. I'm 87, so I thought my God you're not too bad for an old woman. But I was always careful and kept active. That kept me going not like some of them.

One gentleman compared himself to his good friend. He admired her ability to get around, even though she was older and had poor vision:

I admire her determination. She came up here, she stayed at the Admiral, and she walked way over
here and she would walk right over here and go up to the park for coffee with me. I can’t walk as far as her but I try. She’s so damn independent, but then so am I.

For this gentleman comparing himself to his friend encouraged him to try and be as active.

The strategy of comparing themselves to those in less favourable situations allowed the participants to reaffirm their own positive personal qualities. Feeling positive helped them to deal with the lack of confidence they felt in relation to their fear of falling.

Solitary reflecting was another strategy which the participants used to enhance their self perceptions. It was a cognitive process that all of the participants practised in varying amounts and in various ways. Memories of the past, thoughts about the future, and present circumstances were contemplated.

All participants reflected on their past. One woman reflected on the past because she found the present and future held little hope for her since her fall. Finding comfort and predictability in the past helped her to maintain her sense of value and worth:
I have no future. I can't get out. My friends can't come. I can't plan, it's too uncertain so I live in the past. I like it.

Another woman who was housebound because of her fear of falling dwelt on the past as a way of denying her present circumstances. She reflected on her earlier life because it had been meaningful. Reconciling the realities of her life into her identity was a struggle:

And everybody says you're left here for a purpose and I say, "What kind of a purpose? I'm no good to myself, I'm no good to anybody else. So what purpose am I left for?" It's hard to find meaning in this [life]. So I just live with it and think of the past, the past, yes, the past.

Solitary reflecting helped several of the participants put their present circumstances into perspective. Acceptance of their present circumstances was less difficult for those participants who were able to resolve past regrets. Feeling satisfaction with the past helped some of the participants view themselves favourably:

It's really amazing that, uh, later on that something I didn't like a long time ago, and I
think, gosh, that's sixty years ago. Why should I worry about something that happened that far ago. I've made changes in my life and now, as far as living, I don't, I have no ambition to live bigger than this.

Reflecting on the future and spending time planning each day enabled some of the participants to feel control over their lives. A sense of control gave them a feeling of confidence and improved their self perception:

When I go to bed at night. I think of it all, am I going up to the coffee shop up there tomorrow or will I go down to the Thrifty's. Decisions, decisions and I still make them.

Another outcome of solitary reflecting was the recreation of one's lifestory in order to feel positive about oneself. This was particularly evident with one of the women who had struggled in a difficult marriage. She had raised her children without much support from her husband and felt proud of her will-power and self determination. Since falling and being afraid of another fall, she had recreated her story so that these virtues were an integral part of her perceived success
at coping:

I fell but I recovered. You see, if you didn’t have will-power, you won’t keep your independence at all, but uh, and you have to fight. You can’t think it’s going to come unless you try. Persevere and try, and that’s with me.

This woman rarely got outside and used a walker within her home.

Imagining that their physical abilities would improve gave the participants a feeling of hope and fostered a feeling of control. For some of the participants solitary reflecting enabled them to deny their fear and mentally wish it away:

I think will I get better enough to walk by myself to town and that, I don’t know. Not the way I was at 30 years old, but the way I was before I fell, before I was so scared. I hope for, but I don’t know if I ever will. No it’s just a dream. Wishful thinking as the saying goes.

Fear of falling again affected the participants’ feelings about themselves. They felt less confident, less independent and less able to control their lives. These feelings had an impact on their perception of
themselves. They engaged in solitary reflection in an effort to preserve and reinforce their self-identity. Thinking about the past, the present, and the future generated self-referent knowledge which assisted the participants to maintain feelings of self worth. Solitary reflection provided a validation mechanism which the participants used to reaffirm and preserve their identity.

The fear of falling again stimulated feelings of loss of confidence and control, and undermined the participants self-identity. Thus, to integrate these psychological consequences into their daily living the participants sought ways to preserve their identity. They compared themselves to others and used solitary reflection to regain a sense of confidence and control over their lives. Identifying themselves on the basis of favourable comparison to those less fortunate was comforting and promoted positive feelings. Ignoring the present, denial of their feelings, planning the future, altering the lifestory, and putting things into perspective were techniques used in the process of solitary reflection to promote self worth.
Summary

This chapter has presented the characteristics of the participants and their accounts related to their fear of falling again. The accounts were organized within a framework developed from the themes arising from the data and reflected the influence of the lifespan perspective which guided this research. The meanings of the participants' interpretations were viewed from a broad perspective and were conceptualized into two major themes of adaptation.

Making meaning of the experience of their fear of falling was one of the major themes of the participant's adjustment process and represented their efforts at understanding their fear. As a result of falling they developed feelings of fearfulness and they began to seek meaning for these feelings. The process of making meaning acted as the catalytic agent for the reordered behaviours and activities to preserve their identity. However, there was evidence that this was an ongoing process as evidenced by the continual efforts of the participants to understand and interpret their feelings about their fear. Within this theme the way in which they made sense of their fearfulness was
presented as three elements: linking fearfulness to falling, recognizing other fears, and appraising self.

The second major theme, integrating the meaning of the experience of fear of falling into daily living described the way the participants coped with the disruption caused by their fear. This disruption threatened their physical and psychological survival and as a result the process of adjustment occurred at the behavioural and cognitive levels. Within this theme there were two elements: reordering behaviour and preserving identity. The reordered behaviours were the functional changes the participants made in order to decrease the risk of falling again and to maintain their independent lifestyle. These included altering mobility, changing activities, following routines, and accepting help. These behaviours also influenced the way the participants felt about themselves. Preserving identity involved two cognitive processes: favourable comparison to others and solitary reflection. Their purpose was to elicit positive feelings of value and self-worth as the participants dealt with the loss of confidence, independence, and control which resulted from their fear of falling again. Both of these
strategies provided validating experiences which helped to preserve their identity.

The findings of this study have been presented in this chapter. Many important issues were identified; however, two underlying concepts, control and self-enhancement recurred throughout the participants' accounts. Because of their significance they will be discussed in the following chapter in relation to the literature.
CHAPTER FIVE
Discussion of Research Findings

Introduction

This chapter will discuss the research findings presented in Chapter Four. The most significant findings which emerged from the themes: control and self-enhancement will be reviewed in relation to the relevant literature which is currently available.

The data originating from this research identified fear of falling as a significant concern for the participants. In response to this concern, the participants provided rich accounts of how they interpreted their fear of falling and how they managed their lives in relation to this unrelenting fear. Their accounts were conceptualized into two major themes: making meaning of the experience and integrating the meaning of the experience into their lives. Both of these themes together represented the way in which the participants sought to adapt to their fear of falling again. Emerging from these themes were two recurring concepts: maintaining control and efforts at self-enhancement, and these will be the focus of this chapter.
Maintaining Control

The fear of falling again undermined the participants' sense of control. They felt less able to control another fall and less able to control the activities of daily living. Efforts to maintain control were exemplified by actual behavioural activities as well as cognitive activities.

The participants' initial efforts to maintain control occurred during the process of making meaning. They sought to attribute their fearfulness to events which they could identify, including the fall itself and its consequences. Being able to identify the source of their fearfulness was one way the participants felt a sense of control. Individuals who experience a threatening event will make attributions in order to understand, predict, and control their environment (Taylor, 1983). Causal explanations of some kind were sought by each of the participants in this study. Thus, the participant's process of understanding and interpreting their fear can be understood from this perspective.

Another way that the participants sought to maintain control was by blaming specific circumstances
for their fall and fearfulness. Identifying these circumstances reassured the individuals that they could somehow avoid a recurrence. Assigning blame represents a desire for control (Walster, 1966). Viewed in this way laying blame positively benefitted the individual because it acted as a self-protective mechanism which provided a feeling of control.

The findings of this study indicated that the participants had varying perceptions of control. Perceived control can be either internal or external (Rotter, 1966). Internal control is contingent upon the individual's own behaviour while external control is contingent on others. This helped to explain why some of the participants felt marginally in control, while others felt a significant amount of control even when they lacked the physical resources to actualize their control. This suggested that the perception of control may be more important than the actual behavioural control. Taylor (1983) proposed that illusionary control is beneficial and can motivate an individual to persist in their behavioural efforts to achieve personal control and self-enhancement. She described illusionary control as the perception of the
probability of success even though the outcome cannot be influenced. Not having a strong sense of personal control or perceived control seemed to strengthen the negative impact of the experience of the fear of falling. Therefore, the participants' perceptions of control helped to explain their persistent behaviours toward control and their determination to be independent even in the face of significant losses.

The fear of another fall caused a disruption to the participants' previous activities. They had lost confidence in mobilizing; and, as a result, they limited their activities. Activities within their homes were more predictable and gave them a sense of security and safety. Individuals who feel insecure avoid change and decline to become involved in new or unfamiliar situations (Silverstone and Hyman (1976). It was understandable, therefore, that the participants restricted their activities as a way to avoid situations in which they would have less control.

Another way that the participants sought to maintain control was by following a routine for their daily activities. These routines were familiar and required the least expenditure of energy. Because of
their familiarity the participants' expectations of successfully completing them was high. Control stems from the ability to predict and is heightened when expectations are met (Rothbaum, Weisz, & Snyder, 1982). This position is similar to Bandura's (1977) self-efficacy theory that defines the efficacy expectation as the "conviction that one can successfully execute the behaviour required to produce the outcome." (pp. 193). Therefore, it seemed likely that following routines fulfilled several functions: conservation of energy, accomplishment of daily activities, reinforcement of their own abilities, and a feeling of control. All of these had a psychological benefit for the individual.

The participants exhibited ongoing efforts to control and accomplish meaningful activities. Control was often thwarted because of a lack of resources. The theory of learned helplessness maintains that after repeated, unsuccessful attempts at control, the individual will give up responding (Seligman, 1975). However, most of the participants in this study demonstrated an amazing persistence to find ways to control those aspects of their lives where control was
possible. They established new goals or functions which were within their capabilities. When control over some aspect of their life was not possible they shifted to something else that was controllable. For some of the participants finding new activities was more difficult than for others. This explains the differences in the feelings of competence and control expressed by the participants.

The findings indicated that the ability to make decisions was an important source of personal control for the participants. Having opportunities to be self-determining can be intrinsically motivating and highly rewarding (Deci, 1975). Therefore, the participants' ability to be self-determining enhanced their sense of control and their feelings about themselves. However, conflict occurred and their fear escalated when caregivers tried to usurp their decision-making ability, for example when family members made decisions about the need for formal assistance in the home. Being forced to accept help that was perceived to be unnecessary undermined their feelings of competence. The principle of autonomy is an important consideration in view of the importance of the individual's right to
determine his/her own course of existence. Individuals who are capable of rational thought have the right to be self-determining as long as it does not infringe on the autonomy of others (Hogstel & Gaul, 1991). This principle helped to understand not only the importance of decision-making as an essential component of control but also the importance that the participants placed on their own cognitive ability.

Another dimension of personal control is independence and is characterized by the ability to act on decisions (Johnson, 1991). For the participants, home symbolized their independence; and, in order to maintain it, they accepted help. Although not physically able to act on all of their decisions, they were able to realize them through the efforts of others. They felt a personal sense of control over their independence when they were able to hire, organize, direct, and guide their formal caregivers. Personal control was also realized when they were able to make decisions about which activities they relinquished and which activities they struggled to retain.

The findings of this study illustrated the
importance of maintaining control for individuals who were afraid of falling again. Maintaining personal control was related to the meaning one attaches to an event, predictability of activities, decision-making ability, competence, and independence. Personal control was realized through the participants' direct efforts to reduce the threat of another fall and their accompanying fear, but also from their perception of control. The perception of control was illusionary because actual control was unattainable. However, because it involved a positive interpretation of a situation it helped the individual avoid disappointment and maintain hope. Both types of control psychologically bolstered the identity of the participants.

Self-Enhancement

Feeling afraid of another fall influenced how the individuals felt about themselves. Their identity had been altered and they felt less confident, less competent, and questioned their self-worth. To deal with these feelings, they engaged in cognitive efforts to enhance their sense of self, including social comparison and self-reflection. Threatening events
have been found to affect one's self regard even when the causal relationship was clear (Bulman & Wortman, 1977: Taylor, 1983). Thus, the negative effect of the fear of falling on the individual's self-perception could be understood from this perspective.

Comparing themselves to those in less favourable positions was a strategy which all participants used to some degree. No matter how debilitated or functionally unable the participants were, they compared themselves to someone in a worse situation. As well, they fabricated comparison persons when none existed through their own experiences. The participants used comparison as a means of self-enhancement and as a way to feel more self-worth. This process also seemed to be a mechanism of self-protection which reduced the threat of coping with the fear of falling again. Social comparison theory (Festinger, 1954) was helpful in the interpretation of the findings of this study; however, contrary to this theory the participants thought they were doing as well as or better than other individuals in similar situations. These results suggested that they were making downward comparisons. Individuals when faced with a threat will usually make
comparisons that are self-enhancing and bolster the self-esteem (Wills, 1981). The idea that cognitive activity positively influenced the individuals’ feelings about themselves helped explain why considerable time was devoted to this activity.

Some of the participants used comparison to others as a motivator for their own behaviour. The successful coping of someone perceived to be more disadvantaged than themselves encouraged them to pattern their behaviour similarly. The previous description of the man who tried to emulate his friend’s ability to mobilize illustrated how social comparison was motivational. Not only was this result a psychological benefit to the individual but it also stimulated the same coping efforts. Cognitive illusions can have multiple functions including self-enhancement, instructive, and motivating influences (Taylor, 1983). Thus, social comparison served two needs: it made the individual appear better off and stimulated successful coping behaviours.

The participants limited their physical activity because of their fear of another fall, and as a result they spent long periods of each day in contemplation.
Contemplation and inactivity can have positive benefits for the individual (Atchley, 1985). For the participants, solitary reflection was perceived to be an activity which was beneficial to them, and they used this time to enhance and validate their self-perceptions.

The participants used the strategy of reflecting on past accomplishments in order to feel more positive. The literature on life review and reminiscence was helpful in understanding the process and function of this activity. Butler (1963) proposed that life review is an evaluative process to resolve, reintegrate, or reorganize what is troubling and is triggered by approaching death. However, in this study life review was used to gain a feeling of satisfaction and was being done even though impending death was not a factor. Self-reflecting for these individuals seemed to occur naturally; and, since falling, the time spent in reflecting had increased. Memories of the past acted as a repository of information about themselves that enabled them to make self-references. They selected positive aspects of their lives, and in this way they were able to view themselves in a better

Maintenance of the self-concept depends upon the revision of one's life history, and individuals will remember themselves as more successful than they really were (Greenwald, 1980; Pearlin & Schooler, 1978). Reconstructing the lifestory as a way to minimize dissatisfaction with the past and focus on one's perceived positive personal qualities was another way the participants sought to enhance their feelings about themselves. It follows that their positive sense of identity was aided by ignoring what was troublesome and emphasizing what was positive. Thus, the usefulness of solitary reflecting in the process of reconstruction as a means of self-enhancement was understood.

The findings of this study suggested that some people used denial as a self-protective mechanism. By denying their present needs, the participants were able to protect their self-perception and to maintain a positive perspective. This strategy does have the potential to have a negative outcome if it supports the individual in refusing to accept appropriate help.
Denial may be a positive adaptation strategy if the individual does not distort reality, or action is impossible, or the emotional distress in not pathological (Lazarus, 1981). Another perspective in considering an individual's use of denial was their right to refuse help and their right to live at risk.

The cognitive processes that the participants used in this study were initiated in response to the fear of falling again. Feeling afraid had altered how they felt about themselves and challenged their previous identities. To preserve their identity, they engaged in activities which were self-enhancing, including comparison and solitary reflecting.

It was clear that the behavioural and cognitive activities employed by the participants overlapped functionally and met dual needs. The behavioural activities that the participants implemented were directed toward controlling the threat of another fall and their fear. By achieving a sense of control the participants also enhanced their feelings about themselves. The need to find meaning in the experience helped the participants not only find an explanation for their feelings, but also represented an effort at
controlling the reasons for their fearfulness. Likewise, self-enhancement was achieved through comparison and self-reflection, but also by believing in the ability to control events either through personal effort or others.

**Summary**

This chapter discussed the findings of the study in relation to other research, assumptions, and theories found in the literature. The participants' perspectives as developed in this study differed from some of the literature, while lending support to others. The discussion focused on the concepts of maintaining control and self-enhancement which emerged from the major themes of the study: making meaning of the experience and integrating the meaning of the experience into their lives.

The first concept, maintaining control, described the efforts of the participants to control not only the threat of another fall and their fear, but also to control their lives. Attempts to forestall another fall was a way to protect their physical survival. As they were able to maintain a sense of control, they felt more positive about themselves.
The second concept, self-enhancement, described the cognitive activities that the participants engaged in to reaffirm and validate their sense of self. Their positive self-perceptions were of psychological benefit to them.

The adaptations that the participants made toward maintaining control and self-enhancement were at the behavioural and cognitive levels. These adaptations helped to preserve the individual's identity in the face of living daily with the unrelenting and pervasive fear of falling again.

This chapter focused on a discussion of two of the most noteworthy findings which were presented in Chapter Four. The summary and implications for nursing will be presented in the final chapter.
CHAPTER SIX
Summary and Implications for Nursing

Summary

This study presented a qualitative approach to the understanding of elderly individuals who have fallen and have a fear of falling again. Falling in the community-dwelling elderly is a common problem and poses serious problems for them. Previous research has concentrated on the identification of risk factors and discussions about the impact on the physical well-being of individuals who have fallen. This study differed from previous research by focusing on the individual's perspective of the fear of falling again and the effect it had on daily living.

The importance of this study is also directly related to the increasing numbers of elderly people who choose to live in their own homes. With increasing age the risk of falling rises. Both of these factors have an effect on the services which are provided to individuals living in the community. Thus, to provide care that effectively meets the needs of the elderly individual who is afraid of falling again, nurses must understand the meaning of the experience from the
individual's perspective. Nurses must also understand the relationship between the cognitive adaptations and the behaviours they observe in order to support the individual. Greater understanding will facilitate both the physical and psychological survival of the fearful individual.

The phenomenological method was selected for this study as it seeks to understand and describe the subjective meaning of human experience (Knaack, 1984). Using interview data generated by each of the nine participants in the study, the participant's perspective was constructed. This perspective described the meaning of the fear of falling again and the behaviours that were used in response to the fear.

The lifespan construct provided a useful framework that directed the researcher to consider the physical, social, and psychological qualities which influenced the participants as they dealt with their fear of falling. This framework enabled a broad perspective to be employed in the collection and conceptualization of the data.

The participants' constructions were conceptualized into two major themes: making meaning of
the experience and integrating the meaning of the experience into daily living. Making meaning was presented as three elements: linking fearfulness to falling, recognizing other fears, and appraising self. The second major theme, integrating the meaning of the experience was presented as two elements: reordering behaviours and preserving identity. Two of the most significant findings, maintaining control and self-enhancement, were discussed in relation to current research and literature.

The nature of phenomenological research does not lend itself to definitive statements or is it intended as a method of theory development. However, this study does suggest implications for nursing practice, education, and research.

**Implications for Nursing**

The findings presented in Chapter Five have implications for nursing. They will be discussed as they apply to nursing practice, education, and research.

**Nursing Practice**

The importance of maintaining control and self-enhancement are critical to the well-being of everyone.
However, for the elderly individual who has suffered a loss of mobility, function, and feelings of self-worth, they are even more important. Nursing care, to be effective, should be directed toward optimizing the clients ability to control and to perceive control over their situations. Promoting feelings of control can positively influence self-perception. Additionally, nurses should encourage the use of cognitive processes that enhance an individual's self-regard.

The finding that the cognitive process of making meaning occurred prior to the adaptations which resulted in feelings of control, directs nurses to address this as a first concern in caring for an elderly individual who experiences a threatening situation. Establishing a mutually respectful rapport with these individuals by active listening is necessary in order for the individuals to share their experiences. A thorough health assessment which encourages reflection on the fall event and their fearfulness will assist in exploring causal explanations. Identification of the sources of their fearfulness provides opportunities for the nurse to support the attributions or to provide information that
may initiate reassessment of them. Coaching individuals to interpret their experiences as an opportunity for such positive outcomes as rest, increased safety, and reflection can contribute to an increased sense of control.

The focus of community health care is to assist individuals toward self-care and this study indicates that attention needs to be paid to behavioural activities that help them maintain a feeling of control. During assessment the individuals' abilities should be carefully investigated and a plan developed which focuses on the accomplishment of tasks within their capabilities such as meal planning, getting dressed, and taking their medications. These tasks should be integrated into their daily activities so that they become part of their familiar routines. An awareness and respect for the ritualized behaviours, the need for predictability, their limited energy resources, and the scheduling of nursing visits convenient to the individual are ways that the nurse can promote personal control. Ongoing reinforcement by the nurse about the individuals' accomplishments will facilitate positive feelings of self-worth.
The importance of maintaining control suggests that all interventions toward self care should involve collaboration between the individual and the nurse. This requires that the nurse must be flexible and willing to work toward goals which are perceived by the client as desirable and attainable. Nurses who work with their clients to set mutual goals, choose options and activities to meet these goals can facilitate their client’s decision-making and as a result feelings of control will be promoted. Feelings of self-worth will be enhanced when clients can make decisions about the specific activities they are responsible for in order to meet the mutual goal.

Nurses can assist the individual to overcome the barriers to control through the advocacy role. The role of the advocate is to inform individuals by providing accurate information followed by supporting their decisions. For example, giving the client information on the role of the home support worker, the tasks which they can carry out, and the method of assessing eligibility for this service would facilitate their ability to make an informed decision and enhance feelings of control. Respecting their decisions can
increase feelings of self-worth.

The finding that the accomplishment of meaningful activities helped give the elderly individual a sense of control suggests that nurses need to identify ways to achieve this. Establishing a network of individuals who are afraid of falling again as a support system for each other may assist the individual to perceive greater control through this involvement, maintain social contact, and provide an additional feeling of security.

Community nurses are often the liaison between the elderly who desire to remain in their own home and family members who wish to institutionalize them or to impose their own decisions. The nurse can support individuals to be as independent as possible by encouraging and setting up resources that increase the safety of their living arrangements. For example, arranging for a medic-alert system and safety check system through the postal service are ways that can alleviate the anxiety of the family and at the same time allow the individual to remain independent. Counselling family members, allowing them time to verbalize their concerns, and giving them information
on support groups can also alleviate their distress.

The finding that the perception of control enhanced self-worth and promoted persistence in behaviour toward actual control, directs the nurse to nurture the individuals' illusions of control. The illusion of control can be facilitated by listening and accepting the client's need to predict events so as to avoid disappointment, encouraging persistent behaviour in simple, repetitive tasks, supporting their ongoing attempts to understand their situations so as to derive meaning from them, and recognizing that expectations of control can potentially enhance efforts at control.

Thus, to promote a sense of control in elderly individuals who are afraid of falling again ongoing assessment and evaluation should be carried out. The assessment should determine the personal control desired, the abilities needed to carry out specific activities, acknowledge the uncontrollable situations which would benefit from interventions or illusionary control, and evaluate the need for a sharing of control.

The importance of self-enhancing cognitions was an important finding of this study. Nursing interventions
which encourage the use of social comparison, life review and reminiscence can help promote positive feelings in the individual.

Nurses need to be sensitive to the expressed comparisons that their elderly clients make. Asking open-ended questions that invite further elaboration will encourage them to focus on their strengths, will validate them, and can promote their self-perceptions. Nurses can assist elderly individuals, who do not actively engage in comparing themselves to fabricate comparison persons. Asking questions that help them imagine another individual who would be worse off may encourage them to make comparisons and to view themselves more favourably.

In order for nurses to implement life review and reminiscence as self-enhancing interventions, an assessment must be completed. Determining the individual’s cognitive ability to retrieve stored information, to verbally communicate, and to be physically able to tolerate and participate in discussion for thirty minutes or more can be accomplished during an initial head to toe assessment. Further information can be collected through the use of
a mental status tool, for example the Folstein (1975) mini-mental state. A thorough history should be completed including details about the formative years, schooling, family life, work life, significant life events, hobbies, and interests. Setting regular time aside which is convenient to the individual for reminiscence validates the importance of their personal memories and life history. During this intervention the nurse should use simple prompting questions and silence to enable individuals to share their memories. The nurse must be sensitive, supportive, and non-judgemental.

Caregivers need to be informed of the value of reminiscence and life review. Teaching them to facilitate these strategies can help bridge the gap to communicating in a more meaningful way with the individual. These strategies also have the potential of increasing the individual’s sense of belonging and participation through the shared memories. Another creative way to aide personal reminiscence is through the use of a memory book which can include photographs, letters, mementoes, and written details of the past which provides evidence of the individuals’ past
accomplishments and past successes at coping with life stresses.

Social comparison, life review, and reminiscence allow elderly individuals to view themselves positively. While individuals engage in reflection, they also have the opportunity to restructure their life story, find alternate causal attributions for their feelings, problem-solve daily activities, and reinterpret their present circumstances based on the past.

**Nursing Education**

Fear of falling created stress for the individual and resulted in multiple losses and efforts to adapt. Nursing education should include loss theory, information on normal age-related losses, coping and adaptation research. Application of this knowledge within a supervised setting early in a nurse’s education would facilitate the learning of this information.

The education of nurses in the basic programs has focused on diagnosis and interventions in an acute care setting. Given the trend toward maintaining elderly individuals in their homes, early hospital discharge
programs, the projected increase in the population of individuals over the age of 65, and the number of individuals in this age group who will fall, it is imperative that there be a shift in the content and focus of nursing education programs. Increased emphasis on gerontology and community nursing are needed to meet the needs of elderly individuals living in the community. Opportunities for clinical placements, for example, in Home Nursing Care, Long Term Care, and Adult Day Care throughout the basic education programs would help to prepare nurses for community work.

It is recommended that educational institutions establish a specialty in community nursing with a strong focus in gerontology in order to adequately prepare nurses to practice in this setting. This focus is critical because the elderly constitute approximately 75% of the community nurse’s caseload. As well the community setting requires that the nurse have advanced problem-solving and critical thinking skills in order to practice effectively without supervision or immediate peer support. More specifically and based on the findings of this study,
this level of nursing education should also include a significant component on cognitive adaptations. As the elderly living in the community become more dependent and housebound, they will spend increased amounts of time in solitary activities. Community nurses need to be able to guide and encourage their elderly clients who are afraid of falling to use their time in ways that will potentially benefit them. They need to understand and support their cognitive illusions, comparisons, and self-reflecting. Having an extensive clinical practicum with opportunities to integrate and apply the information on loss, stress, and adaptation of the elderly to threatening events in community settings will enable the nurse to meet the needs of their elderly clients more effectively.

Nursing Research

Further research is needed on the adaptations elderly individuals make in situations where they feel threatened. Comparing the themes from new research with the study data and the current literature is important in developing a strong knowledge base about the reactions of the elderly to threatening experiences.
The findings of this study indicated that maintaining control was an important way that the elderly individual adapts to the fear of falling again. Therefore, research that tests the relationship between control activities and fearfulness, well-being, and feelings about self are indicated. Determining the effectiveness of actual control and the perception of control as strategies to foster feelings of self-worth would be useful in the planning of care to meet the needs of individuals who experience a threatening event. Exploring the effects of a shared model of control between the client and nurse will help to identify the outcome of control on client morale, satisfaction, and fear.

The functions that specific cognitions serve and their relationship to actual behaviour merits further attention. Examination of this relationship with other groups of elderly individuals who are experiencing losses and threats to their well-being would increase our understanding and enhance the planning and delivery of health care to them.

Another line of research that is suggested would be the study of the reactions of individuals to
threatening situations where their efforts at control and self-enhancement are unsuccessful. What happens to an individual's identity when efforts are thwarted?

Reminiscence and life review need to be studied to determine their usefulness as a nursing intervention with elderly individuals living in the community who are afraid of falling. What triggers this process? Do they influence adaptation to stress? What are the short and long term effects on morale, mood, and self-esteem? These are a few of the questions that could be studied. In addition, more knowledge about how these strategies affect the caregiver's relationship and communication with the elderly would be useful to include in the development of courses for formal caregivers and in the teaching of family members.

In conclusion, this study has described the meaning of the experience of fear of falling from the perspectives of elderly individuals who have previously fallen. The meaning of the experience centered around the participants' efforts at adaptation both behaviourally and cognitively. Based on the significance of the findings it is important that nurses who care for these individuals focus not only on
their physical recuperation but on their mental recuperation. Nurses who understand the adaptations that the elderly make when they are afraid of falling again can improve the elderly individual's ability to function and inspire them to find new meaning in life. Thus, nurses will be more effective in meeting the needs of individuals who are afraid of falling again.
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Appendix A

Letter of Information

My name is Marilynne Convey, and I am a Registered Nurse working on my Master of Science in Nursing degree from the University of British Columbia. The topic I am studying for my thesis is concerned with understanding the fear of falling that elderly individuals experience following a fall.

This letter is to invite you to participate in my study. I am interested in understanding what fear of falling means to you and how it affects your daily living. Very little is known about this subject, and I think it is important for nurses who care for elderly individuals to have a better understanding of this fear.

If you are willing to participate in my study, I would like to meet with you in your home two or three times. Each interview will require 30 to 90 minutes. During the initial interview, I will ask you questions about your experience concerning your fear of falling. Follow-up interviews will be a time for us to clarify the original information and for you to describe additional thoughts or feelings about your fear. All
interviews will be tape recorded so that I can pay close attention to what you are saying. The information will be confidential; no names will be used on the tapes or the transcribed notes. Access to this information will be limited to myself, my thesis advisors, and my typist. At any time during the study you may request erasure of the information, and at the completion of the study the information on the tapes will be destroyed.

Participation in this study is voluntary, and you are free to withdraw at any time. Withdrawal from this study will not affect your contact or services through the CRD Care Programs.

If you decide to participate or have other questions, please call me at 592-8179. The supervisor for this project is Angela Henderson and her office number is 822-7435. You can also give permission to your nurse for me to contact you. I look forward to speaking with you. A summary of the study will be sent to interested participants.

Sincerely,

Marilynne Convey
Appendix B

Consent Form

Title of the Study: Fear of Falling: The Experience of Elderly Individuals Who Have Previously Fallen

Investigator: Marilynne Convey, R.N., B.S.N.

Advisor: Angela Henderson, R.N., M.S.N.

I _______________ give my consent to participate in the study of fear of falling which has been explained to me by Marilynne Convey and is being conducted through the School of Nursing at the University of British Columbia.

I understand that this study involves one to three interviews of 30 to 90 minutes duration in my home and that the interviews will be tape-recorded. I understand that: (a) participation in the study involves no risks or discomforts to me; (b) my participation is voluntary and that I may withdraw at any time; (c) refusal to participate in the study or withdrawal from the study will in no way interfere with the care and services which I will receive; (d) all information personally identifying me will remain strictly confidential, and (e) I may contact Marilynne Convey at 592-8179 or Angela Henderson at 822-7435 if I have further questions about the study.

I acknowledge receipt of a copy of this consent form.

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Appendix C

Trigger Questions

1. What is your experience of falling?
2. Describe your feelings about falling?
3. Describe your fear of falling?
4. Describe how your feelings affect you on a day to day basis?

Note: Specific information on the fall event will be solicited from the participants and will include the following:

Number of falls.
Circumstances of first, subsequent, and last fall.
Reaction of family, friends, and neighbours.
Risk factors - eg. medications, environment, and health.