THE MEANING OF FALLING FOR ELDERLY COMMUNITY-DWELLING INDIVIDUALS

By

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Abstract

The Meaning of Falling for Elderly Community-Dwelling Individuals

Falls in the elderly Canadian population pose a serious health problem; they are the leading cause of accidental death in persons aged 65 and older. The most common serious injuries associated with falling are hip fractures; more than 19,000 Canadians sustain a hip fracture yearly as a result of a fall.

A review of the literature reveals that most of the studies on falling have been conducted in institutional settings. Community-based studies have identified the risk factors associated with falling to assist in case-finding and fall prevention. However, qualitative studies of falling for elderly community-dwelling individuals are non-existent.

The purpose of this study is to describe the meaning of falling for elderly community-dwelling individuals. The phenomenological approach to qualitative methodology was used for this study. This approach seeks to describe human experience as it is lived. Individuals 65 years of age or older were contacted through a Long Term Care Unit. Eight women became informants, participating in repeated interviews guided by open-ended questions. From the content analysis of the data, three major categories of data that were common to the participants were identified and developed. The three categories represent levels of perception in relation to falling, which together represent the entire meaning of falling. At the first level, par-
participants interpreted the various aspects of their falls. The second level describes the reactions to falling. The third level describes how participants coped with falling in the context of coping with aging.

These findings revealed that falling was viewed as a symbol of aging and therefore, the emotional reaction to falling occurred in the context of growing old. Furthermore, it was found that coping with falling occurred in the broader context of coping with aging. The implications for nursing practice, education, and research were identified in light of the research findings.
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CHAPTER ONE

Introduction

Falls in the elderly Canadian population pose a serious health problem. Falls are the leading cause of accidental death in persons aged 65 or older (Metropolitan Life, 1982). In Canada in 1977, there were 1,818 deaths attributed to accidental falls; 72% of these falls were in persons 65 years of age and over (Nicholls & Davies, 1980). These mortality statistics neglect a substantial number of deaths which occur some interval of time after the fall event has occurred, thus obscuring the causal relationship (Gryfe, Amies, & Ashley, 1977). The actual incidence of falls is unknown because they are generally reported only when there are fall-related injuries severe enough to require medical attention (Gryfe et al., 1977). The most common serious injuries associated with falling are hip fractures; more than 19,000 Canadians sustain a hip fracture yearly as a result of a fall (Hogue, 1982). Hip fractures can have a negative impact on the general health of elderly individuals and the costs to the health care system associated with treatment of hip fractures are substantial.

The U.B.C. Model for Nursing (U.B.C. School of Nursing, 1980) states that the nurse’s role is to nurture the individual during maturational events and unpredictable events in the life cycle. For the elderly individual living in the community, falling is an unpredictable event which requires the development and use of suitable coping behaviors. In order for the nurse to
nurture the individual, she will find it useful to understand what the experience of falling is like from the individual's perspective.

**Background And Significance Of The Problem**

A review of the literature reveals that the majority of studies on falling have been conducted in institutional settings such as acute care hospitals and long term care facilities. The purpose of the studies has been to determine the cause of falls so that appropriate preventive measures could be taken thereby reducing costs incurred by fall-related injuries and ensuring the delivery of safe care.

The causes of falls have been well-documented in the literature (Chipman, 1981; Davis, 1983; Gordon, 1982). Any physiological condition that affects gait or balance can contribute to falls in the elderly who, with advancing age, experience increasing weakness and sway, loss of sensation in the lower legs, and abnormal reflexes (Morse, Tylko & Dixon, 1985). Falls in institutions are also more prevalent in patients who have multiple diagnoses, the most common pairing being cardiovascular and neurological conditions (Morse et al., 1985). Medications such as antihypertensive agents, antidepressants, hypnotics, and tranquilizers can increase the likelihood of falling (Gordon, 1982; Sobel & McCart, 1983). Environmental factors in the institutional setting that contribute to falling include hazardous equipment, unfamiliar setting, poor lighting, and inappropriate footwear (Morse et al., 1985).
Based on the knowledge of the causes of falls in institutional settings, current studies are focusing on the development and testing of nursing assessment tools which can accurately identify the fall-prone patient (Innes & Turman, 1983; Morse et al., 1985). Current nursing studies are also attempting to identify interventions that nurses use to prevent falls in institutions (Morse & Black, 1986).

Community-based studies have identified several risk factors for falls. These include: advancing age, poor health status due to chronic illness, impaired mobility and postural instability, and a history of previous falls (Campbell, Reinken, Allan & Martinez, 1981; Perry, 1982; Prudham & Evans, 1981; Wild, Nayak & Isaacs, 1981). Additionally, fallers were more likely to show evidence of cognitive impairment and to take more medications such as diuretics and tranquilizers than non-fallers (Prudham & Evans, 1981; Wild et al., 1981). In some studies, women were found to have a greater tendency to fall (Prudham & Evans, 1981; Sheldon, 1960). Campbell and colleagues (1981) found a significantly increased incidence of depression in people who fell but due to the retrospective nature of the study it could not be determined if the depression preceded the falls or developed as a result of the falls.

After reviewing the literature on falling, the writer has found that there is little information on the individual's subjective experience of falling. Omery (1983) stated that to describe the total systematic structure of lived experience, it is necessary to understand both the cognitive subjective perspec-
tive of the person who has the experience and the effect that perspective has on the lived experience or coping behavior of that individual (p. 50). There have been no studies to date that have described what the experience of falling is like for the elderly community-dwelling individual although several authors have hypothesized about the experience. Feelings of fear, shame, incompetence, and embarrassment have been associated with falling in the literature. Perceptions that falling is a sign of aging, and attitudes of resignation to being old and weak, are believed to be common experiences of elderly persons who fall. Furthermore, several authors have described their perceptions of how persons cope with falling and have implied that the coping behaviors commonly used result in increased risk for falling.

Falls are a common experience for elderly community-dwelling individuals; it is estimated that one-third of persons 65 years of age and over experience one or more falls each year. From what is known about the causes and risk factors for falling and from what is suspected about the subjective experience of falling, the writer has concluded that this phenomenon in the elderly community-dwelling population is an important area of concern for nurses. With the increase in the elderly population, and the trend in health care to maintain the elderly in their homes for as long as possible, it can be assumed that the incidence of falling will increase and will continue to be a major health concern. Increasingly, the role of the community health nurse will be to provide ongoing support to the elderly in their homes. This support will include assistance in coping with normal changes related to aging as well
as with health problems such as falling. But before community nurses can be effective in their supportive role, they will find it useful to understand what falling is like from the individual's perspective.

**Theoretical Framework**

The U.B.C. Model for Nursing (U.B.C. School of Nursing, 1980) is the theoretical framework that will guide this study. The individual in this model is viewed as a behavioral system made up of nine subsystems: achieving, affective, ego-valuative, excretory, ingestive, protective, reparative, respiratory, and satiative. Falling is considered an unpredictable event in the life cycle which affects the entire behavioral system and requires the development of suitable coping behaviors to satisfy basic human needs, achieve stability, and reach optimal health. Each subsystem is composed of an inner personal region which includes a need and abilities to meet that need as well as a psychological environment which includes forces and a goal. Falling is considered a force that has meaning for the psychological environment of one or more subsystems. Because each subsystem is interacting and interdependent with every other subsystem, the meaning that falling has in one or more subsystems affects the entire behavioral system. It is the researcher's belief that the meaning of falling for the elderly community-dwelling individual can be understood by examining the existence of falls in the psychological environment of the subsystems, which in combination, represent the individual as a behavioral system. This understanding will direct nurses to assume a broad
perspective when assessing individuals so that all relevant data are considered, thus enabling them to make more rational decisions when dealing with elderly community-dwelling individuals who have concerns about falling.

Statement Of The Problem

The literature reveals a dearth of knowledge about the meaning of falling for the elderly community-dwelling individual. It is important for nurses to understand what the experience of falling is like so that they can care more effectively for individuals who have concerns about falling.

Purpose Of The Study

The purpose of this study is to answer the overall question: What is the meaning of falling for the elderly community-dwelling individual?

The specific questions that directed this study are:

1. How do individuals describe what it is like to fall?
2. How do individuals explain the circumstances of their falls?
3. How do individuals describe their feelings associated with falling and the potential for falling?
4. How do individuals explain how they cope with falling and the potential for falling?
5. How do individuals describe the effects of falling on their daily lives and expectations for the future?
6. How do individuals conceptualize the various aspects of falling which together represent the meaning of falling for them?

**Definition of Terms**

**Fall**: an untoward event in which the individual comes to rest unintentionally on the ground (Morris and Isaacs, 1980).

**Meaning**: the individual's interpretation of his or her cognitive subjective perspective of the phenomenon of falling and the effect of that perspective on the lived experience or coping behaviors of that individual (Omery, 1983, p. 50).

**Elderly community-dwelling individual**: a male or female person 65 years of age or older who lives in a house or apartment which is not part of a residential care facility.

**Introduction To The Methodology**

The phenomenological approach of qualitative research was used for this study. In contrast to the traditional scientific method of quantitative research which attempts to control or predict behavior, the aim of the phenomenological approach is to describe experience as it is lived (Oiler, 1982, p. 178). It is an inductive, descriptive research method and is particularly suited to nursing research when the goal is to understand human experience. The phenomenological method is appropriate for this study in which the researcher wishes to understand the meaning of falling from the perspective of the elderly community dwelling individual.
In order to study the phenomenon as it is experienced, the researcher becomes immersed in the phenomenon (Oiler, 1982). The researcher actively engages in the interactive process rather than controlling for researcher bias and in this way the researcher becomes a participant-observer (Oiler, 1982). It is critical that the researcher does not allow any presuppositions to influence the interviewing process and therefore brackets or sets aside any thoughts or biases already formulated about the phenomenon (Field & Morse, 1985). During the interviews, the researcher uses open-ended questions to avoid putting personal interpretations on the participants' statements (Oiler, 1982). The role of the subject in phenomenological research is viewed as co-researcher. In contrast to quantitative research methods where the subject is manipulated by the researcher, the researcher in phenomenology engages in cooperative dialogue with the subject who is considered to be a knowledgeable informant (Knaack, 1984, p. 110).

Assumptions

The writer assumes that falls are an unpredictable event in the life cycle and that they could have meaning for any subsystem within the behavioral system. It is also assumed that there are shared aspects of the meaning of falls and that these shared aspects can be identified by analyzing the descriptions and explanations articulated by individuals. Further, the writer assumes that individuals' retrospective accounts will provide valid and accurate data with regard to their experiences with falling.
Limitations

The data include only the perspective of the elderly individual participant. It was anticipated that family members or significant others would have valuable insights with respect to the topic; however, the goal of this study was to describe the experience from the perspective of the individual. In keeping with the nature of the method to be used, the findings of this study will only be generalizable to the group studied. Due to the time and financial constraints of a Master’s thesis, the number of participants will be limited.

Summary

Falls are considered to be a major health problem for the elderly; however, there is little information available on the subjective experience of the problem. In this introductory chapter, the research problem was described from a nursing perspective, thereby providing a rationale for the study. The theoretical framework, methodological perspective, assumptions, and limitations of the study were subsequently outlined. In the following chapter, the existing literature pertinent to this topic is reviewed. In Chapter Three, the methodology used in this study is described and in Chapter Four, the findings and interpretation of the data are presented. A discussion of the findings is presented in Chapter Five. Finally, Chapter Six includes a summary, conclusions, and implications for nursing.
CHAPTER TWO

Literature Review

Introduction

This chapter reviews pertinent literature on falling in the elderly population. The purpose of the study is to answer the overall question: What is the meaning of falling for the elderly community-dwelling individual? The theoretical framework that is used for this study directs the nurse to assume a broad perspective when assessing individuals so that all relevant data are considered. To this end, the literature selected for presentation reviews the current knowledge of falling to establish the knowledge base about the subjective experience of falling available and upon which nurses make decisions in their practice. The review is organized into three sections: 1) causes of falling in the elderly 2) risk factors for falling in the community-dwelling elderly, and 3) the experience of falling.

The Causes of Falls in the Elderly

A review of the literature reveals that the majority of studies on falling have been conducted in institutional settings such as acute care hospitals and long term care facilities. The purpose of the studies has been to determine the causes of falls so that appropriate preventive measures could be taken thereby reducing costs incurred by fall-related injuries and insuring the delivery of safe care. The causes of falls have been well-documented in the
Generally, the causes have been categorized as either extrinsic or intrinsic to the individual. Extrinsic causes are largely considered to be environmental hazards. Unfamiliar environment, improper foot-wear, floor glare, and hazardous equipment in the patient's pathway have been identified as the most common environmental hazards in institutional settings (Barbieri, 1983; Morse et al., 1985; Sehested & Severin-Nielsen, 1977). Medications have been identified as the other significant extrinsic cause of falls. Institutional-based studies have shown that individuals who took multiple medications were at increased risk for falling (Wells, Middleton, Lawrence, Lillard & Safarik, 1985). Specific medications that have been found to increase the risk for falling in the elderly include hypnotics, tranquilizers, sedatives, tricyclic antidepressants, antihypertensive agents, and diuretics (Barbieri, 1983; Sehested & Severin-Nielsen, 1977; Walshe & Rosen, 1979).

Intrinsic factors that contribute to falls include any physiological conditions that negatively effect gait or balance. Despite the statements made by geriatric experts that falls should not be considered as a normal part of the aging process, but rather are due to pathophysiology, medications, and environmental hazards often in interaction, it has been demonstrated that age-related physiological changes do contribute to falling. Decreases in visual acuity, restriction of the visual field, increased susceptibility to glare, impaired depth perception, and deficit in gaze stability have been demonstrated to occur with advancing age and impair the ability to anticipate a fall and take corrective action (Liebowitz & Shupert, 1985; Stelmach & Worringham,
1985). Additionally, age-related changes in the vestibular function, proprioception, and vibratory sense can contribute to balance impairments and increase the risk for falls (Stelmach & Wortingham, 1985). Gabell, Simons & Nayak (1985), in a study of 100 healthy elderly individuals, found that abnormal plantar reflexes, slow recovery of pulse-pressure following a rest period, and gait and balance disturbances following a rest period with sudden increase in environmental lighting were predisposing factors to falling.

Disease-related pathophysiological changes are also significant intrinsic factors for falling. Cardiovascular disorders such as arrhythmias, valvular disease, and vasovagal responses and neurological dysfunctions such as stroke, seizures, and trauma are the primary or secondary diagnoses most frequently identified for patients who fall (Rubenstein & Robbins, 1984; Walshe & Rosen, 1979). Any condition that causes syncope, orthostatic hypotension, dizziness, and mobility impairment can increase the risk for falling. These include: diabetes, parkinsonism, acute infections, hypoxias due to anemias and respiratory conditions, arthritis, hypothyroidism, foot problems, and severe osteoporosis with spontaneous fracture (Rubenstein & Robbins, 1984). It is felt that individuals with a diagnosis of chronic brain syndrome fall because of gait impairment related to pyramidal tract disorders rather than the associated mental confusion (Brocklehurst, Exton-Smith, Lempert-Barber, Hunt, & Palmer, 1978).
Knowledge of the causes of falls in institutional settings is useful for nurses when assessing the safety needs of patients. Current nursing research on falling is focusing on the development of assessment tools that nurses can use to identify the fall-prone patient (Innes & Turman, 1983; Morse et al., 1985). Current nursing studies are also attempting to identify interventions that nurses use to prevent patient falls in institutional settings (Morse & Black, 1986). In the community, nurses also need to be aware of the causes of falls in their elderly client population when assessing and planning care. Although the environmental hazards in the community will differ from the hazards of the institutions, the causes of falls for the elderly in institutions and the community are similar (Gryfe et al., 1977).

Risk Factors For Elderly Community-Dwelling Individuals

There have been few community-based studies conducted on falls in the elderly population. Only one Canadian study could be identified in the literature, and although it has several merits, it cannot be considered as a realistic community-based study because it was conducted with an ambulatory institutionalized population (Gryfe et al., 1977). The majority of community-based studies have been conducted in England where living situations and support services for the elderly differ from those in Canada, making a comparison of the factors associated with falling in the elderly populations difficult. Furthermore, most of the studies that have been done are limited by their retrospective nature, and their restriction to cases severe enough to
require medical treatment or to be followed by death related to the fall event (Gryfe et al., 1977). Nevertheless, Wild and colleagues (1981) estimated from retrospective information obtained from a control group that the incidence of falling in the elderly community-dwelling population is twenty times higher than the incidence of reported falls. This information indicates that there are many elderly people living in the community who are experiencing falls but because they do not sustain injuries with their falls, it is possible that their concerns about falling are not being addressed.

The majority of community-based studies have attempted to identify the risk factors for falling to assist in case-finding and fall-prevention programs. The risk factors will be presented and discussed.

Advancing age is the most significant risk factor for falling in the community-dwelling population (Prudham & Evans, 1981; Sheldon, 1960). Campbell and colleagues (1981) found that 45% of persons in the 80 to 89 age group had fallen and in the 90 to 99 age group, 56% had fallen, whereas overall, 34% of the individuals over the age of 65 experienced at least one fall in the previous year. In another study, the rate of falling which was expressed as incidents per 1000 persons at risk per year, rose after age 75; 451 in the 75-79 age group, 665 in the 80-84 age group, and 891 in the 85+ age group (Gryfe et al., 1977).

Poor health status has also been identified as a risk factor for falling. The criteria for judging health status differed in each community study that was reviewed making it difficult to define what is meant by poor health. In a
study of 384 patients admitted from the community to hospital for treatment of a hip fracture from falling, poorer physical state associated with low skin-fold thickness and neurological disease was evident when compared to controls (Brocklehurst et al., 1978). Campbell and colleagues (1981) associated functional disability or difficulty in performing activities of daily living, with poor general health, and found this to be a major predictor of falls caused by intrinsic factors. Prudham & Evans (1981), in a case-controlled comparison of fallers to non-fallers, found that fallers had more medical diagnoses than non-fallers and viewed this as an indicator of poor health status. Another study associated impaired general health of those that fell to errors in environmental perception, slowing of responses, and leg weakness (Wild et al., 1981). Not only has poor health been shown to be a risk factor for falling, but it is also a risk factor for serious injury, particularly hip fracture (Brocklehurst et al., 1978).

The third risk factor that is associated with falling in the elderly community-dwelling population is impaired mobility and postural instability. Wild and colleagues (1981) tested for gait and balance and found that people who fell were more likely than controls to have abnormal gaits and balance. Another community-based study of 553 participants who fell found that disorders of gait and the use of walking aids were predictors of falls (Campbell et al., 1981). Brocklehurst and colleagues (1978) found no statistically significant difference in mobility between individuals that were admitted for treatment for hip fracture from falling and individuals in the control group.
However, the criterion used to determine mobility was questionable; it was judged on the ability of the individual to go outdoors rather than on testing a person's gait and balance. Factors other than mobility could have affected individuals' abilities to go outdoors. However, it is significant that for the fracture group, only one third of those aged 85 and over had been able to leave the house in the past year and 9% had been chair or bedridden. Although the individuals in the control group were slightly more mobile, the difference was not statistically significant.

The fourth risk factor for falling is a history of previous falls. Brocklehurst and colleagues (1978) found that in the group that sustained hip fractures, a history of falls was obtained more often than in the control group. However, the difference in these two groups was significant only for subjects over the age of 85, indicating that this risk factor is strongly associated with advancing age. In a large study of 2497 elderly community-dwelling individuals, Prudham and Evans (1981) found that 28% of the participants had fallen in the previous year, and 46% of this group had fallen more than once. Craven and Bruno (1986) found that 50% of those that had fallen had experienced two to four falls in the past year, and 11% had fallen more than four times. In another study of 125 community-dwellers who had fallen, 50% had experienced more than one fall while only 10% of the controls had fallen more than once (Wild et al., 1981). There is a strong association in the literature between increased mortality rates and frequent falls in elderly persons. Gryfe and colleagues (1977) noticed a clustering of falls prior to death in
some subjects and suggested the possibility that falls may be premonitory events of death.

Women were at greater risk for falling than men in community-based studies (Campbell et al., 1981; Gryfe et al., 1977; Prudham & Evans, 1981). It has been argued that women are at greater risk for falling because the life expectancy for women is longer than for men and advancing age is a significant risk factor. However, Gryfe and colleagues (1977) found a higher rate of falling in females compared to males in all age groups, the overall female to male ratio being 1.3:1. The large sex difference in falls among the elderly may be explained by the usually greater activity of older women in household occupations which may lead to falls (Gryfe et al., 1977, p. 208). Campbell and others (1981) noted that women were receiving considerably more psychotropic drugs than the men in their study and suggested that this contributed to a higher rate of falling in women.

Some other risk factors for falling of a social and psychological nature have been identified in the literature. However, due to the design of the studies, methodological weaknesses limit the generalizability of the factors. Nevertheless, it is the writer's belief that they are important areas of concern for nurses.

The living arrangements of elderly community-dwelling individuals have been examined in some studies and the significance of living alone as a risk factor is not clear. Perry (1982) found no association between living arrangements and falling after controlling for medical and functional status.
However, the attrition rate in this study was high and the sample group was small; only 64 of the original 105 subjects were interviewed at the end of one year. In a much larger community study, living alone was associated with an increased risk for falling; however, it was also associated with being old and female (Campbell et al., 1981). The literature suggests that living alone contributes to social isolation which in turn increases the risk of falling (Hogue, 1982); however, this suggestion has not been substantiated through research. Regardless of whether living alone is a risk factor for falling, little is known about what it is like for individuals who do have concerns or experiences in relation to being alone when they fall and being unable to get appropriate help. This should be an area of concern for community nurses.

Cerebral dysfunction, depression, confusion, and dementia have all been implicated in falls but due to several problems with terminology and methodology, the association is not clear. For example, Campbell and others (1981) found that the group of people who were recurrent fallers tended to be more depressed but depression was not found to be a major predictor for those liable to experience recurrent falls. Furthermore, due to the retrospective nature of the study, it could not be determined if the depression preceded the fall or was a manifestation of falling. Wild and colleagues (1981) reported that 62% of the people who fell and required medical treatment for their falls had moderate to severe cognitive impairment as compared to 32% of the non-faller group. However, the researchers did not indicate how the impairment was assessed nor did they make a clinical diag-
nosis of the cause of the impairment; depression, confusion, and dementia can each cause cognitive impairment and have differing implications for nursing care.

The Experience Of Falling

The literature reveals a dearth of knowledge about what the experience of falling is like from the individual's perspective. Authors make suggestions and hypothesize about the experience but their conclusions are not research-based. To describe the structure of lived experience, it is necessary to understand both the cognitive subjective perspective of the person who has the experience and the effect that perspective has on the lived experience or coping behavior of that individual (Omery, 1983, p. 50). The theoretical literature according to the three components of experience, cognitive appraisal, emotional response, and coping can be used to make some predictions about the experience of falling and justify the need for nurses to understand this phenomenon from the individual's perspective.

The cognitive subjective perspective is the thinking and feeling part of the structure whereby the individual cognitively appraises the fall and circumstances surrounding the fall trying to ascribe a cause to the event (Lowery, 1981). Concurrently, the individual interprets the significance of the causal attributes and circumstances in accordance with his or her personal values and beliefs. This interpretation generates an emotional response or feelings (Lazarus & Folkman, 1984, p. 273). The second structural part of the
falling experience, the effect of the individual's perspective on the lived experience or coping behaviors, is behavioral in nature and is in constant interaction with the cognitive subjective perspective. The individual cognitively searches for potential resources to assist with coping, generates and evaluates possible solutions, selects suitable coping behaviors, and implements them. The selection and implementation of a particular coping behavior is determined by the initial cognitive subjective appraisal.

There have been no studies done to indicate what the elderly think about their falls. However, anecdotal comments and suggestions from authors indicate that this is an area that nurses need to investigate and understand if they are going to act in a supportive role with community-dwelling individuals. One author suggested that the elderly attribute their falls to old age and that they view falling as "the beginning of the end" implying that the elderly believe that the predisposition to falling is irreversible and progressive (Tideiksaar, 1986).

Emotions or feelings in relation to falling are generated when the individual interprets the personal significance of the causal attributes of the fall in accordance with his values and beliefs. There have been no subjective studies conducted to describe the emotional experiences of elderly community-dwelling individuals who fall; feelings that are identified in the literature are largely the assumptions of the authors.

Fear is the most common feeling alluded to in the literature in relation to falling. It is suggested that the elderly are fearful because of the conse-
quences that they may face as a result of falling. Injury resulting in loss of mobility and independence is the major consequence of falling; morbidity statistics confirm that this is a substantial consequence (Hogue, 1982). Fear of institutionalization and associated losses such as loss of home and control over daily activities is another feeling that has been suggested in the literature. Studies done to determine the precipitating problems for nursing home admission found that frequent falling was the most common precipitating cause (Smallegan, 1983). Fear of death from falling, though it has not been identified in the literature, should be addressed in light of the one-year mortality statistics following a fall (Wild et al., 1981). Although studies confirm the gravity of the consequences of falling and therefore validate the fears that elderly persons must experience, there have been no studies to confirm and describe the fears from the individual’s perspective.

The literature on falling also implies that self-esteem in the elderly person is diminished due to the feelings of embarrassment, incompetence, and shame that are assumed to be experienced by the individual. Except for a few quotations from elderly persons who fell in one institutional study confirming feelings of shame and embarrassment (Morse et al., 1985), there have been no studies that confirm that falling reduces self-esteem. However, given the risk factors associated with falling such as impaired balance and gait, advancing age, poor health status due to chronic illness, and a history of previous falls, it would be useful to determine individuals’ self-perceptions in order to understand what the experience of falling is like.
There have been no studies that have examined how the elderly cope with falls. Generally, it is believed that individuals lose confidence in their ability to ambulate safely and therefore restrict their activities to avoid another fall. (Hadley et al., 1985; Mossey, 1985). It has been suggested that the major consequences of activity restriction, whether it is self-imposed or due to immobilizing injury related to a fall, are increased immobility, deteriorating general health, social isolation, depression and, therefore, increased risk of falling (Hogue, 1982). If this is the case, the writer believes that we need to better understand this coping behavior in order to provide effective support to individuals.

Nonreporting of falls is another coping behavior that has been documented in the literature (Gryfe et al., 1977; Wild et al., 1981). Injury was rare in the cases reported by these authors. However, it is a concern from a preventative perspective in that individuals will, with repeated falls, eventually sustain an injury if the extrinsic or intrinsic causes are not corrected. The rationale for nonreporting from the individual's perspective has not been studied, although it has been suggested in the literature that the elderly do not wish to cause their families to worry about their safety and that unless an injury is sustained, the elderly do not feel that their physician can be of assistance (Tideiksaar, 1986). The writer believes that an understanding of the rationale for this coping behavior will enhance nurses' abilities to provide more effective care.
Summary

This chapter reviewed literature which might provide information as to the elderly community-dwelling individual's perceptions of the experience of falling. The emphasis of research to date has been on the causes and risk factors associated with falling; there is a dearth of information on the subjective experience of falling from the perspective of the individual. Little is known about the elderly individuals' perceptions of the causes of their falls. The associated feelings and coping behaviors that are identified in the literature are largely the assumptions and suggestions of authors rather than research findings. The following chapter describes the methodological process used for this study.
CHAPTER THREE

Methodology

Introduction

The phenomenological method was used for this study to enable the researcher to understand and describe the meaning of falling from the perspective of the participants. In this chapter the following methodological topics as they were applied in the study are addressed: participant selection, data collection, data analysis and ethical considerations.

Selection of Participants

In the use of the phenomenological method, the informant becomes a co-researcher and therefore, selection of the participants is dependent upon their ability to function in this role. Purposeful sampling is one sampling design used in qualitative research whereby informants are selected who will facilitate the development of the theory because they "have specific characteristics or knowledge which will add to, support or refute the theory, thus enhancing the researcher's understanding of the setting" (Field & Morse, 1985, p. 95). The following is a description of the selection criteria, the procedure for selection of participants, and the characteristics of the individuals who became co-researchers in this study.
Selection Criteria

The following criteria for selection of participants were purposefully developed and used in order to ensure a sampling of informants who were knowledgeable about the phenomenon of falling and could increase the researcher's understanding through their descriptions. The rationale for establishing the specific criteria are subsequently given. Each informant will:

1. have experienced at least one fall in the previous 12 months.
2. be able to recall and describe the falling experience.
3. be living in a house or apartment which is not part of a care facility.
4. be able to converse fluently in English.
5. be living in North or West Vancouver.
6. be 65 years of age or older.

To ensure familiarity and optimum recall of the details of their falling experience, it was specified that at least one fall had occurred within the previous twelve months. It was felt that confused or depressed individuals would have difficulty in their ability to recall and describe their experiences with falling to the depth required of this study. Therefore, to screen out potential participants who were too confused or depressed to participate in the study, it was specified that individuals have the ability to recall and describe their falling experience. Because the focus of the study is the experience of falling for community-dwelling elderly individuals, it was specified that participants not
live in a care facility where factors such as environmental hazards and social support can alter the experience. The researcher is fluent in English only, therefore, it was specified that participants be fluent in English to facilitate ease in expressing their thoughts and feelings, and to promote understanding by the researcher. Participants were required to live in North or West Vancouver due to time and cost factors and to allow the researcher to interview the participants in the familiar setting of their own home. The age specification was to ensure that the falling experience was described from the perspective of the elderly individual.

**Recruitment Procedure**

A specific procedure to acquire participants was planned and followed. The nurse assessors at the Long Term Care Department of a local health unit were given a verbal explanation of the study by the researcher and the selection criteria were discussed in detail. Over the course of approximately three weeks, the nurses considered their clients for the study as they made routine visits to them in their homes. If the individual met the selection criteria, the nurse explained the study and asked for permission from the individual to be contacted by the researcher. This step, obtaining permission to be contacted, was necessary to ensure that the individuals did not feel that there was a breach of trust on the part of the assessor and in light of suggestions in the literature that falling can be a sensitive issue for some elderly persons. A letter of explanation, provided by the researcher, was left with the individual (see Appendix A). Once individuals agreed to be called,
the nurse referred their names to the researcher, they were contacted by telephone, and further explanation was given. If an individual agreed to participate, an appointment was made for the first interview. At the outset of the first interview, the individual's consent to participate was formalized by the signing of a consent form (see Appendix B).

Characteristics of the Participants

Eight women participated in this study. Their ages ranged from 72 to 87, with a mean age of 82. One woman had experienced only one fall in the past year while the others had had more than one fall. Two had been hospitalized in the past 6 months for treatment of fractures of the hip and knee and both of these women had experienced previous fractures in the past few years. Four women had had fractures of bones in the past but sustained only bruises and lacerations with their recent falls. Two women had never sustained a fracture; however, they reported substantial bruising and lacerations from their falls.

Seven of the participants lived alone; the eighth shared a home with a daughter who was absent from the home during the day. Of those who lived alone, five lived in apartment suites, and two continued to live in their own homes. One apartment-dweller had to walk up one flight of stairs to her suite while the others used an elevator. The two women who lived alone in their homes had two or three stairs to contend with at the front and back doors. The woman who lived with her daughter lived in a split-level home and had to go up a flight of stairs to the bathroom and bedroom.
All participants had severe gait impairment; one woman was only able to take four or five steps. They all required a walking aid although one woman refused to carry a cane that was recommended by the physiotherapist. Standing up from a chair was difficult for all participants and their initial few steps were very unsteady. Additionally, they were observed to sit down in an uncontrolled fashion, simply falling backwards into their chairs. All of the women had multiple, chronic health problems which had the potential to cause falls or impair mobility. These included congestive heart disease, hypertension, diabetes, cerebrovascular disease, peripheral vascular disease, and immobility from previous fall-related injuries. All participants were noted to have visual deficits and five of the seven complained of "glare" problems from cataracts. All women took at least two prescribed medications and one woman took eight.

Five of the eight participants were dependent on family members for transportation although they went out no more than twice a week. Two women drove their cars for social outings although one sold her car during the study. The eighth participant took the bus to the seniors’ center once a week and depended on a friend to drive her home. Grocery shopping was done by family members or friends except in one case where the participant lived next to the grocery store and did her own shopping. All participants received home-maker help at least once a week.
Data Collection

Knaack (1984) states that the phenomenological method requires an "attitude that seeks to meet phenomena on their own terms and not to press them into the mold of preconceptions" (p. 111). It is the researcher's responsibility during the data collection process, therefore, to "evoke description from his co-researcher without telling his co-researcher what to say" (Knaack, 1984, p. 111). The interview technique is often used to collect data and various strategies are employed by the researcher to facilitate a thorough and rich description of the experience during the interview. Effective listening skills are necessary and include the technique of bracketing whereby the researcher consciously sets aside any personal preconceptions about the phenomena (Knaack, 1984). Additionally, the researcher formulates and asks open-ended questions to encourage the co-researcher to describe all aspects of the phenomena that have personal significance and meaning. Furthermore, reflective listening skills are utilized whereby the researcher listens for key words or statements, and responds by asking the co-researcher to explain these statements more fully (Knaack, 1984).

Data were collected during in-depth interviews ranging in length from one to three hours. In keeping with the phenomenological method, the researcher used techniques that would facilitate the role of the participant as co-researcher. Reflective listening and open-ended questions were used to encourage a thorough and rich description of the experience. Interviews were conducted in the comfort of the participants' homes to ensure security
in expressing feelings. The initial interview was guided by sample interview questions (see Appendix C). However, the researcher listened for cues and responded with further open-ended questions. Subsequent interviews were guided by the fruits of analysis and the U.B.C. Model for Nursing framework which directed the researcher to assume a broad perspective when gathering data.

Six of the eight participants were interviewed twice. In the cases of the remaining two, second interviews were not possible. One woman went out of town to stay with her grandson for a month and was unavailable at the time of the second interviews. The other woman had family from out of town come to stay with her at the time of the second interviews and was reluctant to discuss her concerns about falling in their presence. The second interviews generally occurred four to six weeks after the original interview. Data collection proceeded in conjunction with ongoing analysis of the data whereby the researcher looked for themes within individual descriptions, compared and contrasted themes between individuals, validated perceptions of themes, and rejected themes that did not appear to have shared meaning. It was an evolutionary process, and towards the end of the second interviews, the researcher was able to ask more pertinent questions based on a clearer conceptualization of the meaning of the experience.

The interviews were all audio-tape recorded in order to facilitate data analysis. Additionally, the researcher kept written field notes of the interviews, the telephone conversations, and the often extensive discussions that
occurred either before or after the recorded interview. Field notes are used to supplement other forms of data gathering such as tape-recording where pertinent environmental and behavioral observations can not be recorded (Field & Morse, 1985). In the case of this study, observations about the living environment, non-verbal behaviors that conveyed mood or affect, and mobility factors were recorded.

Although the literature describes a common research dilemma where there is a role conflict between nurse researcher and nurse clinician (Field & Morse, 1985), this problem did not occur in this study. The researcher anticipated that the women in this study would request information about falling and how they could prevent falls; however, such requests did not occur. Perhaps because the study was originally introduced and explained to the participants by their nurses who maintained an ongoing clinical relationship with the participants, this problem was avoided.

Data Analysis

The process of data analysis occurred simultaneously with data collection. The audio tapes were transcribed by a typist and the transcriptions were subsequently checked by the researcher by listening to the tapes and reading the text simultaneously. Misconstrued words were corrected to ensure verbatim accounts.

Giorgi's interpretation of the phenomenological method was used to guide data analysis in this study (Giorgi, 1975). Initially, each transcript was
read straight through to gain a sense of the whole experience for each individual. The transcript was then read slowly and key statements or passages were identified, reflected upon, and a meaning assigned based on the researcher's interpretation. Through constant comparative analysis, the meaning units of each transcript were compared with the descriptions of other participants and common themes and variations within each theme emerged. Simultaneously, the researcher sought to validate and clarify the themes and variations through further interviews (Giorgi, 1975, pp. 74-75). In keeping with the phenomenological perspective that the quality of the description is determined by its ability to be recognizable by those people who live the experience (Oiler, 1982), the researcher sought acknowledgment from the participants that the themes and variations were relevant representations of their individual experiences. In relation to these, an overall organizing framework to describe the meaning of falls for participants was developed.

It has been suggested that credibility should be the criterion for evaluating qualitative research rather than validity which is the criterion used in quantitative research (Sandelowski, 1986). Credibility of a study is defined as presentation of "such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognize it from those descriptions or interpretations as their own" (Sandelowski, 1986, p. 30). Strategies are employed by the researcher to the ensure accuracy of description and therefore the credibility of the study. For example, evidence disconfirming tentative constructs is sought in the ongoing and ter-
minal analysis of data (Field & Morse, 1985). Instead of simply labelling the processes used in the study, the researcher describes and justifies what was actually done so that any reader can follow the progression of events and understand their logic (Sandelowski, 1986, p. 34). And finally, validating the descriptions with the subjects confirms the credibility of a qualitative study.

For this study, the researcher considered the data initially from a naive perspective and as analysis proceeded and themes emerged, a conscious effort was made to ensure that themes were valid by continually reviewing and reflecting on the data. When certain pieces of data did not seem to fit with the emerging themes, they were carefully examined to determine if they should be included as an atypical part of the shared experience of falling or if they should be discarded. Validation of the themes and their variations with the co-researchers was done on an ongoing basis.

**Ethical Considerations**

The approval of the U.B.C. Behavioral 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 this study.

Participation in the study was voluntary. A written description of the study was given to potential participants (see Appendix A) followed by a verbal explanation by the researcher. Written consent to participate was obtained prior to the initial interview. The written consent form clearly stated
that the individual was under no obligation to participate, could withdraw at any time, and could refuse to answer any questions without any risk to future and present health care. Participants were given a copy of the consent form (see Appendix B).

Confidentiality was maintained. The audio tapes and transcriptions were coded and only the researcher knew the identity of the participants. Access to the audio tapes and transcriptions was limited to the researcher, the two members of her thesis committee, and her typist. The audio tapes will be destroyed when the study is completed and none of the written material pertaining to the study used names or identifying information.

At the request of the participants, a written summary of the findings will be mailed to them once this thesis is complete. There were no anticipated risks in this study, and the participants' expressions of appreciation in having an empathetic listener indicated that there was therapeutic value inherent in the interviews.

Summary

In this chapter, the design and methodology for this study were described. Discussion was included with regard to participant selection, data collection, data analysis, and ethical considerations. In the next chapter the findings of the study are presented.
CHAPTER FOUR

Findings And Interpretation

Introduction

In this chapter the findings of the research are presented. An integrated description of the meaning of falling from the perspective of the elderly community-dwelling individual is presented in the form of an account generated from and in relation to the data provided by the individual participants. This description of falls evolved from constant comparative analysis of the participants' explanations of their experiences and in relation to the specific questions that directed this study:

1. How do individuals describe what it is like to fall?
2. How do individuals explain the circumstances of their falls?
3. How do individuals describe their feelings associated with falling and the potential for falling?
4. How do individuals explain how they cope with falling and the potential for falling?
5. How do individuals describe the effects of falling on their daily lives and expectations for the future?
6. How do individuals conceptualize the various aspects of falling which together represent the meaning of falling for them?
Falling was a significant event in the lives of the eight women that participated in this study. The significance was evidenced by several observations. First, participants were able to recount their stories easily and in explicit detail indicating that the event was of such importance that the details could not be easily forgotten. In spite of the fact that several participants complained of short term memory loss, they were all able to recall their falls in the detail described. The language that participants used to describe their reactions to falling was also indicative of the significance of falling. For example, they used words and phrases such as "desperate," "helpless," and "I'd be better off dead," indicating a deep emotional component to their experiences with falling. Furthermore, the significance of the phenomenon was evident in their need to repeat their accounts of specific falls in the same interview and in subsequent interviews. The significance is illustrated in the stories of three women:

And then I thought again, later on I thought, I wonder if I could crawl up to the back door. I was by the rhododendrons...stand, pull myself up, ease myself over to the lawn, like say this is the lawn, move myself, and then I thought, oh, if I do that I've got no protection. I'll have nothing to cover myself up with. And I was glad I didn’t because my knee was broken. I knew that it was hurting and the leg was swollen but I didn’t realize that I had broken it. So I gradually got back and was willing to sit there all night. It was an awful experience, really!
This woman remained on the ground in her garden overnight for sixteen hours until a neighbor discovered her. It rained throughout the night and she experienced extreme pain and discomfort.

Two other women described their experiences with falls:

I couldn’t move. The man downstairs heard it and he came up and I had the chain on the door and he kept calling my name and I said I can’t get up, I can’t move. So I laid there...nobody home...the phone was here and I was over there. I looked at the phone and inch by inch I got the phone. I pulled it down and dialed the operator. I told her to get the ambulance, I live in an apartment and I’m all alone, and I’ve fallen and I can’t move. She said what’s your name and address and they will be there right away. In ten minutes they were there and they just kicked the door in!

Well, you see, I’ve got no strength, I can’t get up. It took me about a good 15 or 20 minutes before I finally got myself up on my knees, crawled over to the edge of the bed and got up, and then I managed to wriggle up on the bed and I laid there for a while until I got my breath, you know. And then I got up and straightened the chair up. Falling is desperate, you know, when you can’t move.

From these accounts, it is apparent that falls were events that had significant meaning to the participants and knowledge of the researcher’s interest in this event stimulated lengthy descriptions of the circumstances of their
falls. Several women commented that, even though they had experienced several falls, this was the first opportunity that they had had to talk to anyone at length about their falls. By way of explanation they claimed that they were reluctant to talk to their families because it caused them to worry, they felt that it was inappropriate to talk to their doctors, and they perceived that the long term care nurses did not have sufficient time to listen to all of their concerns in relation to falling.

The participants perceived the profound impact that falling had on their lives on three different conceptual levels. For this reason, the findings are presented in terms of three categories which together represent their entire perspective of the meaning of falling. At the first and most superficial level, participants interpreted the various aspects of their falls. This category of data consisted of three components: appraising the circumstances of their falls, recognizing losses, and finding explanations. At this level, participants came to view falls as a major symbol of growing old. The second conceptual level includes the participants' reaction to their interpretation of falling. This level also contains three components: worrying about falling, managing the worry, and accepting falling. At this level participants came to terms with falling by accepting their falls as an inevitable part of growing old. The first and second levels were explained in terms of the third and most profound level. Because participants' interpretations and reactions to falling were associated with aging, coping with falling occurred within the context of coping with aging. This level contained two components: regaining abilities and search-
ing for meaning. Participants found new meaning to growing old as they looked for opportunities to enhance the quality of their lives at this third level. Together, the three levels represent the the whole meaning of falling for the participants. Thus, the way to understand the meaning of falling in its entirety is to understand the three levels and their interrelationships. For this reason, the findings are presented in three categories which together represent the meaning of falling for the participants.

Interpreting Falling

"Interpreting Falling" is the first and most superficial level whereby participants interpreted the various aspects of their falls and sought an explanation for falling. This category of data consisted of three components: appraising the circumstances of falling, recognizing losses, and finding explanations. The findings are presented according to the three components.

Appraising The Circumstances Of Falling

All participants were frail elderly women with multiple health problems and their falls could have been caused by any number of factors which were clearly recognizable to the researcher. Despite these seemingly obvious causes, all participants demonstrated a lack of insight into the cause of their falls. For example, one individual stated that "my equilibrium is all shot" but she could not provide an explanation for the cause. Her falls occurred without warning and as she fell to the ground slowly, she was unable to stop the fall. One woman had deduced that her falls were due to a pinched
nerve in her neck although she had never been medically diagnosed with this condition. Another participant, who fell while rushing to the bathroom after taking a strong laxative, found the episode so embarrassing that she could not recall falling. She rationalized that she had taken the laxative on two previous occasions without incident and therefore rejected suggestions that the laxative had caused her fall. She spent several weeks puzzling over the incident, which she describes in this passage:

   I talked about it too much...I don't worry but I, you see, I'm trying to put the pieces together. Because, you can't have one thing happen that doesn't show any sign somewhere else, if you know what I mean?

   Another woman also rejected her family's suggestion that the medication she had taken for sleep had caused her to fall. She had fallen and sustained fractures on previous occasions and her gait and balance were noticeably impaired. She described what happened in the following passage and did not attribute her fall to her impairments nor the medication she had taken:

   I woke up about 12 midnight and came out and looked around and thought, I'm hungry. I sliced a piece of bread that I had baked, and I have a nice chair that swings around, it's a swivel chair. I had a glass of milk and put it on the table over there, and grabbed the chair, my foot slipped and it threw me.
When participants fell but sustained no injuries they often described their falls quite succinctly as in the following statement:

I'm down and that's all I can say about it. No pain or anything! No nothing.

In general, participants did not draw conclusions as to the cause of their falls by appraising the actual fall. Instead, their thoughts shifted to their health and physical condition.

All participants perceived that they were in good health which they generally defined as being without pain. As one woman stated:

I think when you get along in years and you're not in any pain in any particular spot, you're lucky, you know.

[R: So being pain free is something that is important]1

Well, to feel that you're in good health...to be pain free...that's necessary.

Even one woman who was severely impaired from fractures sustained from previous falls, and who also experienced arthritic pain felt that she was in good health. She describes her perception of her health:

The doctor said when I had a cardiogram, he said it's ticking like a teenager. He came into the room and said I hear you're a very healthy

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1 "R" is used to identify the researcher in the body of this chapter.
young lady. I said "oh am I?" and laughed...I've got arthritis in my knees and my arms. Apart from that...it's not a disease really, is it? It's just a condition isn't it? You don't die from arthritis do you?

In appraising their health, participants often compared themselves to friends who they thought were in poorer health. For example, one woman thought of one friend who belonged to her poker group:

See in the group that I played, six of us...um...one has lost, is losing her sight. Well, when I think a little thing like this with me, compared to what she is going through, she can't play, you can only go have lunch with her or tea with her.

And another woman who was recovering from a fractured hip compared herself to her sisters:

When I look at my poor sisters, the two of them, you know they are in pain, [one sister] has been in pain for two years, all her life, all her toes grown into one. One big toe way over here. I don't have any of that, no trouble with my feet, my legs, I am lucky, very lucky.

All participants also appraised their health in terms of mental status. Except for one participant who at the initial interview was over-sedated, all emphasized their abilities to understand what was going on in the world through television, radio, and newspapers. Even though some participants experienced some short term memory loss, and for example, could not remember what they had eaten for breakfast that day, they appraised their mental
competence on their knowledge of what was happening in the world. One woman stated:

You see, being here all day long...I listen, I listen to the radio or on, on the T.V. and I never miss a thing. I know what, I know more that’s going on than you do probably, because you’re so busy you don’t even know what’s going on.

For the participants, attributing a cause for their falls involved an appraisal of the fall and themselves. The causes of their falls which were obvious to the researcher, such as impaired mobility, medications, and chronic illnesses, were not considered by the participants to be directly responsible for their falls. Additionally, they minimized their poor health. This apparent lack of insight and minimizing their poor health was a mechanism that was used initially to avoid having to come to terms with their underlying thoughts about falling. Those underlying thoughts had to do with losses that they were experiencing as a result of falling.

**Recognizing Losses**

Participants reflected on the recent changes that had occurred in their lives. Many of these changes were interpreted as losses.

One such loss was in relation to their strength and level of energy. Participants complained of chronic fatigue and weakness which interfered with their activities:
The only way it's changed me is that I'm always tired and I don't like it. I want to write letters and I just cannot make myself do it. I can't make myself...

I get weaker by the day it seems to me. I can't do everything. I can't go shopping for instance as easily as I would like, you know, go and get a quart of milk or anything like that.

Their expectations that they would regain their strength if they exercised and resumed their regular activities were not met. One participant's description illustrates this unmet expectation:

The whole thing was very shattering because I'm not getting going the way I was before. With the children, I've been out to dinner at their house, mostly for lunch...then it started getting late and I was dead tired and all I wanted was to get home... And I don't know if I should rest more or exercise. I heard people say, "Well if you'd get up and walk that leg will clear up," well it doesn't and I exercise with the weights....

Similarly, one participant who fractured her knee thought about her inability to walk even though she had expected to do so if she exercised routinely:

I've got no strength in the legs and yet I've exercised. I exercised twice a day, half an hour morning and half an hour in the afternoon. My muscles are stronger from here but it doesn't help me to walk you
see. I thought when my muscles were better, I would be able to walk, but it doesn’t help my legs to walk.

Beyond the losses of strength and energy, participants recognized even more significant losses such as losses in mobility and independence. When participants were no longer able to ambulate or stand without difficulty, they realized how much impact this had on every aspect of their lives. One woman stated that since her fall she didn’t do anything much because, "to begin with, I...it’s hard to walk."

Living in a house as opposed to an apartment exaggerated these losses for two women in the study. The responsibilities associated with maintaining their homes, especially gardening and outdoor maintenance activities, were particularly difficult in light of their loss of mobility. For many years they had experienced feelings of pride and accomplishment from tending to their homes and gardens, but their present inability to perform such activities increased their frustration as described in this passage:

Usually I have a lot of greenery around here, but, I can’t do anything anymore. I can’t go out there and sweep this place. See, I can hardly stand up properly.

All participants recognized that falling had a noticeable effect on their daily activities; except for occasional outings, they realized that they were unable to manage outside of their homes:
You can’t go anywhere, you can’t do anything, you know, like often you hear about things going on and different concerts and things you would like to go to. There’s no darn way you’re going.

Participants lost their confidence in being able to cope outside their homes; they were afraid of getting into a situation where they might fall again. To them, the world outside of their homes was an unsafe place that they were hesitant to enter. Consequently, several days would go by where participants did not leave their homes or apartments unless there was a family member or friend that accompanied them and could ensure their safety:

I haven’t been out since my niece brought me home after Thanksgiving Day. I went out there in White Rock for the weekend. She brought me back on Monday night. I haven’t been out since. I have been out in the hall here and out on the patio but that’s it.

In another instance, one woman who had been discharged from hospital in May did not venture outside her home until October.

In addition to recognizing losses related to mobility, participants described increasing dependence as another form of loss. For example, one woman described how falling had affected her sense of independence:

It’s [falling] cut off my independence. I can’t look after myself the way I should do. You see, I have to have my, a friend of mine does my shopping for me... then my goddaughter looks after me, when she comes she will wash and set my hair, cut my toenails. That’s some-
thing I can't reach anymore and I couldn't go to the pod...[podiatrist] what do you call them? Ah, you know, even if I took a taxi, I don't know if I could walk up there or not.

Another woman succinctly described her perceptions of changing independence after her fall:

It happens and then you put yourself into someone else's hands that knows what to do really. That's all I can say...I'm just dependent on someone else helping me.

For the participants in this study, falling changed their lives in that it lead to various losses. Following a fall, they initially noticed that they were tired and weak. They expected to regain their strength and energy but this expectation was not met. They also recognized a loss in mobility and realized how important walking had been to them. As a result of losses in mobility, they lost their confidence in venturing outside of their homes. Thus, they perceived a more general loss of independence because of the experience of falling.

Finding Explanations

The participants provided an explanation of their falls and the resultant losses in relation to growing old. For the participants, falling was the point of recognition that they were old even though age-related changes had been previously noted:
And it makes you realize that, at least I didn't realize how...I knew I was old. I'd never felt young for my age particularly, but I was able to do everything. But not the last year or so.

For the youngest woman in the study, aged 72, falling conjured up significant thoughts of aging:

Yes, it [falling] made me feel old. I suddenly realized, like I never had any...I had very...I was...I've been very...my legs were very supple. Never had any problems with my legs ever. You know what I mean? I never...they didn't ache or hurt. And it's...you suddenly think, my God, I really am old!

Prior to falling, participants had not really thought of themselves as being old. For some who felt that they looked particularly youthful or "well-preserved" as one woman put it, they did not disclose their age to others prior to their falls. However, after they fell, their perceptions about their age changed and they began to disclose their age to people that they came in contact with:

Well, I never used to tell my age. People used to guess my age...they'd say, "Oh somewhere in the late sixties or so." And I'd never say anything. But since this happened...[the fall] I don't know...I just think people should know, you know. Like the girl at the lab where they took my blood...I thought that she should know.
Falling not only caused participants to recognize their age, but it also caused them to wonder what the experience of getting even older was going to be like. As one woman explained:

Well then you, you just wonder what it’s going to be like...just getting older. I mean you don’t need bangs [on your head when you fall], you’re going to be weird anyhow.

She continued on to describe how she perceived her future if she became bedridden from fall-related injuries:

...then I knew how people felt...people who are stuck in the house, in bed, and on their own. It’s, uhm, at my age, anything can whip you off suddenly or you can go into long, long, aching horrible illnesses.

And as their thoughts about aging shifted to the future, they thought about unfinished business:

I don’t think I have a future. No, I’m trying to, uhm, arrange so that everything will be okay after I’m gone. I don’t know what will happen. Yes, it made me very sad I hadn’t done an awful lot more than I did because you know and then, oh, all the things and the straightening out of the...I thought, my Lord, this is it and I haven’t done this and I haven’t done that, and I haven’t written to people...you know, I mean, that should have been done and I have to do it now.

Participants’ explanations of why they did not seek their doctor’s help when they had fallen but had not injured themselves further confirms their as-
sociation of falling to old age. They believed that falling was not an illness but an inevitable part of aging and because they thought that their doctors’ concerns were for illness, they saw no reason for seeking attention for falls. These perceptions are described by one woman who saw her doctor regularly but did not mention her problems with falling:

Well, I think that I’m eighty-six. I’m an old lady and he can’t do a thing for me, you know. I didn’t get any pills. I just got some for my heart and he says my heart is okay.

For the participants, falling was the point of recognition of growing old. This recognition stimulated thoughts of the future, unfinished business, and growing older. They found an explanation for their falls in relation to growing old as they came to view falls as a major symbol of aging.

Thus participants’ interpretations of their falls was a cognitive process that involved three components. The participants appraised the circumstances of their fall, which not only included an examination of the fall but also an examination of themselves, in order to attribute a cause to their falls. They did not consider some obvious causes to their falls; this apparent lack of insight was initially used to avoid having to come to terms with underlying thoughts about falling. Rather, they seemed preoccupied with various losses that they had come to recognize and associate with falling. These included losses in strength, energy, mobility, and independence. Furthermore, participants explained both their falls and the resultant losses in the context of
the larger issue of growing old and came to view falling as a major symbol of growing old.

Reacting To Falling

"Reacting To Falling" is the second conceptual level in which the participants perceived the phenomenon of falling. This level includes the participants' reactions to their interpretations of falling and consists of data organized into three components: worrying about falling, managing the worry, and accepting falling. The findings are presented according to the three components.

Worrying About Falling

All participants were afraid of falling which caused them constant worry. This was evidenced by their ability to recall and describe their falls in explicit detail, especially the physical sensations of the fall. One woman describes the anxiety related to body control that she continues to experience several months after her fall:

Well, I'm very nervous...I'm all right sitting but when I get up on my legs, I have a sort of shakiness. I don't visibly shake like that, but I felt as if my whole body from top to bottom feels like it's quivering somehow. That's how I feel and I don't move without that [walker]...I'm very, very careful.
Notwithstanding the sudden and unpredictable nature of falls for all participants, several other uncontrollable factors contributed to their fear of falling: the inability to get on their feet after a fall, the embarrassment or humiliation experienced, the possibility of having to relocate, and the dependency on others.

The experience of not being able to get back onto their feet after a fall caused participants to worry about recurrence of the experience and how they would manage. For seven of the eight women, living alone and not having assistance readily available compounded their worry:

I often...you see this is one of those things that used to worry me when I was in bed. I thought, if I fall down and can't get to the phone, and if I get to the phone I can't remember their numbers, what are you going to do? It's an awful feeling you know. Helplessness. I just don't think about it. Just hope for the best.

Embarrassment or humiliation was another factor for causing worry in the participants. When they fell in public or in the presence of people anywhere, they were very embarrassed, as one woman describes in this passage:

I had friends a couple of years ago, from England, and they stayed with me and we were talking on the stoop here, outside, and uh, I was going to take a step and was sure that my heel caught on something and down I went. You should have seen how badly I fell. So embar-
rassed, I had my nose right into the ground, my glasses came off, and no breaks or anything...

Participants regarded falling as a sign of incompetence and therefore felt that people who observed their falls considered them to be incompetent:

I didn’t hurt myself in any way. But where did they come from? I didn’t see anybody around...and all of a sudden there were young men, about half a dozen of them picking me up. And that was kind of embarrassing in a way, but uh, anyway...

[R: Can you tell me why it was embarrassing?]

Well, it seems so stupid to fall (chuckled). It is, it doesn’t... I don’t know, it just seems stupid.

Several participants experienced this acute embarrassment about falling whether or not it was observed by others. One woman described her feelings this way:

It’s stupid to fall. No I don’t...

[R: Tell me more about that...you said that it’s stupid to fall?]

Well it is! I mean, I was brought up with the idea that you didn’t fall over your feet. You walked carefully and properly and you ran and as long as you exercised lots you aren’t going to fall...if you did, you’d fall because somebody pushed you...
The prospect of having to relocate to some kind of a care facility caused further worrying for participants. They recognized that injuries sustained from a fall could cause increased immobility and dependence and therefore prevent them from living in their own homes; to live in their own home until they died was an option that they all hoped was possible.

The participants expressed a negative attitude towards care facilities for a variety of reasons. First, they valued their independence and liked to do things the way they had always been done. For example, one woman described how she hated to have things done for her:

They put the kettle on, they fill it almost for only two cups of tea...it irritates me, you know what I mean. It’s silly to do those sort of things, they don’t use their heads. I can’t say anything of course.

This woman disliked the idea of having others do everything for her and felt that she would be very frustrated in a care facility. Living in a care facility was also viewed as unnatural because one no longer had the opportunity to perform lifelong tasks in a familiar setting, as one woman explained:

They’re afraid of, not so much of, of the care and the people there, they’re afraid because they’re pulled away from all they’ve known, all their things around them, which they lived for in a way. They dust, they clean, they uh, those are part of their life. And you pull them out of there...
Other participants had developed certain perceptions of what residents of care facilities were like and didn’t want to be like them:

And I don’t want to go up there and see those people sitting around when they’re half asleep and hanging in chairs, tied into chairs...you know I, I don’t want to see it anymore. I don’t want to be part of it. I’d rather stay here and take whatever comes. And I’ll do the best I can as long as I can.

Furthermore, participants perceived that residents of care facilities were unhappy and preferred not to be there. One woman described how her sister-in-law acted every time she visited:

Oh, every time, it was ghastly, you would go and see her, because that’s all she’d say, "Get me out. Take me away, take me!" Because they know, because the woman in the next bed is dying. Then down the hall, is uh, [a woman] that doesn’t know where she is and then that’s all around them.

One woman who was waiting to be admitted to an intermediate care facility, was not looking forward to the move. She explained that she had lived at the facility for a month and that she did not like the experience because she found socializing difficult:

You really felt that you are always alone. I feel that way kind of because, you know they...they’re pleasant and they come down to meals
and all that sort of thing, but...you can’t pick up at that age and get very friendly with people. I don’t think.

For the reasons stated, the prospect of relocating to a care facility was regarded negatively by all participants. They recognized that more falls would hasten the need to relocate which therefore increased their worries about falling.

The final factor which caused participants to worry about falling was their reluctance to become a burden to their families. Five of the eight participants communicated with a family member, usually a son or daughter or adult grandchild, at least once a day. They enjoyed the interactions, but they disliked the thought of being dependent on their families. A common expression that they used was, "I don’t want to be any trouble." However, they were often caught in an interesting dilemma, because, out of concern for their elderly family members, families would often encourage dependence. One woman described an example of this:

I walked over on Friday to get a perm, my hair was driving me crazy and when my granddaughter found I went, she phoned to take me, it’s just across the road...so she phoned the hairdresser’s and said to keep me there, they would come and get me. I don’t like being treated like that.

This over-protective tendency caused some participants to have second thoughts about living with their families. One woman recalled the period in
her life when her mother lived with her and realized her error in encouraging her mother to be dependent. By not allowing her mother to participate in normal household chores and activities, she perceived that she had made her mother feel "useless" for the last five years of her life.

In contrast, many participants expressed deep concern about the possibility that they might be a worry to their families. One woman, who was moving to a care facility in the near future, was doing so because she felt that by living in her own home, she was causing her daughter to worry too much about her safety. She stated:

It isn't something I really want to do...I'm doing it because it's the easiest thing for everybody.

One woman, who was hospitalized for a fractured hip, reported that shortly after surgery she had experienced some frightening hallucinations in which she felt that her family was rejecting her:

Then my granddaughter came in and she stood there. I asked her what she had been telling the children. Not to come near me? And she just shook her head. Tell me if I've done something wrong. And I started to cry. Really cry. She'd walk away. It was just terrible.

This woman felt guilty that she had caused trouble and worry for her family. She stated later that she never wanted to put her family through that kind of experience again and said, "The next time I fall, I'll stay down."
Worrying was the significant reaction to falling for the participants in this study. They worried because they felt that they were living at risk for falling and they knew that another fall could add to their losses. Four factors heightened their worries: not being able to get back on their feet after a fall and being unable to call for help, the need to relocate to a care facility, the embarrassment or humiliation of falling in the presence of people, and feeling that they were a burden to their families. To manage their worries they implemented a number of strategies.

Managing The Worry

When asked if they worried about falling, participants indicated that they had worried in the past but that they had done certain things to reduce their worries. As one woman stated, "I don't worry...I just take care of it and I don't fall." Of course, with each new fall, their worrying increased until they developed new strategies. One woman stated, "Oh, I'll get over this one [fall] too, provided that I live that long." Their strategies provided control and predictability in their daily lives thereby reducing their worries about falling.

The most noteworthy strategy used by participants to manage the worry was to restrict their activities by staying at home; they felt more secure in their homes and therefore chose to remain there most of the time. As one woman stated:
I don't worry about it [falling] as long as I am here [at home] but I wouldn't go out. Oh, I have changed my mode of living. I just made up my mind that I've got to stay here.

Many claimed that their confidence was significantly reduced after a fall. Because the world outside their home was perceived as unpredictable, their chances of falling outside were presumed to be much greater. One woman's confidence was so badly shaken after a fall that she felt that she would not recognize anything outside of her home:

I just wondered if, how things had changed, that the whole world had probably changed outside...well I thought, now if I go out, I won't know the way anywhere.

By staying in their familiar environment, participants felt a sense of control over their daily lives.

As described earlier, the women in this study worried over being embarrassed if they fell in public, but they also worried about being unable to get help if they fell when they were unable to get help at home. Routine telephone contact with family or friends was a strategy they used to counteract this concern. Some participants called their families at the same time every day. For example, one woman called her daughter every night to let her know that she was safely in bed:

Oh, I have to phone every night when I go to bed. I always say, "Good night, Irene, I am in bed," this is, I'm saying this to my daughter.
Another participant, who had no family living nearby, received a telephone call from her homemaker every morning:

And everybody that knows that I fall you see, like my homemaker calls me every morning when she...she lives in Squamish and she comes here to work in these buildings. She has her breakfast in the next... at a friend's place in the next building. She calls me every morning about half past eight, "How are you today?" "Oh, I'm on my feet." "Good!"

If the participants did not answer the telephone or make their routine call, families became concerned and usually followed up with an immediate visit.

The telephone system gave participants a sense of security in knowing that someone would recognize a problem and eventually come to their aid. It was not a foolproof system, however, as one woman discovered. She fell in her garden and remained there all night until the neighbour called to make her routine check in the morning. When she was discharged from hospital and returned home, she felt overwhelmed by being alone again:

I felt like crying a lot you know...well I suppose it was just my condition of...my health wasn't good. I felt good in the hospital. I don't know...you feel you've got all these responsibilities when you're on your own. It's a different world when you come out.
Her confidence was partially restored and worries reduced when she rented an electronic call alert system. Unfortunately, however, technical problems with the system caused her to continue to feel insecure:

You never know what's in front of you. You have things happen to you that you never expect, don't you? I couldn't say, but I must say, I'm very cautious now.

Predictable daily routines and rituals were further strategies developed by individuals to enhance their feeling of control and thereby reduce their worries about falling. The daily routine of bathing, dressing, and eating usually took most of the morning to complete; participants stated that they usually were not "presentable" until noon. They performed each task slowly and carefully and took frequent rest periods to conserve energy. Participants disliked any interruption to their routine, such as visits by the researcher or appointments with the doctor. One woman who had wanted to participate in a senior's fitness program decided not to attend because it started at nine in the morning. She rejected the thought of disrupting her morning routine:

No everything happens over there, you know, at nine o'clock in the morning. And even one of the doctors, or somebody or a nurse said, "No don't go for that!" It was the physiotherapist..."That's too early for older people, they shouldn't leap out of bed and go and do exercises."
To decrease the risk of falling, individuals avoided getting on their feet as much as possible. For most of the afternoon, they sat in their favorite chair while watching television and kept everything that they might need such as the telephone, T.V. program schedule, and remote controller within easy reach. Overall, watching television was their primary activity not only because it was entertaining but also because there was no risk for falling and no energy output required. Their favorite programs usually consisted of talk shows, and they expressed an admiration for the hosts of such shows; "Oprah" and "Donahue" were often mentioned and admired for their ability to interact with the audience. One woman stated that "television was a Godsend for older people."

Even though they relinquished some independence by accepting homemaker help for their household chores, all participants appreciated this assistance. They recognized that homemakers enabled them to continue to live in their own homes and thus maintain control over their daily lives. They developed a close relationship with their homemakers and viewed them as friends. They felt comfortable in asking them to do extra duties that were not part of the normal routine but facilitated their ability to manage. For example, often homemakers would call ahead to see if participants needed any grocery items or they would notice when participants were running out of toiletry items and go out of their way to purchase them on sale.

Participants in the study developed their own strategies for ambulating in their homes. For every problem that was encountered in ambulating,
they developed a method for dealing with the problem and incorporating it into their routine. As one woman stated, "I've got it down to a fine art really." Even though six women used walking aids, they found it difficult to perform some tasks with their aids. They therefore used pieces of furniture or the walls to maintain their balance. Walkers and wheelchairs were cumbersome, especially in the bathroom. Two women described how they managed:

The bathroom is small and so you scrape the wall, so I just get up, hold the door knob and wash basin and then I can hold onto that until I get to the toilet.

I just am more cautious and I stay here and when I go down and get the mail or dump the garbage I'm very cautious to reach out and touch the wall...it keeps me balanced sort of.

Any task that participants had to perform close to the floor required that they get onto their hands and knees. Getting up from that position was difficult and done by crawling to a low chair, bed, or couch where they could pull themselves up:

Well, you see, the homemaker, she doesn't use...she won't get down and wash the floor on her hands and knees, she uses one of those squeegee things. I don't like that, doesn't do a very good job. So every once-in-a-while I like to give it a good cleaning but the problem is I can't get up once I'm down. So I've got a chair over there in the living room and I crawl to that and pull myself up onto it.
Meal preparation was difficult because all participants said that their legs were too weak to stand for any length of time. For supper, most participants ate prepared frozen meals or families dropped off meals that just required reheating. For breakfast, one woman felt that it was easier to routinely prepare part of the meal the night before:

Well, I leave everything ready overnight. I don't eat much breakfast, maybe just prunes and cereal and a boiled egg. That's my breakfast, and that's put ready at night, not the milk...I sit in my chair, the saucepan's there, get the milk out, and put the stove on. Now I can make everything in 10 minutes. Then after I lay down for a rest, then I straighten the bed.

Other participants described similar types of behavior for meal preparation where their routine was ritualistic in nature. These rituals provided a sense of control and predictability:

It's the same thing in the morning. One morning I have cereal for breakfast, the next morning I have poached egg. With a poached egg in the morning I have to take my calcium and my water pill. And the cereal morning I don't take either. Now I take the water pill...I always make a point of taking my glass of water first thing when I get up in the morning.

For outings, all participants had defined a manageable walking distance and would not attempt to walk any further. For one woman, who drove
her own car to the seniors' center once a week, it was necessary to go early in the morning to obtain a parking spot nearby even though her activity did not start until 1:00 p.m.:

My back gets tired, my legs get like they are not going to hold up. Although I drive my car all the time, if I am going anywhere I have to be able to park close enough so that I can walk in, so that it's not too far to walk. When I go to [the seniors' center] on Tuesdays to play cribbage, well lately it's got so that I have to go up there at about half past nine and park where I can find a parking spot close enough, well that means that I have to stay there practically all day. I sit in the car and watch people go in until about ten, then I go in and go to the library and then I go in the dining room and sit and talk until lunch time, have lunch and then at one o'clock we go in and play cribbage. We are through about three, I'm often home at three. I have to park my car down there and walk around here and by the time I get in here I've had it!

Unfortunately for this woman, the inconvenience of finding parking within her defined walking distance became intolerable and she sold her car during the study. Although she rationalized that it made no difference to her, that she could take a taxi for less than it cost her to maintain a car, it was noted that her enthusiasm for outings had diminished:

And at least when you're in a taxi, usually they get you out and get you on your feet, and get you sort of going...but I'm afraid I'm going to
have to stop that too because my walking is so bad. I'm so jittery you know.

Two other women had organized certain activities within their walking distance and felt comfortable and safe in carrying these out. For one woman, a daily walk to the supermarket next door for a few grocery items was a safe distance for her. For another, walking a block to the bus stop and then taking the bus to the seniors' center for her weekly painting class was all that she could manage. She took a taxi home unless she could arrange a ride with someone at the center. Getting on and off the bus was difficult and she depended on the assistance of other passengers. She had begun to lose interest in going to her class each week, stating, "Although you know, I think it's too much...too hard to do. Perhaps this will be all, uh...after this one [painting]." Four other participants had decided that they could not walk safely outside of their homes and therefore went out only when accompanied. These outings usually consisted of a visit to their sons' or daughters' homes for a meal.

Thus, to manage their worries associated with falling, participants implemented various strategies to increase their feelings of control and predictability over their daily lives.
Accepting Falling

Because the participants explained their falls in the context of the larger issue of growing old and came to view falling as a major symbol of growing old, the way they reacted to falling is understood in the same context.

Participants explained that they came to terms with the changes that had been occurring in their lives by simply accepting them. Their expectations had changed as a result of the losses that they had experienced and they felt compelled to accept these changes. Fall-related losses were viewed by all participants as part of a greater number of losses associated with aging. One woman described how she came to terms with this reality:

Well, I have to make up my mind, you know, you have to know this. You’ve only got so long in this world. I’m as surprised as you are that I’m 86, you know. It doesn’t seem possible that I’ve been here all these years, you know. I would like to do the kinds of things you do. In fact, mentally I could. But physically, I can’t. It’s a matter of the spirit is willing but the mind is weak.

[R: So are you frustrated?] No, I’m not frustrated now. I’ve made up my mind that this is the way it’s going to be and that’s the way it’s got to be. You can’t carry on on all cylinders all your life you know. You’ve got to slow down some time. And this is God’s will and so slow down and accept it!
The increasing weakness and lack of energy that they associated with aging, as well as the immobility and dependence caused by falls, changed participants’ expectations of how they would live in the future. They realized that they could no longer do the things that they had done in the past and felt that acceptance of the situation was the way to deal with it.

All participants indicated the need to accept the changes in their lives. However, it was noted that the emotional expressions of acceptance differed among participants. Some participants felt satisfied with their lives despite the fact that they were limited in their functional abilities. One woman was very motivated to get well again because she wanted to spend more time with her great-grandchildren:

   Oh, I love life and I’ve got so much to live for! I’m going to get well again so that I can go up to [granddaughter’s] and be with the children. I love my family and I’ve got so much to live for!

This woman could no longer baby-sit her great-grandchildren because of her immobility but she still looked forward to spending time with them. In this way, she accepted the change and developed new, meaningful expectations of the future.

Conversely, some participants saw no hope for the future and felt that there was no purpose for their existence since they had experienced certain losses. They saw death as a solution to their unhappiness and despair. One woman described how she felt about her situation:
I'm very tired, yes very tired and weak...it's a sad business that we have to get old like that...nothing else left. I'm just wishing for to...get out of here you see.

Thus, acceptance represented attitudes ranging from hope to despair. In the women's explanations of these attitudes, three variables emerged as significant from their perspective. These were: their self-concept, their sense of purpose, and their social interactions.

Some participants in the study exhibited a positive regard for themselves; they felt good about themselves, confident, and thought that they were interesting people. These women had family or friends who gave them positive feedback and support. One woman described her family's advocacy on her behalf stating, "They're so proud of me, my mother's 87, and she does this and she does that." Conversely, those with a poor self-concept felt that people regarded them negatively. One individual felt pressure from her daughter to exercise more and to eat more nutritious meals and felt badly that she didn't behave according to her daughter's wishes. Another woman felt that her doctor didn't believe her when she told him that she had fallen stating, "He thinks I'm a liar...he doesn't believe me! You know, you get a feeling?" Because of these attitudes, certain participants felt incompetent, were lacking confidence, and generally felt badly about themselves as described in the following passage:
I feel really...I used to be so confident, when I think of all those years in business. But now I feel like an old woman, a useless old...it just hit me! Right now I don’t feel too good about myself.

In addition to self-concept, participants’ sense of purpose was a factor in determining their attitude towards accepting falls. When participants were involved in meaningful activities, they looked forward to each day and upon completion of a project or task, they felt a sense of accomplishment and pride. It was clear, however, that the inability to engage in activities that were meaningful would result in a loss of interest in living as described in this passage:

The only thing... I want to live a lot longer, but when I cannot do the things that I want to do and everything that I do I love to do...I don’t want to live if I can’t do them.

Immobility was the most critical barrier to involvement in meaningful activities. For the women in the study who were very frail and immobile, there were few meaningful activities that they could do and they therefore perceived their lives as purposeless.

The number and quality of social interactions in which participants were involved was also a determinant of their attitudes toward accepting their falls. When participants limited their activities by staying home in order to prevent falls, the frequency of social contact was reduced. The frequency of social contact was also reduced because most of their life-long friends had
died. Furthermore, they did not maintain contact with friends that were still living because as one woman stated, "they can’t get out either and besides, you see, everyone’s got their own problems and I certainly don’t need to hear more." Three participants continued to attend group activities that they had attended for years, but the remaining five were reluctant to join new groups. They felt that it was too difficult to make new friends at their age and they also felt that attendance at a group activity was an admission that they had some problems. Furthermore, they felt that they could not participate in certain activities such as craft groups due to visual and other impairments. Except for one participant, who had frequent visits from members of the church that she could no longer attend, the majority of social interactions was with family members.

The participants that had supportive family members living nearby benefited from frequent social contacts. During the interviews, they enjoyed naming all of their close family members and describing their relationships, which indicated to the researcher the importance of family in their lives. For example:

And then my granddaughter, she comes about 10 after 12 and has a grilled cheese sandwich, Nanna makes the best grilled cheese sandwiches.

[R: She comes everyday?]
No, about three times a week, and when I don't know she's coming and she comes and says "Now look, you sit there and I will get my own sandwich." They're awfully good to me, and my daughter, she's coming in today from [out of town]...I have so much to be thankful for.

For two participants in the study who had no close family members, the lack of meaningful social contact resulted in feelings of loneliness and despair as evidenced in this passage:

My mother and my father, and sister and brother are all dead. My husband...everybody I've ever had anything in common with, all my friends, the people I've known, they're all gone. Like I have nobody to talk to...everybody's gone. So it's been lonely.

[R: Can you tell me what being lonely is like?]

Well, you get so that...different things happen and you want to say, oh, do you remember so and so, and you've got nobody to say it to because there's nobody around that remembers. That's what it's like to be lonely.

Thus, individuals explained falling as an integral part of aging and therefore their reactions to falling were associated with their feelings about growing old. They described the way in which they came to terms with their losses and changes associated with falling in terms of accepting falls as part of growing old. Their acceptance represented attitudes ranging from hope to
despair and was influenced by self-concept, sense of purpose, and social interaction.

**Coping With Aging**

"Coping With Aging" represents the deepest and most profound conceptual level of perception. Because participants interpreted and reacted to falling within the context of aging, the way in which they coped with falling occurred within the context of coping with aging. An understanding of this level serves to further explain the first and second levels of perception which altogether represent the participants' entire perspective of the meaning of falling. The data in this level are organized and presented in relation to two components of coping with aging: restoring abilities and searching for meaning.

**Restoring Abilities**

Despite the presence of multiple chronic health problems, participants felt that they were in good health. For most, absence of pain was seen as an important determinant of good health. However, all had noticed increased weakness and fatigue, especially after a fall, which was interfering with some of their activities. They realized that they could no longer be as active and mobile as they had been in the past, but being as active as possible was important to them in maintaining independence:

You might as well be dead. No way do I want them to do those terrible things to make people live. There's no good in being old if
you're not active. So far I've been active enough. I do my grocery shopping, do my own meals, and do my own bit of work around here. Manage to keep myself clean, wash my hair, and shower every day. If I couldn't, forget it!

Participants redefined their optimal level of abilities, taking into consideration their physical limitations. The level of ability varied with each individual in accordance with their limitations. For some participants, the ability to shop and prepare full meals was possible but for others, washing, dressing, and grooming was about all that they could manage. Optimal health for them was merely to have the energy and strength to take care of their basic needs. They developed a variety of coping behaviors to regain their strength and energy and restore their abilities. These included: ensuring that they ate a nutritious diet, performing some type of exercises to maintain their leg strength, and taking some form of vitamin and mineral supplements.

Thus, one way in which participants coped with aging was to be as active as possible. They were motivated to be active in order to ultimately maintain their independence. To achieve this goal, they redefined their optimal level of abilities and developed a variety of coping behaviors to restore them. Therefore, their strategies for preventing further falls were but one aspect of their overall objective of reducing the impact of aging by restoring their physical abilities.
Searching For Meaning

All participants in the study thought about dying and wondered about the circumstances that would lead to their death:

Oh, one of these days, I’ll either, uh fall and break something and I’ll have to go to the hospital and then a nursing home or something. Something unforseen will happen like that or else, I’ll just kick it in!

That’s all!

They hoped that their death would be sudden and without pain and lengthy suffering. Some women stated that they would like to die soon; one woman said that she had a "death wish." For other women in the study, life was satisfactory and they felt that they had some reason to live.

The difference in the participants' satisfaction with their lives can be explained by their perceptions about the meaning of their lives. A comparison of the various aspects of their lives and their expectations for the future provides an understanding of this meaning.

Throughout the interviews individuals often reflected on their lives and described meaningful events from the past. For some participants, accomplishments were an important part of their lives and recollection of their accomplishments gave them a sense of satisfaction which they savored and enjoyed sharing with the researcher:

Sure, I'm quite efficient you know. I've had a...the west coast of Vancouver Island when I lived up there I had a hotel up there for a while,
for two years. When I came down here I had a small confectioner's store up on [street] and then after I married, we lived over here for a while and then we moved to [suburb], I had chinchillas. I had a chinchilla ranch...and I'm proud of it because I did it myself. I had no help. My husband was working in a mill all day, so I did it all myself.

Those chinchillas were definitely my efforts.

The pride and pleasure that was revealed in the tone of their voices and facial expressions was indicative of a continuing satisfaction with their lives despite the fact that they could no longer achieve such accomplishments. Additionally, these women described satisfaction with the opportunity to share these accomplishments in the present by describing them to others. Therefore, reminiscing about their life experiences was an important way of making sense of growing old.

Some women in the study also reflected on their lives and felt satisfaction that they had "lived life to the fullest." One woman said that if she knew that she was going to die that day, it wouldn't bother her, because she "had lived every moment." As she stated, "I had fun, and I dashed around and even in my seventies I zoomed around." They felt that they hadn't missed much in life and as the Grey Cup parade was being held at the time of one interview, one woman assured the researcher that she didn't regret being unable to attend it:

And all the things that you see about people...like the Grey Cup. I've been through that, I went all through that when the Eskimos were out
here the first year. And I wrangled around on the streets with all the crowd and so on and like that, and saw the parade and all that.

In contrast to the participants who experienced continuing satisfaction with their lives based on past accomplishments, some participants regretted missed opportunities in life and others felt that they would never recover from lost achievement opportunities. One woman described how she felt about the family business in which she had been involved for years:

And because when we were in business we had the phone in our home so I could be a housewife and take care of business. I was busy but I was home. I couldn't go out for lunch or anything because the phone was going all the time. We had a very busy business. When he [husband] let it go it just destroyed me. Even though I was asthmatic I could still handle it at home. And I missed it because we built it up from nothing.

Reflection on the past for participants such as this woman conjured up feelings of disappointment and regret, and the energy for life that was evident in some was absent for these particular women. Thus, the capacity to reminisce about past accomplishments and experience satisfaction with these accomplishments provided meaning for the lives of some of the participants. In this way, life satisfaction is one factor that explains the difference in participants' ability to find meaning in living and aging.
Although all participants were no longer able to do the things that they were able to do in the past, some were more successful than others in finding activities that provided new meaning to their existence. The most frequent example of meaningful activity was their ability to do things for their families. Two women who were still able to manage fairly well in the kitchen enjoyed cooking for their families; one baked cookies and cakes for five separate families on a regular basis while the other liked to have her family over for dinner:

Like, I'm okay as long as I can help my kids. I feel worthwhile. Like, I'm a good cook right? And I can have them over for dinner, and that's great, that makes you feel great. And, that...so therefore I feel like I'm useful. And I do little favors for my son and his wife and the kids, and so I feel I am still part of the human race...so I'm not useless. "Doing" for their families not only gave them a sense of purpose but it also relieved some of the anxiety arising from their perception of being a burden for their families. As long as families appreciated and gave recognition for their efforts, they felt worthwhile. But when participants did something for a family member and it went unrecognized, they became discouraged:

But I'm not knitting anymore right now...it's just...I've got nothing, no reason for knitting. I knitted a pair of socks for my nephew for his birthday. It took him two weeks to come around after his birthday to...before he got them. I think he was here last Monday or Tuesday. I haven't seen or heard from him since.
Thus, for the women who were mobile and had an attentive family, there seemed to be more opportunities to find new, meaningful activities.

In contrast to the meaning associated with new activities, some of the women in the study found pleasure in the feeling that they no longer had to do things that they didn’t enjoy doing. Some claimed that they felt more relaxed than they had throughout their lives:

I don’t get anything done. And now I get help with the cleaning and the laundry. So I’m more sluggish than ever.

[R: Tell me how you feel about that.]

Oh I feel fine! [laughing] It’s the way I am...and I don’t kick against things anymore.

[R: Can you describe that to me?]

Well I used to force myself, you know, to do things I didn’t like to do. Uh, I don’t know what exactly. I seem to do pretty well all that I enjoy doing now...you just go with the flow...

Another woman who stated that she had worked very hard throughout her life now enjoyed the luxury of not having to spend her time working:

I watch football, hockey, golf, uh, tennis sometimes. I watch anything sportswise.

[R: Were you involved in sports when you were younger?]
Never had time. I never had time for play because I was working too hard. So I do it this way.

Thus, for her, giving up old responsibilities led to opportunities for new pleasures.

Developing meaningful relationships with family members, especially grandchildren, was a further way in which some participants in the study gained a feeling of satisfaction and added new meaning to their lives. Three participants described their relationship with a particular grandchild and indicated their pleasure in being able to influence that individual as illustrated in this passage:

And then there's my grandson...he's engaged now. He brings his fiance to visit...and we have good old talks, you know. And I give him a lot of advice. Grandparents and grandchildren are closer in some ways than fathers and mothers and children. In some things...my grandson will tell me things that he doesn't think his father and mother are old enough to know! (laughing)

However, for five of the eight participants there did not appear to be any particularly special relationships with family members, therefore, this method of finding meaning was not available to them.

Although most of the participants had attended church at some point in their lives, only one woman continued to attend. One participant received visits from people from the church but chose not to attend because she
preferred not to be seen in a wheelchair and felt that that was the only way she could get into the church. The one participant who did attend church found her beliefs comforting in her later years. She stated that her fear of falling was due to a lack of faith and described how she overcame her fears through her religion:

I've got to quit worrying. I've got to have more faith in God and not worry about falling, you know. This is the thing. When you get older, you get this [feeling] probably, and it's when you're younger you don't bother, you know. But when you get older and that's all you've got, and you suddenly realize how much it means to you, God's care, and this feeling of frightening, hanging on everywhere, this lack of faith, you know. So if you have any kind of faith at all, you've just got to quit worrying about it and go about your business, and look forward to each day instead of being frightened of each day.

Thus participants' expressions of the meaning of their lives differed. This difference can be partially explained by their varying degrees of life-satisfaction. In light of the many losses that they had experienced as a result of falling and aging, participants also needed to look for new ways to find meaning in their lives. For some, the abilities and opportunities were available to enable them to find new meaning to their lives as they grew older. Thus, coping with falling could only be understood in the fullest sense if one understood how these women were coping with creating meaning out of the fact of their aging.
Summary

In this chapter, the participants' descriptions of the meaning of falling were presented. The meaning is conceptualized on three levels of perception.

At the first and most superficial level, participants interpreted the various aspects of their falls. This level consisted of three components: appraising the circumstances of falls, recognizing losses, and finding explanations. In appraising the circumstances of their falls, participants lacked insight into the probable cause of their falls. They appraised their health, minimizing the seriousness of their poor health but recognizing a deterioration in their strength and energy. The participants recognized the losses that had resulted from their falls, particularly the loss of mobility and independence. In finding an explanation for their falls, participants recognized a relationship between falling and growing old; they came to view falling as a major symbol of aging.

The second level of perception includes the participants' reactions to their interpretations of falling. This level also consisted of three components: worrying about falling, managing the worry, and accepting falling. Worrying about falling was the significant day-to-day emotional response that emerged from participants' interpretation of falling. All participants felt that they were at risk for falling at any time due to the sudden and unpredictable nature of their falls. The worrying was centered around four factors. The fear of falling when alone and not being able to get up or to summon help was a
major concern of many. When falls occurred in public or at home but in the presence of people, individuals felt embarrassed or humiliated and they therefore worried that they might fall whenever they were in public. The possible need to relocate to a care facility or to their families’ homes because of increasing dependence and immobility was another factor that intensified their worries; individuals valued independent living and disliked the prospect of giving it up. Depending on families for assistance caused participants to worry that they were a burden for their families. Further, they recognized that another fall could increase this dependency.

To manage their worries, participants implemented various strategies to increase their feelings of control and predictability over their daily lives and thereby reduce their risk for falling. Participants explained that they came to terms with falls by simply accepting them. But because they explained their falls in relation to aging, accepting their falls meant accepting them as an inevitable part of growing old. The degree of acceptance was reflected in attitudes ranging from hope to despair and was influenced by self-concept, sense of purpose, and social interaction.

These first and second levels of perception were ultimately explained by the third and most profound level at which participants explained their experience. Because participants’ interpretations and reactions to falling were associated with aging, coping with falling occurred within the context of coping with aging. This level contained two components: regaining abilities and searching for meaning.
Participants wanted to be as active as possible so that they could maintain their independence. In order to do this they redefined their optimal level of abilities and then developed new coping behaviors. Because of the many limitations caused by their losses associated with falling and aging, it was necessary for participants to look for new opportunities to find meaning in their lives. Therefore, to understand how participants coped with falling, one must understand how they coped and found new meaning in the fact that they were growing old.

This chapter has presented the findings of this study. In the next chapter, the findings are discussed.
CHAPTER FIVE

Discussion of Findings

Introduction

This chapter provides a discussion of the research findings presented in the previous chapter. The discussion focuses upon the significance of the findings in terms of the well-being of the elderly community-dwelling individual who has concerns about falling.

The chapter begins with a general discussion of how the U.B.C Model for Nursing (U.B.C. School of Nursing, 1980) guided the study. The remainder of the discussion is organized into three sections which relate to the levels of perception as described in the findings of Chapter Four: 1) Interpreting Falling 2) Reacting to Falling, and 3) Coping With Aging. Aspects of the findings will be summarized and discussed in relation to the findings of other researchers and the claims of theorists. In addition to the literature discussed in Chapter Two, further literature is introduced to shed light on the research findings.

The U.B.C. Model for Nursing (U.B.C. School of Nursing, 1980) is the theoretical framework that guided this study. The individual in this model is viewed as a behavioral system made up of nine subsystems: achieving, affective, ego-valuative, excretory, ingestive, protective, reparative, respiratory, and satiative. Falling was considered an unpredictable event in the life cycle
which affected the entire behavioral system and required the development of suitable coping behaviors to satisfy basic human needs, achieve stability, and reach optimal health. Each subsystem is composed of an inner personal region which includes a need and abilities to meet that need as well as a psychological environment which includes forces and a goal. Falling was considered a force that had meaning for the psychological environment of one or more subsystems. Because each subsystem is interacting and interdependent with every other subsystem, the meaning that falling had in one or more subsystems affected the entire behavioral system.

It was found that falls had a profound impact on each participant as evidenced by the frequency of lack of goal achievement and need satisfaction in most if not all nine subsystems which together represented the entire behavioral system. An understanding of the meaning of falling for the participants was achieved by not only examining the existence of falls in the psychological environment of the subsystems, but also in relation to additional data such as other forces existing in the psychological environment, abilities, and coping behaviors. Furthermore, the interacting and interdependent nature of the subsystems led the researcher to understand the effect of falls on the entire behavioral system. Altogether, this data provided a broad perspective for understanding the meaning of falling for the participants.
Interpreting Falling

To date, community-based studies on falling have focused on determining the causes and risk factors associated with falling. There have been no studies to determine the elderly person's perceptions of falling. The findings in this study indicate that participants lack insight into the causes of their falls. For example, although the researcher could attribute three falls to medications, the participants involved did not believe that the medications were the cause of their falls. Individuals discounted their pathophysiological conditions, maintaining that they were in good health which they related to being without pain. They demonstrated a knowledge deficit with regard to age-related physiological changes that could cause falling.

Researchers have reported that the elderly do not necessarily define health in terms of the presence or absence of pathology (Butler, 1980). Although people aged 75 and older experience more pathological disorders than do younger adults, they rate themselves as being healthier (Ferraro, 1980; McPherson, 1983). In light of the findings of these studies, therefore, the finding that participants perceived that they were in good health possibly explains why they did not attribute the cause of their falls to their chronic disabilities or their age-related physiological changes.

Participants evaluated their health in two other ways. Mental competence in relation to knowing what was occurring in the news, was an important aspect of meeting the need for mastery. The way in which they kept in touch was through the media. Watching television, listening to the radio, and
reading the newspaper gave them a sense that they were connected to the world, mentally alert, and therefore healthy. They also evaluated their health by comparing themselves to others who were less healthy. Knowing that there were others who were "worse off" was a way to reduce their concerns about their own health.

The participants noticed a change in their strength and energy levels which interfered with their capacity for activity. Furthermore, they discovered that they could not regain this despite the various exercises that they did and the extra rest periods that they took throughout the day. Adequacy of personal resources, both internal and external to the individual, has been shown to be an important factor for the elderly in their perception of competence (Culbert & Kos, 1971). Furthermore, the coping resources of the elderly are reduced when they have diminished physical strength and reserve (Miller, 1983). It is understandable therefore that the impact of their diminished strength and energy was significant and explains the threat to the participants' needs for mastery and activity.

Participants recognized losses associated with falling, the most significant being loss of mobility and independence. Their loss of mobility affected their ability to: walk, care for their homes and gardens, go anywhere outside of their homes, manage their activities of daily living, and go shopping. For the participants who continued to live in their homes as opposed to an apartment, these losses were exaggerated, and they felt very frustrated by their inability to care for their homes and gardens. Furthermore, the loss of
mobility rendered them unable to do many things without the assistance of others and they therefore felt dependent.

According to Culbert and Kos (1971), independence, or the ability to provide for one's needs, is the most important aim of the majority of the elderly, regardless of their state of health (p. 607). Given this knowledge, the significance of falling to the participants is made more evident. The recognition that falls have caused injuries which resulted in immobility and ultimately dependence is a critical point in their interpretation of their falls. The significance of their loss of mobility and independence explains why falling had such profound meaning for these participants.

Although participants in this study did not directly attribute their falls to aging, falling was integrally associated with aging, and for some, falling was the point of recognition that they were old. Falling also caused participants to think about getting even older, about unfinished business, and about their eventual death. Tideiksaar (1986) suggested that the elderly attribute their falls to old age and that they view falling as "the beginning of the end." However, this was only a suggestion and not researched-based. The findings of this study do not support Tideiksaar's suggestion, but rather, indicate that falling was perceived as a symbol of aging. According to Lazarus and Folkman (1984) one must appreciate individual interpretations of the cause of a phenomenon before one can understand emotional reactions to it. This interpretation is based on personal values and beliefs. Thus, the way in which the participants interpreted their falls explains their reactions to falling. Be-
cause they viewed falling as a symbol of aging, they reacted to falling in the context of aging.

**Reacting To Falling**

The findings of the study indicate that participants reacted to their interpretation of their falls at a deeper level of perception. At this level, the participants described the pervasive effect of the potential for falling on their daily lives.

**Constant worrying about falling** was the major day-to-day emotional response of the participants. Their recognition of previous losses associated with falling caused them to realize that another fall might mean further losses and an uncertain future. The literature on the subjective experience of falling does not recognize the existence of worrying in the elderly community-dwelling individual. Worrying is associated with anxiety in the literature and this literature can be used to explain participants’ worries.

**Anxiety** is a state of inner distress with thoughts of dread, fear, foreboding, or anticipation of harm (Klerman, 1983, p. 5). In the case of the participants, their anxiety related to their fear of falling is explained in light of their previous losses and their anticipation that further falls could result in additional losses.

**Anxiety or worry** is viewed as a positive factor in some instances when it motivates individuals to develop new coping behaviors in response to unmet needs and thereby reduces the anxiety (Eysenck, 1983). Lange (1978)
states that worrying is one of the affective tasks in hoping that forces the person to think about the hoped-for and consider other possibilities and outcomes. Worrying can be beneficial for finding supports for hope, considering alternatives, and preparing for anticipated stress and substitute hopes (Lange, 1978, p. 181). This view of worrying explains participants' needs to manage the worry related to falling and growing old through the use of various strategies. Worrying motivated them to implement various strategies to achieve their goals and thereby ultimately maintain hope. The literature also states that depression can be anticipated when anxiety is not reduced or when hope is lost (Lange, 1978; Miller, 1983). This idea might explain why participants demonstrated attitudes ranging from hope to despair in accepting falls as an inevitable part of growing old. Perhaps for some participants, their coping behaviors were ineffective in reducing their anxiety and maintaining hope. Furthermore, the literature on stress explains the effects of too much anxiety and can contribute to an understanding of the participants' reactions to falling and the resultant losses. Stress is defined by Selye (1974) as the nonspecific response of the body to any demand made upon it (p. 14). The energy required to resist a stressor is finite; following long and continuous exposure to the stressor, exhaustion and eventually death occurs. For the participants, the potential for falling and the possible consequences of falling were a constant stressor, which required emotional energy in the form of worrying for resistance. Thus, worrying about falling in addition to their already
diminished level of energy and strength, further reduced the ability of the participants to cope.

The findings indicate that the possibility of having to relocate to a care facility potentiated the participants’ worries about falling. The stress of relocating elderly persons has been well-documented in the literature (Tobin & Lieberman, 1976). Studies have shown that the elderly experience less relocation stress when they have control over the decisions surrounding their move (Pino, Rosica & Carter, 1978). In the case of the participants, it was their perception that they would have no choice but to relocate if an immobilizing fall occurred. Given their perceptions of no-control over the decision to relocate and the value they placed upon independent living, the significant impact of this factor on their worrying is clear.

Three other factors increased the participants’ worries about falling: embarrassment and humiliation when there were witnesses to their falls, being a burden on family, and the inability to get up from the floor. Findings in the study indicated that these stressors caused participants to feel "stupid," incompetent, helpless, and useless. In the literature on the experience of falling, authors allude to these themes; however, these themes have not been addressed in detail in the literature. In light of the way in which participants described themselves, the researcher was directed towards the literature on stigma to understand their feelings.

Persons are stigmatized when expectation based on a value judgment of what persons of a certain social identity should be differs from what they
actually present to others (Blackwell, 1978, p. 37). Page (1984) stated that individuals can come to recognize that they possess a stigma through self-recognition. Through the socializing process, members of society gain an understanding of the various types of prevailing stigmas.

In the case of this study, participants had come to stereotype the elderly based on myths that the elderly were, for example, incompetent. When individuals experienced an event in which their behavior could be classified as incompetent, such as being unable to get up from the floor after a fall, they became aware of a prevailing stigma. The idea that participants felt stigmatized if they fell in the presence of others and needed assistance to get up explains why the concern for falling in public intensified their worries.

Individuals also can come to recognize that they have a stigma through audience recognition; unintentional stigmatization occurs when so called "normals" tend to be over-sympathetic or inhibited during contact with the stigmatized (Page, 1984, p. 11). In this study, the sympathy of strangers who picked participants up from the ground, and the over-protective behaviors of families caused them to feel stigmatized. Because participants perceived that further falls would intensify such feelings, it is understandable that the stigma associated with being elderly intensified their worries.

The findings indicate that the participants devoted substantial energy and time to managing their worries; the most significant activity was to restrict their activities by staying home. Their homes offered them security and they felt that their chances for falling were much greater outside their
homes. As a consequence of this restriction, participants felt that they could no longer enjoy certain activities such as attending church, participating in programs at the seniors' center, and attending concerts. Indoors, participants also restricted their activities by avoiding having to get into a standing position too often.

There have been no studies that have examined this aspect of falling. However, it is believed that individuals lose confidence in their ability to ambulate safely and therefore restrict their activities to avoid another fall (Hadley et al., 1985; Mossey, 1985). The findings of this study substantiate this belief. It has been suggested that the major consequences of activity restriction are increased immobility, deteriorating general health, social isolation, depression and therefore, increased risk of falling (Hogue, 1982). Such a claim would seem to be supported by the findings of this study.

Television served as a distraction that helped participants divert their concerns away from the worries associated with falling. The function of television in the lives of elderly community-dwelling individuals has not been addressed in the literature; however, for the participants in this study, several functions can be identified. Because the participants had restricted their activities by staying home, television provided an important way for them to feel connected to the world. The fact that their favorite programs consisted of talk shows where the host interacted with the guests and audience indicates that such programs met some of their needs for social affiliation. Furthermore, watching television was deemed by the participants as an
important way to stay mentally alert. Participants also stated that television prevented boredom and that it was the easiest and safest form of entertainment in light of their impaired mobility and decreased stamina. In light of the findings, television is considered to have significant meaning to the participants in terms of managing their worries.

The extensive and detailed morning routines that participants developed and followed were also an important way in which they managed their worry. Independence in activities of daily living is recognized in the literature as an important component of positive self-esteem (Parent & Whall, 1984). Because their losses limited their ability to carry out many lifelong activities, it is conceivable that their morning routines replaced these activities and provided them with feelings of accomplishment that they had overcome some barriers to their independence and therefore contributed to positive self-esteem.

Participants reported that the way in which they came to terms with their worry was to accept falling as an inevitable part of growing old. Acceptance represented attitudes that ranged from hope to despair and these attitudes were affected by three factors: self-concept, sense of purpose, and social interaction. For the purpose of this discussion, despair will be considered here as one of a complex of feelings and attitudes that contribute to depression (Lange, 1978).

Depression has been identified as the most common mental health disorder in the elderly (Hawranik & Kondratuk, 1986). Because of diagnostic
and detection difficulties, the incidence rates for depression in the elderly are not clear. However, it has been claimed that the incidence may be as high as 20 to 50 percent (Hawranik & Kondratuk, 1986). Thus, it is likely that some of the participants in this study were depressed even though efforts were made to exclude participants who were obviously suffering from the disorder. In light of the profound losses that the participants experienced as a result of falling, it is possible that falling contributed to depression.

Acceptance of falling as an inevitable part of growing old reflected attitudes ranging from hope to despair. This attitude was influenced by self-concept, sense of purpose, and social interaction. These findings are substantiated in the literature; poor self-esteem, social isolation, and purposelessness have been implicated along with several other factors as contributing factors for depression in the elderly (Hawranik & Kondratuk, 1986).

Thus, the findings that describe participants' reactions to falling by worrying, managing the worry, and accepting falling as an inevitable part of growing old, have not been specifically addressed in the literature. However, the general literature on anxiety, stress, stigma, and depression sheds some light on their reactions.

Coping With Aging

Because the participants interpreted and reacted to falling in the context of aging, the way in which they coped with falling was in the context of
coping with aging. Together, all three levels of perception represented the whole meaning of falling for them.

One way in which the participants coped with aging was to develop new coping behaviors that would facilitate their ability to remain as active as possible. They therefore developed various coping behaviors that would restore their strength and energy. However, this required a change in expectations with regard to their abilities and in light of their various limitations. Consequently, they redefined their optimal level of abilities. The coping behaviors that they developed to regain their abilities were related to diet, exercise, and vitamin supplements.

To understand how the participants were motivated to change their coping behaviors and to facilitate this discussion, theory on change was examined. Schein (1976) examined the kinds of changes in individuals that are related to values and beliefs and imply the giving up of something to which the person has previously become committed and which he values (p. 98). He stated that individuals are motivated to change their behavior when there is a disconfirmation or lack of confirmation in their cognitive structure. The individual reacts by experiencing guilt-anxiety. He scans the environment for new information and "examines the regions of a life space ... learning to discern more and more aspects of [himself] and [his] environment" (Bigge, 1984, p. 225). From this examination the individual gains insight and is able to conceptualize aspects of himself and the environment in a new way, which has been called cognitive restructuring.
The findings of this study indicate that the participants restricted their activities by staying home and did not seek outside assistance in developing new coping behaviors related to regaining their abilities. According to Schein (1976), the individual must look to other people and the environment for information that will provide insight and thereby enable the individual to plan more effective coping behaviors. Because the participants limited their access to resources that could have provided them with appropriate information, their new coping behaviors related to regaining abilities may have been ineffective.

Because of the many limitations caused by their losses, it was necessary for participants to look for opportunities to enhance the quality of their lives and they thereby gained a new meaning of what it was like to grow old. The findings indicate that there was a difference in meaning among the participants and this difference was reflected in their wishes to die or their desire to live.

A comparison of the various aspects of their lives revealed that some participants felt pride in their accomplishments of life and appreciated the opportunity to share them. They also felt that they had "lived life to the fullest." Other participants regretted missed opportunities in life and grieved over lost work roles. While some participants found that doing things for their families was meaningful and rewarding when they got recognition for these activities, other participants either got no recognition for what they did for their families, or they had no close family members with whom to relate.
Some participants felt that they had the freedom to make choices about the activities in which they participated. Others felt guilty if they did not behave or do the things that others expected of them. Some participants related how they had developed very special relationships with certain family members while others did not share the same experience.

These findings which indicate a difference in meaning for the participants can best be explained in relation to life-satisfaction and successful aging. Although the requirements for life-satisfaction in the elderly and successful aging have not been well-defined in the literature due to problems in developing appropriate tools to measure subjective well-being in the elderly (Horley, 1984), a review of the literature suggests some broad requirements. Social interaction and the presence of significant others is an important determinant of happiness (Tobin & Neugarten, 1961). Engagement in meaningful activities that provide a sense of self-worth is another important factor (Havighurst, 1968). Accepting age-related losses and changes and developing new expectations for the future are identified by Novak (1985) as further aspects of life-satisfaction and successful aging. Novak (1985) considers these factors as requirements for the process of growing old:

There is a unique set of values at work here and these people know it. They are not trying to win fame or fortune. They have been through that phase of life and are now discovering new meaning in life. They speak about silence, thinking, caring, devotion, a concern for others, and a desire to remain self-sufficient as they age. They are busy and
involved, active and committed. But they are also withdrawn and quiet, thoughtful and reserved. Above all they are responding to the challenges aging poses for them, and in the process they are discovering how to grow old (p. 298).

Thus the difference in meaning as described by the participants can be explained in terms of the presence or absence of some broad requirements for life-satisfaction and successful aging.

For some participants, there was little satisfaction with their lives due to factors over which they felt they had no control. The feelings of these participants can be explained in relation to the concept of powerlessness. Seeman (1959) identified the concepts of powerlessness, meaninglessness, normlessness, isolation, and self-estrangement as the five basic variants of alienation. He defined powerlessness as "the expectancy or probability held by the individual that his own behavior cannot determine the occurrence of the outcomes, or reinforcements, he seeks" (p. 784).

The elderly are vulnerable to feelings of powerlessness due to limited coping resources and multiple losses and stressors (Miller, 1983). Miller (1983) stated that limited coping resources for the elderly might include: less physical strength and reserve, decreased psychological stamina, diminished social support network, lower self-esteem, and decreased energy (p. 109). The losses and stressors experienced by the elderly are numerous and can be grouped into sociological, physiological, and psychological categories. The most common stressors and losses include: death of spouse, deteriorating
health, retirement and limited income, relocation, altered body image due to age-related physiological changes, and stereotyping of the elderly. The findings of this study illustrate the relationship between falling and many of these stressors and losses. In addition, they illustrate the way in which falling reduced the coping resources necessary to find satisfaction and meaning as individuals coped with the fact that they were growing old.

**Summary**

In this chapter the findings of the study were discussed in relation to the findings of other researchers and the claims of theorists. The discussion was presented in three sections which relate to the three levels of perception as described in Chapter Four: 1) Interpreting Falling 2) Reacting to Falling 3) Coping With Aging.

At the first and most superficial level, participants interpreted the various aspects of their falls. Their lack of insight into the causes of their falls and their poor health was explained by the literature in relation to the older person's perceptions of health. The significance of their losses was substantiated in the literature. Falls triggered thoughts of getting old and participants came to view falls as a major symbol of aging.

The second level includes the participants' reactions to their interpretation of falling. Worrying about falling was the significant day-to-day response and the function of worrying was explained in the literature in terms of motivating the individual to develop new coping behaviors in response to
unmet needs. The concepts of stress, relocation, and stigma further explained the reactions to falling. Participants managed their worry by implementing various strategies. Participants came to accept falling as an inevitable part of growing old and expressed attitudes of acceptance ranging from hope to despair.

The first and second levels of perception are explained in terms of the third and most profound level. Because participants' interpretations and reactions to falling were associated with aging, coping with falling occurred in the context of coping with aging. Participants wanted to remain as active as possible, and in order to do this, they redefined their optimal level of abilities and developed new coping behaviors. In light of the losses experienced, it was necessary for participants to look for new opportunities to enhance the quality of their lives. In doing so, they found new meaning to growing old. The level of meaning was dependent on their coping resources and was explained in the literature in relation to life-satisfaction, successful aging, and powerlessness. Thus, to understand how they coped with falling, one must understand how they coped with and found new meaning in the fact that they were growing old.

This chapter provided a discussion of the research findings presented in Chapter Four. In the next chapter, the summary, conclusions, and implications for nursing are presented.
CHAPTER SIX

Summary, Conclusions and Implications

Summary

This study was designed to gain an understanding of the meaning of falling for elderly community-dwelling individuals. Falls in the elderly Canadian population pose a serious health problem; they are the leading cause of accidental death in persons aged 65 and older. The most common serious injuries associated with falling are hip fractures; more than 19,000 Canadians sustain a hip fracture yearly as a result of a fall (Hogue, 1982). Hip fractures can have a negative impact on the general health of elderly individuals and the costs to the health care system associated with treatment of hip fractures are substantial.

The majority of studies on falling to date have been conducted in institutional settings and the purpose of these studies has been to determine the cause of falls so that appropriate preventive measures can be taken. Community-based studies have identified several risk factors for falling in the elderly community-dwelling population. However, the literature reveals a dearth of information on the subjective experience of falling.

With the increase in the elderly population and the trend in health care to maintain the elderly in their homes for as long as possible, there is a growing need to develop more home support services to assist the elderly to
cope with normal changes associated with aging as well as with health problems. Given the estimate that one third of people aged 65 years and over experience one or more falls in a year, it is an important function of community nurses to support the elderly in coping with falls and the potential for falling. But before community nurses can be truly effective in their supportive role, they must understand the experience of falling from the individual's perspective.

The phenomenological method of qualitative research was used for this study. The aim of the phenomenological method is to describe human experience as it is lived (Oiler, 1982). This method was particularly suited to this study in which the researcher wished to understand the meaning of falling from the perspective of the elderly community-dwelling individual. The role of the subject in phenomenological research is viewed as co-researcher and the researcher engages in cooperative dialogue with the subject who is considered to be a knowledgeable informant (Knaack, 1984, p. 110). Because little is known about the subjective experience of falling, elderly community-dwelling individuals who had had experience with falling were considered to be knowledgeable informants and were chosen to participate in this study.

Eight women acted as co-researchers in this study, responding to open-ended questions during the course of in-depth interviews. All of the interviews were audio tape-recorded and the tapes were subsequently transcribed verbatim. The process of data analysis occurred simultaneously with data collection. Through constant comparative analysis, the meaning units of each
transcript were compared with the descriptions of other participants and common themes and variations within each theme emerged. Simultaneously, the researcher sought to validate and clarify the themes and variations through further interviews.

The U.B.C. Model for Nursing directed the researcher to assume a broad perspective when gathering data so that all relevant data were considered. The participants perceived the profound impact that falling had on their lives on three different levels. For this reason, the findings were presented in terms of three categories which together represent their entire perspective of the meaning of falling.

At the first and most superficial level, participants interpreted the various aspects of their falls. This category of data consisted of three components: appraising the circumstances of their falls, recognizing losses, and finding explanations. Participants appraised their falls and their health and in doing so they demonstrated a lack of insight into possible causes to their falls. They also minimized their poor health. They noted a decrease in their strength and energy level which they were unable to regain in accordance with their expectations. Losses associated with mobility and independence were recognized. Falls triggered thoughts of getting old and participants came to view falls as a major symbol of aging.

The second level of perception includes the participants’ reactions to their interpretation of falling. This level also contains three components: worrying about falling, managing the worry, and accepting falling. Worrying
about falling was the significant day-to-day response to falling and the worry­ing was centered around four factors: the inability to get up from the floor after a fall, the possibility of relocation to a care facility, the embarrassment of falling in the presence of others, and being a burden for other family mem­bers. To manage their worries, participants implemented various strategies to increase their feelings of control and predictability over their daily lives. Restricting their activities by staying home was the most significant strategy. Other strategies included: maintaining regular telephone contact with families or significant others, developing predictable daily routines and rituals; accepting homemaker help; developing ambulating strategies; and defining a manageable walking distance for outings. Participants came to terms with falling by accepting their falls as an inevitable part of growing old. The degree of acceptance represented attitudes ranging from hope to despair and were influenced by self-concept, sense of purpose, and social interaction.

The first and second levels of perception were explained in terms of the third and most profound level. Because participants' interpretations and reactions to falling were associated with aging, coping with falling occurred within the context of coping with aging. This level contained two com­ponents: regaining abilities and searching for meaning.

Participants wanted to remain as active as possible, and in order to do this, they redefined their optimal level of abilities and then developed new coping behaviors. Because of the many losses that the participants had ex­perienced, it was necessary to look for new opportunities to enhance the
quality of their lives. In doing so, they found new meaning to growing old. Thus, to understand how they coped with falling, one must understand how they coped with and found new meaning in the fact that they were growing old.

Conclusions

The research findings lead to a number of conclusions about the meaning of falling for elderly community-dwelling individuals.

The causes of falls are not of major concern to older people. They are more concerned with broader aspects of the experience than a cognitive understanding of the causative factors and preventive measures associated with falling.

The most significant emotional response to falling is worrying. Older people worry not only in response to their fear of falling, but also in response to the numerous losses associated with falling.

In the perceptions of older people, falls are linked with stupidity and incompetence. This link is strengthened when there are witnesses to their falls.

Falls trigger concerns about independence because they cause injuries that result in loss of mobility. Loss of mobility in older persons affects most aspects of their daily lives and ultimately their level of independence.
Television watching is an important way in which elderly community-dwelling individuals manage worry. It also serves the functions of maintaining social connection, facilitating mental alertness, preventing boredom, and providing safe and accessible entertainment.

Daily routines are another way of managing the worry. In addition, they serve the function of providing a measure of control, promoting feelings of accomplishment, preserving independence, and promoting self-esteem.

The research findings also indicate that older persons associate falls with aging. Coping with falls, therefore, is only part of the larger issue of coping with aging.

Elderly community-dwelling individuals use two general categories of strategies to cope with aging: restoring strength and energy, and developing a sense of meaning and hope in relation to growing old.

Nursing Implications

The findings of this study have implications for nursing practice, education, and research. These will be discussed below.

The finding that the participants coped with falling in the context of coping with aging has implications for nursing practice and education. When caring for elderly persons who have experienced falls, nurses need to address their concerns about growing old. Losses and potential losses associated with both falling and aging demand attention. Nursing care should be directed toward assisting individuals in coping with these losses. Nursing education
should include not only loss theory but also specific information about age-related losses and the coping resources of the elderly.

The task of coping with falls in the context of coping with aging has implications for nurses to act in a long-term supportive role. The components of successful aging and effective coping suggest that nurses can act in a counselling role to enhance meaningful family relationships, promote self-esteem, recognize individuals' contributions in life, and promote a sense of purpose. As the trends indicate, elderly people living in the community do fall and will continue to fall. While prevention of falls is a necessary component of nursing care, these findings suggest that ongoing support to enhance the quality of individuals' lives as they come to terms with both falls and growing old should be the primary role for nursing. In order for nurses to function in this capacity, they will need advanced education in theories related to aging and expert ability to apply the theories in practice.

Within the context of the U.B.C. Model for Nursing (U.B.C. School of Nursing, 1980), the findings have utility in providing direction for nurses who care for elderly persons with concerns about falling. The findings direct nurses to take a broad perspective in the assessment of the meaning of falls, thereby enabling nurses to identify more relevant data. The findings of this study suggest that falling has predictable meaning in the protective, affective, ego-valuative, satiative, and achieving subsystems of the client as a behavioral system. Thus, the profound impact of falling can be understood in relation to
the way in which falling is a negative force upon the individual's abilities to meet his basic human needs.

Worrying, the major emotional response to falling, is something that nurses should address directly in their assessment of elderly community-dwelling individuals. Because the findings indicate that daily routines served so many important functions, nurses should recognize the benefits of daily routines and assist individuals to develop and refine such routines.

Nurses also need to recognize the importance of independence for elderly persons and the perceived relationship between independence and competence. Nursing interventions that promote independence might restore an individual's self-esteem, and result in feelings of competence. Nurses should assess individuals' capacity to perform activities of daily living, identifying forces and abilities requiring manipulation. Any barriers to independence should be addressed. For example, installing safety equipment in bathrooms and teaching individuals how to get in and out of their bathtubs safely would facilitate independence in bathing and grooming. Teaching individuals new ways to prepare simple, nutritious meals would also promote feelings of accomplishment and positive self-esteem. For example, microwave ovens and frozen convenience foods could facilitate meal management for frail elderly individuals. Furthermore, the use of grocery shopping services would enable individuals to obtain necessary groceries and at the same time, promote their independence and feelings of competence.
Because the prospect of having to relocate to a care facility intensified their worries about falling, these findings indicate that there is a need for nurses to take an active role in discussing concerns related to relocation so that these worries can be alleviated. In cases where relocation is a strong possibility due to increasing dependence, nurses can use the strategy of life-review to assist individuals to draw upon life experiences to facilitate the use of previously effective coping behaviors. In addition, the anxiety of being a burden to families can be reduced by using the life-review strategy to assist the elderly to recognize the important contributions that they have made to their families in the past, and to identify ways to continue to take an active role in their families. Furthermore, over-protective families could be assisted to cope more effectively by teaching them the importance of independence for their elderly family member.

Nurses need to look at creative and sensitive ways to reduce the social isolation that occurs as a result of restriction of activities. Telephone "buddy" systems, visiting programs, and support groups for elderly, immobile, community-dwelling individuals might promote positive self-esteem. Furthermore, development of effective and affordable devices to alert others of the need for assistance after a fall could greatly reduce the worry for those people who live alone.

The finding that television is an important aspect of their lives signals the need to use the television more effectively to meet the needs of the elderly, immobile people in the community. For example, in light of their need for
some form of exercise, fitness programs designed for their special needs is one way that nurses could capitalize on television as a medium for health promotion. Community nurses could regularly present health-related programs on local cablevision stations and could involve seniors in the planning and presentation of such programs.

Community nurses need to be aware of the relationship of stigma to falling and the possible role that it plays in the coping behaviors of elderly people who experience falls. For example, individuals might not report falls unless the injuries are serious enough to require medical attention and thereby reduce their chances of getting appropriate assistance to cope. Therefore, nurses need to be sensitive to the fact that elderly persons might not express their concerns about falling. Developing a trusting relationship with elderly individuals is the first step in promoting disclosure of concerns about falling.

The findings of this study indicate that there should be two primary foci for community programs directed at the needs of elderly persons with concerns about falling. First, resources should be directed toward ways to assist the elderly to restore their strength and energy. For example, nurses could organize neighborhood walking programs to provide a safe and enjoyable way for the elderly to exercise. Second, programs need to focus on ways to assist the elderly to find meaning and hope as they grow older. Community seniors’ centers that offer purposeful activities in a comfortable social milieu can assist the elderly to cope with the fact that they are growing old. However, such programs must pay attention to the particular needs of the
elderly; inadequate transportation systems for individuals who are immobile and afraid of falling is one example of a common barrier to participation. Programs addressing these themes could play a role in both prevention of falls and coping with the repercussions of falls.

To date, the education of nurses on the care of the elderly has focused primarily on the ill-elderly in hospital settings. However, the findings of this study indicate that the elderly with problems related to falling are more concerned with the losses and changes associated with aging than with their chronic illness. Given the trend toward promoting seniors’ wellness and maintaining the elderly in their homes for as long as possible, nursing education should be focusing on the concept of wellness in relation to the care of the elderly. The placement of nursing students in seniors’ centers, adult day-care centers, and home-care programs for their geriatric clinical experience, would be effective in developing a wholistic, wellness-oriented view of the elderly. Furthermore, the recognition of geriatrics as a specialty area within nursing would enhance the development of specialized programs in both basic and continuing education for nursing, and would ultimately promote the development of positive attitudes toward geriatric nursing.

Further research is needed to achieve a greater depth of understanding of the meaning of falling from the perspective of the elderly community-dwelling individual. It would be useful to identify the elderly people in the community who are at risk for serious repercussions associated with falling and least able to cope. Implications for the delivery of health care ser-
vice need to be determined in light of the findings that participants did not report falls, nor did they seek medical attention unless there were substantial injuries. Exploring the family's perceptions and concerns related to the elderly family members' falls would be useful in order to assist them in their supportive role. Because of the preponderance of elderly women living in the community, all of the participants in this study were women who were referred by nurse assessors in the community. It would be useful to examine the experiences of elderly men to determine if their experience differs from that of women.

Further studies are recommended to determine how elderly community-dwelling individuals with concerns about falling can be assisted to cope more effectively. Knowledge about how they view what the health care system can offer is required. In addition, more knowledge about the perceptions of both families and health care providers with regard to falls would permit better planning of effective use of all human and system resources.

In conclusion, this study has described the meaning of falling for a sample of elderly community-dwelling individuals. Its findings will contribute to nurses' understanding of what falling is like from the individual's perspective and therefore will enable them to make more rational decisions when caring for elderly community-dwelling individuals who have concerns about falling.
REFERENCE LIST


APPENDIX A
LETTER OF INFORMATION

My name is Tessy Orlando. I am a Registered Nurse currently working on my thesis for the Master of Science in Nursing program at the University of British Columbia. I am studying the meaning of falls for elderly persons living in the community.

This letter is an invitation for you to participate in my study. You are under no obligation to participate and if you choose to participate you may withdraw from the study at any time. The health care that you receive will in no way be affected by your decision to participate or not participate.

If you are interested in sharing with me your experience with falling, I would like to meet with you in your home approximately two to three times. Each interview will last for 30 to 90 minutes. On the initial interview I will ask questions about your experiences and concerns related to falling. Subsequent interviews will be approximately four weeks later and will provide an opportunity for you and me to clarify and expand on the information that you initially shared with me.

Each interview will be tape-recorded so that I may listen closely to what you are saying without having to take notes. All information that you share with me is confidential; the tapes will be numbered so that your name will not appear on them and a code will be used when the tapes are transcribed. Access to the tapes and typed transcripts will be limited to my thesis advisors, my typist and myself. You may request erasure of taped information at any time and at the completion of the study all tapes will be destroyed. All written material arising from this study will maintain your anonymity.

Participation in this study is voluntary. It is hoped that the information provided will help nurses to better understand what falling is like for the elderly living in the community. Participants who are interested will be sent a summary upon completion of the study.

If you are interested in participating or have further questions regarding the study, please call me at xxx-xxxx. If I am not at home, leave a message on my answering machine and I will return your call. When your nurse gives me your name I will phone you to clarify any questions you have and to inquire about your interest in participating. I look forward to speaking with you.

Sincerely,

Tessy Orlando
APPENDIX B
CONSENT FORM

Title of the Study:
The Meaning of Falls for the Elderly Community-Dwelling Individual

Investigator:
Tessy Orlando

The purpose of this study has been explained to me by Tessy Orlando and I agree to participate in this research project. I understand that this study involves approximately two interviews of 30 - 90 minutes duration in my home and that the interviews will be tape-recorded. I understand that my involvement in the study will be confidential and that my name and any identifying features will be deleted from all sources of information. I understand that I may refuse to answer any questions and may withdraw my consent at any time without any risk to future and present health care. If I have any further questions about the study, I understand that I may contact Tessy Orlando at xxx-xxxx for clarification.

I acknowledge receipt of a copy of this consent form.

Signature

Date ____________________________ 1987
Appendix C
SAMPLE INTERVIEW QUESTIONS

1. What is it like to fall?
2. What do you think caused you to fall?
3. Do you worry about falling? If so, please describe your worries?
4. Do you think that you will fall again? If so, what do you anticipate will happen?
5. Has falling changed your feelings about yourself? If so, in what way?
6. Has falling affected your feelings of safety in any way? If so, in what way?
7. Has falling caused you to change your daily activities? If so, in what way?
8. Have your plans for the future changed as a result of falling? If so, in what way?