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Research Article

The Lived Experiences of the Fear of Falling in the Elderly Patient: An Interpretive Phenomenological Study

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Abstract

Background: Falls are a common and serious problem in the elderly as has been highlighted by the National Institute for Health and Clinical Excellence (NICE). Recent guidelines suggest people over the age of 65 years old are at risk of falling. There have been many consequences of falling reported. Fear of falling (FOF) has gained recognition as a health problem and a falls risk factor in the elderly,

Objective: To gain insight into the FOF in the elderly.

Method: This study used an interpretive phenomenological methodology. Recruitment involved six participants over the age of 65 from a National Health Service (NHS) falls prevention service. Data was collected through semi-structured interviews and were video recorded on an IPad. The video recordings were transcribed and analysedutlising interpretive phenomenology analysis (IPA).

Results: Four super-ordinate themes and ten sub-ordinate themes were drawn out of the data. The Four main super-ordinate themes were entitled (1) Impact of ageing after falling; (2) Consequences of falls; (3) The need for support and (4) Feelings of Inferiority.

Conclusion: This research provided lived insights into what is behind the FOF and how it affects patients. Through having a better understanding of the FOF, more effective assessments and management plans can be developed. The visual evidence can inform training programs and aid health promotional material in the health care setting.

ABBREVIATIONS

FOF: Fear of Falling; NICE: The National Institute of Health and Care Excellence; IPA: Interpretive phenomenology Analysis

INTRODUCTION

Falls are a common and serious problem in the elderly [1,2]. Recent Guidelines CG161 [1 p5] state that 'People aged 65 and older have the highest risk of falling, with 30% of people older than 65 and 50% of people older than 80 falling at least once a year.' Falls are estimated to cost the NHS more than £2.3 billion per year [1 p5]. Fall related injuries, can lead to hospital admission, on-going health care once back in the community and possible referral to a nursing home. The human cost of the patient's quality of life after the fall must also be considered. As the population of elderly people is growing it is likely that the numbers and costs of fall-related injuries and hospitalisations will also to rise. The World Health Organisation [3] has also identified falls in the elderly as a rapidly growing health issue. Todd and Skelton [4] emphasize the importance of falls prevention intervention to minimize the mortality, morbidity and suffering for elderly people and their families, in addition to the costs to the health service. Todd and Skelton [4] classified the risk factors for falls into three categories, intrinsic, extrinsic, and exposure to risk. The NICE guidelines CG161 [1] also identify risk factors and recommend a multifactorial assessment to recognise patients at risk. In the multifactorial assessment they recommend assessment of the elderly person's perceived functional ability and fear relating to falling. FOF has gained recognition as a health problem and a falls risk factor in the elderly [4].

In a literature review of 16 qualitative studies into the experience of falling Bailey, Jones and Goodall [5] found that fear was a major theme. This demonstrates that the participants

identify fear as the main factor associated with their falls. FOF has been defined as 'a lasting concern about falling that can lead an individual to avoid activities that he/she remains capable of performing' [2, p35]. Although FOF is recognised as a health problem and a falls risk factor in the elderly [4]. NICE guidelines CG161 [1] contain no recommended assessment tool or management of FOF to guide clinicians. Existing research into FOF is mainly quantitative. There are only small number of qualitative studies investigate the experience of falling and falls. A recent study aimed to gain an understanding of older people's perceptions of falls prevention advice. They used focus groups and interviews of 66 people aged 61–94 years. Thematic analysis revealed participants interpreted 'falls prevention' as meaning hazard reduction. They report their findings suggest that older people do not reject falls prevention advice because of ignorance of their risk of falling, but because they see it as a possible threat to their identity and autonomy [6]. There is little research qualitative research that focuses on the risk factor of FOF from the patient's perception.

This research aims to gain an alternative perspective on FOF by using a different research approach to previous studies. It will focus on the individual's experience of FOF and gain insight into their experience. Focusing on the individual allows the person to reflect on their experience and share how they feel it has affected them. This research can be used as a starting point for understanding FOF. This will bring new knowledge that will bridge the research gap into how FOF affects the individual and may lead to further negative experiences.

MATERIALS AND METHODS

Ontological and epistemological position for the researcher

The philosophical position adopted for this research is that a sense of reality depends on an individual's lived experience. From an ontological position there are multiple perceptions based on a person's own construction of reality [7]. Epistemologically, reality does not exist independently of the individual's mind. This concept applies to the researcher whose prior knowledge and experience of the subject will color how the research is designed and interpreted. The research question is broad to allow participants to include whatever they feel is relevant rather than being restricted by a more specific question. The study is inductive using the descriptions of the participants' lived experiences to explore and interpret themes.

Methodology and method

An interpretive phenomenological methodology approach was used in this study to explore the participants' lived experience of FOF. Interpretive Phenomenology was the chosen methodology as it explores in detail how people make sense of their personal and social worlds [8]. By applying this approach the aim was to explore how the world appears to the participants and how it is made meaningful. The participants interpreted their experiences, and the researcher used their own interpretation to come to an understanding of the participants' experience.

There has been debate in the literature on the appropriate sample size for interpretive phenomenological studies but overall the consensus is between three and ten participants [9,10]. Owing to the close exploration of experience, understanding and perceptions of the fear of falling only a small homogenous group of participants is recommended [10]. This is the reason six participants have been recruited for the study. The participants were recruited from the Falls Prevention Rehabilitation sessions provided by a NHS Trust. The data was collected using semi-structured interviews, which were video recorded. The interviews were semi-structured and contained open-ended questions aligned with the research aims. The questions focused on the individual's experience of falling and how it made them feel and affected their lives. For example one of the questions was "Can you describe how you were feeling straight after your fell?" The interviews took place in the participants' own homes and lasted approximately one hour. Video recording the interviews obtained data such as expression, gaze, and body language, which would have been lost in audio recording. Video recording the interviews enabled the researcher to watch the interviews multiple times and rigorously examine them to aid interpretation of the participants' interactions [11]. Pseudonyms were used to keep the participants confidentiality. The data was transcribed and analyzed by the principle researcher utilizing Interpretive Phenomenological Approach (IPA) [9]. IPA as described by Smith, Flower and Larkin [9] demonstrates the key essential processes needed to undertake analysis of qualitative data. They identify 6 main stages; stage 1 reading and re-reading; Stage 2 Initial noting; Stage 3 developing emerging themes; stage 4 searching for connections between themes; stage 5 moving onto the next case; stage 6 looking at themes across all cases. Within this study this approach was implemented in the analysis process.

This Research has been approved by the NRES Committee South East Coast, reference number: 15/LO/1114 and the local Research and Development committee.

RESULTS AND DISCUSSION

All the patients were over the age of 65 years old and had had a fall in the last 6 month. However all they all have different daily lives and individual experience of falling. Table (1) gives information of their demographic characteristics.

The analysis explored how the participants made sense of their personal experience of the FOF the researcher interpreted the participant's perceptions. Four Super-Ordinate themes were produced (Table 2).

Super-Ordinate Theme 1: Impact of ageing after falling

The World Health Organisation has aimed to challenge stereotypes in the published document Healthy Ageing [12]. They are aware that elderly people are often assumed to be frail or dependent and a burden to society [12]. The analysis of the data revealed that there was a significant relationship between FOF and being ashamed of ageing.

During the interviews all the participants at some point mentioned ageing and feeling old following their fall. Being ashamed of ageing was also a key topic from three of the woman participants.

"You feel old. I am old, but I don't want to be old" (Jane)

Table 1: Participant demographic characteristics.

Participant (pseudonym)	Age	Living arrangements	Number of falls
Annie	85	Lives alone	Multiple
Mary	74	Lives with her disable husband	3-6
Mia	80	Lives with her husband	3
Henry	82	Lives alone	Multiple
Jane	81	Lives alone	3
Ben	78	Lives alone	Multiple

Table 2: Table of Themes produced from the analysis.

Cluster of Themes: The lived Experience of the Fear of Falling				
Super-Ordinate themes	**Impact of ageing after falling**	**Consequences of falls**	**Need for support**	**Feelings of Inferiority**
Sub-Ordinate themes	Ashamed of ageing	Fighting the fear of falling	Importance of support	Losing control
	Feelings that falling in old age causes more damage	Perceived increased risk of falling and injury outdoors	Feeling alone	Social denial
	Ageing makes life harder		Understanding their falls	

"The ageing process, it's not a pretty sight." (Mary)

As we become older the end of existence gets closer. Throughout the interviews the word "old" is repeatedly used by all of the participants. The repeated use of this word could suggest that feeling old is the same for them as losing the ability to live the life they once had.

The participants blame their age for putting their bodies more at risk. At this stage in their lives the participants are finding that age is playing a negative role in their daily life. They all refer to the "then and now." This reference to time is their reflection on their lost youth and how being elderly puts them more at risk of injury.

"I am more fearful now than I ever was. Umm, because of my age, because umm, I know that bones get more brittle, as you get older. Umm, there is that fear than I am really going to hurt myself" (Annie)

There is a fear of injury and the possible consequences of falling are at the front of their minds. The participants mention the loss of independence and confidence they now have after their falls and how it makes them feel older. Becoming elderly can symbolise the loss of independence. This limits their activities and reduces their quality of life.

"I've not been round the shops since, not even to get a paper. It has knocked my confidence and made me feel a lot older." (Mary)

This has impacted on the participants' daily lives and has prevented them from doing what they were able to do in the past. The words 'difficult' and 'struggle' were used throughout the interviews. Through the interpretation process it could be argued that they feel old age is a struggle. This is how they now perceived their lives. Participants also felt that becoming old made them more susceptible to falls. This is supported by Faes et al. [13], where patients and their caregivers also felt that falls were caused by age. Roe et al. [14], also found that falls were perceived as a consequence of ageing and part of the life course. Myers, Powell and Maki [15] reported that elderly people who have never had a fall still had a fear of falling. A relationship between physical and psychological changes in elderly people's attitudes of falling was also reported.

Super-Ordinate Theme 2: Consequences of falls

All the participants had multiple falls which increased the struggle to keep their independence and quality of life.

"I get slapped down again, perhaps because I have a fall" (Annie)

"And I can't stop myself once I have started to fall. It's just, that's it, and you're going down." (Annie)

The participants talk about this cycle of being knocked down and having to keep getting back up again. They experience a constant struggle to carry on with life and not let the falls beat them.

"I won't give in, I will struggle every day. "(Jane)

"It would get to the stage it was healing up nicely and then I would fall over again." (Ben)

Mahler and Sarvimaki [16] produced a theme of 'The strength of the will and the ego'. One of Mahler's participants admitted to living with the FOF, but said 'You have to go on and you will conquer your fear.'

They realise this is a fight for survival and they have to stay positive and determined. However all the participants expressed great concern about going outdoors. There appears to be anxiety concerning the environment, the surface they walk on and the impact this may have if they fall over.

"Well if you fall outside it's a lot harder than if you fall inside where you got carpet and everything like that" (Henry)

When reviewing the literature, Mahler and sarvimaki [16] produced a theme of 'the outside jungle'. One of the quotes from the research was "The outside door was the threshold to a dangerous world".

There is a concern relating to being in crowds. Mia and Jane expressed the fear that people might knock them over. In their own homes this cannot happen and they feel it is safer to stay inside.

"I terrified of people, if I see a crowd of people and if they're going to step back and run me over "(Jane)

The symbolic construction of meaning within advanced IPA could suggest that the fear of crowds is perceived as survival of the fittest. There is fear that the environment outside is more dangerous and that they are not fit enough to survive against the crowds of people.

Super-Ordinate Theme 3: Need for support

The participants had varying social networks. They talked about how their support network affected their present situation and influenced their views on falling. The participants that had social support talked about being a part of something, and being wanted. In addition to feeling cared for, social support made participants feel included. They felt they needed a purpose in life in order to have something to live for.

"I got something to go on for."(Henry)

However, three of the participants talked about living on their own and the feeling of loneliness. The feeling of loneliness can cause a powerful sense of isolation and disconnection.

"It's one of the loneliest places to be when you're on your own. You're looking at four walls."(Henry)

There is also a concern about who is going to help them if they are home alone.

"Who is going to find me?" (Henry)

Loneliness is also report by Faes et al. [13], patients described being social withdrawn and this attributes to their (FOF) and loss of physical capabilities. Isolation and loneliness are commonly experienced by elderly people, particularly those who have lost a spouse or who live alone [12].

Another key topic that was discussed by the participants was being able to understand why they were falling. Understanding the reason for their falls gave the participants an awareness of what was happening to them and the emotional ability to tolerate the experience. Annie felt that she did not know why she was falling and that nobody else knew why either. This led to frustration and despair, because she had no understanding of what was happening to her. She looked up to the ceiling, as if looking for the answers, then paused and shook her head as she faced forward.

"Why am I keeping falling? What's wrong with me?"(Annie)

The other participants showed an awareness of why they had fallen, and a positive attitude about the health care they were receiving. They talked about their situation improving and how beneficial the rehabilitation has been. In contrast Faes et al, [13] reported that patients and caregivers felt they could not be helped and that nothing could be done to reduce their FOF. Recent research has shown that uptake to falls prevention programs is low [17].

Super-Ordinate Theme 4: Feelings of Inferiority

The feeling of inferiority can occur after a negative experience. Falling can result in low self-esteem. Those who have fallen can feel too discouraged to carry on with the life style they previously had. Falling can have a huge impact on people's quality of life, the way they see themselves and the way they think others see them. The participants use the words "loss" and "lost" throughout their interviews. Using IPA the words "loss" and "lost" can be interpreted as participants losing control of their own reality, and of the life they had before falling.

Mahler and Sarvimaki [16] found that participants described living with FOF as learning to live with the challenge of losing control at different levels. The participants talked about losing control during and after falling. They expressed concern at having no control at being unable to get back up after falling.

"I didn't realise that I, umm, my foot had come out of the actual slipper, and I must of, I walked along there, then I found I was on the floor. And then I was quite wet. What's great, and you know, it's marvellous, you have lost your slipper in the rain, you have your trousers all wet and then you're trying to get up. I grabbed that bird thing and that fell over, then I crawled along and grabbed hold of the lamp post, and pulled myself up from the lamp post. And I think the worst thing about falls is when you're actually, when you're on the floor and you're trying to get up, and it's frightening to be honest."(Ben)

Some of the participants used blame to try and regain control. Self-blame comes from a belief that they had control of the situation and should have stopped themselves falling. They felt they were doing something wrong that was causing the falls but they did not know what it was.

"What am I doing wrong?"(Annie)

Using blame to hold others responsible for their falls can prevent the participants from moving forward and facing the future. The theme of 'blame' was identified by Horton [18], who explored gender differences and the risk of falling. Horton reported that women tended to blame falls on their own carelessness. Referring back to the data, two of the woman blamed themselves for their falls.

Some of the participants denied having a problem with falling. Refusing to accept the truth about falling and admit it to others was a subject that came up in the interviews. One of the reasons for this was because they did not want to see themselves as vulnerable. They were not willing to admit their vulnerability and wanted their reality to stay as it was.

"There's nothing wrong with me. I don't need any help, and I wouldn't tell anyone about the falls. They probably know because I have had the ambulance several times, and wondered why. But no, I'm fine. If anyone asked me, I have nothing wrong with me."(Mary)

This is reported by Faes et al. [13], where participants denied and hid the fact that they had had a fall. Some of the participants tried to make it sound less severe by saying "it was just a stumble" (p841). The analysis shows that the FOF is multi-factorial with many elements coming together to produce the fear behind the falling.

Video Analysis

When analysing the video data the approach that was taken was to remain at case level and use descriptive analysis to produce coding. Using IPA methodology, the coding was then interpreted by the researcher. The video data revealed non-verbal descriptive body language which has been used to produce descriptive coding, See Table (3).

Video analysis the descriptive coding produced from the video analysis is closely linked to the themes produced from the IPA (Table 3). Some of the participants used denial as a coping strategy. The use of humour to remove the seriousness of their falls was seen in the videos. This appears to reduce the fear and stress they would have if they did not use humour. Also the use of positive attitude and hope was used as a coping strategy. Annie, Mia and Ben talked positively about the health support they were receiving and the improvement in their health. They smiled when talking about their support, which reinforced their satisfaction with their care. The need for support was greatly discussed by all of the participants. Annie and Henry talked about feeling alone. Their faces showed sadness when they talked about their FOF and being alone with no one to help them. FOF was greatly discussed, and the participants expressed a fear of injury and the loss of their independence. The video recording shows Annie, Mary and Jane shaking their heads and looking away from the researcher when discussing the injury they could do to themselves. This showed frustration and fear of what could happen to them if they fell again.

Limitations of the research

Reflecting on the recruitment of participants, the method used was a poster hung up in the Falls Prevention Clinic. It was hoped that patients attending the Falls Prevention Clinic would be recruited. However targeting this group of patients limited the range of participants recruited. It could be suggested that the patients attending the clinic had accepted their falls and were ready to move forward in their rehabilitation. It could be argued that patients not attending a Falls Clinic would have a different attitude to their experience based on their different stage and understanding of the fall. However it could be argued that a homogenous sample fits into the analysis of IPA [9].

The data was collected using semi-structured interviews. This is recommended by Smith, Flower and Larkin [9] when using IPA. It allows the participants to express their lived experience. The participants have free speech to discuss what they feel is essential to their experience and to guide the interviews in the direction they feel is important. This fits into the interpretive phenomenological approach by allowing the participants to reflect and share their meaning. However this can potentially be a limitation as the interview can move away from the research topic.

The methodological approach adopted for this research was interpretive phenomenology. Due to the small sample size recommended for this approach, the findings cannot be generalised to all populations. However the research contributes to a developing body of research exploring what the fear of falling means to the individual and how the experience has impacted on their life.

The lived experience of the researcher's life could cause bias in the personal interpretation and analysis of the data. It is important to consider whether the researcher being an NHS employed podiatrist affected their interpretation of the data. The role of reflexivity makes clear the researcher's personal insight and involvement in the research. Through reflexivity it is hoped the reader is able to see the stance of the researcher. During the whole process the researcher used reflective diaries to document their reflections of the research. The use of spider diagrams and mind mapping was used in structuring the analysis and demonstrating how the themes were interpreted.

Suggestions for future research

Reflecting on the emerging themes it can be interpreted from this research that one of the main elements around FOF is how the patients feels about themselves and how they feel there is stigma attached to them. Health promotion relating to falls prevention is needed to help challenge the stigma attached to falls in the elderly. The finding of this research suggests that the current existing falls awareness prevention programs are not as effective as they should be. This is not to say that the current strategies do not make a difference, but perhaps these falls prevention programs could be more patients centred and that the need to focus on the

Table 3: Video Analysis.

Descriptive Coding	Interpretation	Participants
Laughing about a negative experience	Using humour to block out the seriousness of their falls. This could be used as a coping strategy.	Annie Mary Henry Ben
Keeping their hands busy	Comforting themselves and reducing the anxiety they feel during the interviews.	Annie Mary Ben
Shaking of head and looking away when talking about loss of independence and falling	The shaking of the head and looking away is a sign of frustration and the fear of damage to themselves.	Annie Mary Jane
Expression of sadness when talking about being alone	Loneliness is a feeling that was discussed and this could be the fear of being alone and having no one to help when they fall.	Annie Henry
Expression of happiness when talking about improvement.	There is still positive attitude and feeling of hope that their situation is going to improve.	Annie Mia Ben

emotions and feels of the patient are missing. Taking this aspect into account for future research will be the patient in the centre of the falls crisis for the elderly patient.

CONCLUSION

This research has attempted to approach the understanding of the fear of falling from a new theoretical perspective, previously under-researched in current literature. This research is adding a new dimension to the current health service frameworks which exist to support patients in their homes once they experience a fall. This research is putting the patient at the center of their experiences of the FOF and the problems they have lived through to continue with their lives. This reattach is not suggesting that we ignore current strategies for supporting falling at home; this research is adding a new qualitative layer to a problem that will continue to grow as the elderly population lives longer in future.

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