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ORIGINAL ARTICLE

The Experiences of Older Adults Labeled as a High Fall Risk: A Generic Qualitative Inquiry

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Abstract

Falling is a multifaceted phenomenon that greatly impacts older adults. Throughout fall research, the aspect of fall risk labeling has been unobserved. This study aimed to explore the perceptions of older adults given high fall risk labels. The focus of the study surrounded the research question, "What is the experience of older adults who have been labeled as a high fall risk?" Eight older adults aged 65-85 participated in this generic qualitative inquiry, with each participant given a high fall risk label during hospitalization. The study utilized a semi-structured interview model with interviews conducted in library study rooms throughout the western United States. Data were analyzed using thematic analysis with constant comparison. Results from this study indicated that participants defined a high fall risk as an individual who experienced a reduction or loss of health. Despite receiving their high fall risk label during hospitalization, participants did not view themselves as high fall risk, instead of viewing themselves as independent and autonomous beings. However, indications were made that the participants perceived a change in how others saw them after being given a high fall risk label. Findings from this study supported Erikson's stages of psychosocial development by providing a connection between theory, problem, and outcome, demonstrating the resurgence of complex developmental stages initiated by high fall risk labeling. This study provided tentative and initial findings that older adults negatively perceive high fall risk labels that challenge their identity. Increased research will continue to be needed exploring how older adults retain a sense of identity despite a variety of mental and physical challenges that research has shown older adults face.

Objectives

Falls pose a universal public health problem that occurs in a multitude of settings. Falling is an unintentional or unplanned action where the body suddenly and unexpectedly moves from a higher position to a lower level, such as the ground or floor, without control [1]. Worldwide statistics show an estimated 646,000 individuals die annually from falling, with older adults suffering the greatest number of fatal falls [2]. As the population advances into old age, the group will experience declines in sensory-motor control and functioning [3-5]. Falls have been cited as the most common safety incident among hospitalized patients [6].

The prevention of falls during hospitalization has seen increased focus within the past decade. The Centers for Medicare and Medicaid Services implemented payment changes designed to encourage the prevention of falls, and as of October 1, 2008, Medicare no longer reimburses healthcare institutions for injuries that occur from falling during hospitalization [7]. The emphasis on fall prevention has continued with the Joint Commission mandating accredited hospitals perform fall risk assessments on inpatients [8].

Fall research often focuses primarily on the identification of risk factors [1,5,9], prevention [10], and intervention [11] with a tendency to examine the cause of the fall rather than an individual's experience. The impact of fall risk labels on self and collective identity has been overlooked in research despite indications that connections with health can shape or alter personal identity [12]. In this study, the researcher focused solely on the subjective experiences of older adults who were given a high fall risk label during hospitalization. The methodology allowed for exploring factors associated with aging to further knowledge of normative life

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events by utilizing Erikson's epigenetic stages of human development [13-15] to focus on Jung's sense of self [16].

Lack of awareness or miscalculated risk of falling can impact behavior and hinder behavioral changes that promote fall prevention. Fall prevention is contingent on behavioral change; however, research has shown that fall prevention regimens are ineffective [17]. When individuals cannot recognize or accept their risk for falling, they may be less likely to participate in preventative measures. Little is known about older adults' perception of high fall risk labels and what factors may motivate engagement in fall prevention activities [18].

Erikson proposed a comprehensive psychoanalytic theory of psychosocial development focused on ego, individual identity, and social identity [13-15]. Erikson delineated eight interrelated stages that every individual must pass through during their life cycle, with an individual's identity experiencing continued growth as it incorporates both experiences and challenges. Each stage builds upon the successful completion of previous stages, with unsuccessful stages projected to recur as deficiencies in the future. Revision of this work added the ninth stage of psychosocial development in which individuals confront the previous eight stages of development again with the negative beliefs having a dominant role over the positive [19].

Throughout the aging process, an individual's ascribed roles often change, presenting challenges to his or her identity. Older adults must confront functional and cognitive declines encouraging the reemergence of earlier stages within Erikson's theory [19,20]. If not successfully navigated, physical functioning and ability changes can lead to mistrust of capabilities and sense of self, negatively impacting development and successful aging [19]. While current literature addresses the impact of falling [21], fear of falling [22], and the influences of self-perception of health, functioning, and well-being [12,23], a prominent gap remains in how older adults experience fall status labels from a developmental perspective.

The purpose of this study was to gain new information about the experiences of older adults who were given a high fall risk label. Self-perceptions of aging have been linked to physical and psychological well-being [12,23]. Older adults with negative self-perceptions of aging often experience higher levels of disability and lower levels of physical functioning and overall health [12]. An understanding of the aging process is essential to increase the quality of life among older adults.

This research study supports Erikson's stages of psychosocial development by providing a connection between theory, problem, and outcome. Advancing Erikson's theory may enhance scientific knowledge on the resurgence of complex developmental stages that reoccur in later life, linking emotional and physical changes. Erikson's theory of psychosocial development was used to provide a means for understanding identity challenges. Identity development is seen as a lifelong and widely unconscious process that enables decisive character elements and virtues [24]. Abilities, capacities, strengths, and societal structures play a considerable role in developing ego identity [24]. Significant experiences are incorporated into ego identity, developing from adaptations made throughout an individual's lifespan [24].

The unique and multifaceted perceptions, insights, and experiences of older adults are important in shaping future research and health care interventions by informing clinical practice and interventions. Older adults are more frequently diagnosed with chronic conditions and multi-morbidities [25]. The findings from this research study may provide healthcare institutions, healthcare professionals, and the aging community with new insights into the experiences of older adults who meet the criteria for high fall risk labeling.

Methods

For this study, the researcher utilized a generic qualitative research design to gain insight into participant experiences, opinions, beliefs, attitudes, and reflections. The qualitative methodology provides data that is rich in detail from participants' perspectives allowing the researcher to obtain a realistic view of a lived world experience that often is unable to be understood or experienced through statistical analysis or numerical data [26,27]. Each participant in this study provided his or her perspective from the direct interaction of being labeled as a high fall risk.

Criterion sampling occurred after IRB approval and the successful completion of a pre-data conference call. Recruitment flyers approved by the IRB were posted in public libraries throughout a western state in the United States. Inclusion criteria required that participants were born between 1933-1953, had received a high fall risk label during hospitalization, had been hospitalized within the past year, had a minimum length of stay during hospitalization of at least three days, lived independently prior to hospitalization, understood and spoke English as a primary language, and were able to sign their own consent. Each individual that met the study's inclusion and exclusion criteria was notified, and meetings were scheduled in a public library study room at a time that was convenient for each participant.

After informed consent occurred, semi-structured open-ended interviews were conducted (Appendix A). The interviews lasted between 11 to 62 minutes. After the conclusion of the interview, the researcher documented observations by writing field notes. The researcher continued to recruit participants until data saturation

occurred. In keeping with recent generic qualitative studies, this study anticipated 10-15 participants to reach data saturation. However, the final sample size for this study was eight participants as a determination was made that data saturation had occurred and additional interviews would not generate new information [28]. The researcher transcribed and analyzed all data with transcriptions securely stored in a password-protected document file on the researcher's computer. During telephone follow-up, each participant's final comments were uploaded into a computer document, placed in the appropriate participant's file, and securely stored.

Thematic analysis with constant comparison was used for data analysis. The process of constant comparison to previously collected data is a key practice of this style of data analysis [29]. The researcher cross-compared data and persistently searched for similarities within-participant data. Codes and clustered patterns were utilized to process and to track data with coding supporting, recording, and structuring emerging patterns [29].

Results

The objective of this inquiry was to gain knowledge and understanding of how high fall risk labels interact with the aging process, individual identity, collective identity, and self-perceptions of aging. The study revealed new facets of individual and collective identity. The three overarching themes were: (a) A reduction or loss of health defined high fall risks, (b) Participants did not view themselves as high fall risks (c) Participants perceived changes in how others saw them.

Impairments defined high fall risk labels

Howcroft, et al. [30] defined falls risk labels as the result of fall risk assessments comprised of multiple factors including gender, age, height, weight, medical history, functioning limitations, drug and alcohol consumption, and current medication lists.

Loss of balance: When asked to define high fall risk, the participants initially concentrated their explanations on the loss of balance and the physical act of falling. P3 stated, "I would define a high fall risk as a person who is unstable and loses their balance." Similarly, P6 used "poor balance" to describe high fall risk. P4 and P5 described high fall risk as "someone who falls." P1 stated, "someone who falls, ah, is unsteady on their feet."

Perceptions of being old: A second pattern was seen with participants highlighting that high fall risk labels were viewed as a negative perception of being "old" when expanding on this. P8 initially used the words "elderly," "brittle," and "delicate" to describe individuals whom he felt were a high fall risk. When elaborating on this, P8's account linked being old with frailty and the need for additional assistance stating, "Someone who is frail. Someone who needs other people to take care of them. You know the type. They look old. They act old."

Participants did not view themselves as a high fall risk

All of the participants received high fall risk labels during hospitalization, with many hospitalized for serious illnesses and diseases. However, a high fall risk label was often rejected as it did not fit in with strong and capable definitions of how participants viewed themselves.

Ability to maintain independence: For the participants' maintaining independence was a multifaceted concept. When describing themselves, participants often emphasized aspects of independence and activity. For P4, maintaining independence was connected with her ability to live in her home. P4 stated, "I'm still living in the house that [her husband] and I raised our children in. I host all the holidays there. "For P6, her job provided independence. P6 commented, "Even after all my recent troubles, I'm still teaching part-time. I don't think I'll ever be ready to retire." For others, the high fall risk label and subsequent interventions were tolerated as they were linked to hospital policy.

Awareness of limitations: Awareness of limitations and being careful was often referenced when de-identifying as a high fall risk. For the participants, "being careful" helped bring a sense of safety and was viewed as a logical adaptive response to deal with the dangers associated with falling. Participants were aware of their limitations and emphasized psychological and behavioral adaptations. P3 stated, "but I'm careful. I know what I'm doing. I know my limitations."

Positive perception of health: The participants' perception of health affected high fall risk acceptance. The participants perceived themselves to be strong and capable, not requiring the assistance of others to perform basic tasks which weaker or frailer counterparts who were deemed as high fall risk needed. The participants had difficulty seeing themselves in a weakened or altered state that might increase their risk of falling. Instead, participants focused on positive views of their health and their ability to stay active.

Participants perceived changes in how others viewed them

Autonomy was understood as the idea that the participants were able to and had the ability to be their own persons and live their lives according to choices and decisions that were not influenced, controlled, or directed by external forces. Rowe and Kahn [31] indicated that behavioral dimensions are influenced by the degree to which autonomy and control are permitted or denied.

Autonomy challenged: Unilateral policies and

guidelines (i.e., fall risk prevention) are often implemented to help mitigate the risk of falling, with healthcare providers and caregivers penalized or blamed when adverse health outcomes (i.e., falling) occur. For some participants, the pattern of loss of control was apparent. Often resistance to fall prevention interventions occurred as the participants viewed these restrictions as a challenge to their autonomy. Interactions with healthcare professionals were viewed as attacks on the participants' freedom and aptitude to act on their own behalf, with healthcare personnel's expectations for participants' independence perceived to be reduced or less than what participants rated their own self-capabilities.

Changes in how family and friends treated them: P4 said, "I could tell they were worried about me. [Her son] stopped by to check on me every day." When describing a visit by his coworkers, P8 commented, "They think that I'm more fragile now that I'm older. That's how they see it. It's such a strange feeling. To watch people change how they treat you because of your health or your ability to do things."

In conclusion, despite receiving their high fall risk label during hospitalization, participants described themselves to be in good health. The participants thought high fall risk labels were reserved for individuals in poor health, experiencing loss of balance, frailty, and those deemed to be old. Being labeled as a high fall risk did not change how the participants viewed themselves. However, participants perceived changes in how others saw them, especially healthcare providers. Interactions with healthcare providers were viewed as attentive and concerned while also being domineering, overbearing, and interfering.

Discussion

The participants in this study faced declines in health status and perceived threats to their independence. Erikson's theory provided the theoretical framework for this study by highlighting the adaptive functioning of individuals as they encountered stage crises that were triggered by their hospitalization and high fall risk label. Older adults often encounter physical [32] and cognitive declines [33], which expedite changes and challenges to mobility and functioning. For an older adult, the reemergence of stage crises can be generated by the onset of hospitalization, accelerating confrontation with the negative poles of stage constructs.

The participants' defensive reactions (i.e., denial, justification of noncompliance, and apparent power struggles with healthcare providers) could be in response to the confrontation of the second stage crisis (autonomy versus doubt and shame). Throughout the study, the participants discussed their struggles to separate from other older adults deemed frail, weak, and elderly and the need for personal control after being labeled as high fall risk (i.e., restriction of movement, challenges when toileting, being discounted by healthcare providers). The participants identified interactions with healthcare providers to demonstrate a lack of confidence in their ability to stand, walk, or toilet, which necessitated provider intervention and assistance restricting and challenging their perception of control. In response to this, participants maintained control over daily activities, often rejecting assistance and recommended fall prevention measures exhibiting increased risk-taking behaviors and enhanced motivation to maintain independence.

Conversely, healthcare providers' apparent doubt and uncertainty could stimulate older adults to confront deficiencies in motor and cognitive skills with negative evaluations. This could foster embarrassment and mistrust in personal ability inciting shame and doubt, which is encouraged by the loss of self-sufficiency. Shame due to perceived disability, powerlessness, and stigma may also transpire. As a result, an older adult's self-damaging behavior (i.e., noncompliance with fall prevention measures, reduction in physical activity, isolation, or reinforcement of beliefs that enable fear of falling) hinders the treatment and optimal outcomes.

Frustration and shame over a high fall risk label and cognitive and physical functioning changes could lead to antipathy, self-loathing, and disgust, fueling the crisis seen in stage three (initiative versus guilt). While exploring their feelings after being labeled as high fall risk, the participants confronted societal perceptions and expectations (i.e., those labeled as a high fall risk were identified as frail or weak, needed increased assistance, were in poorer health, and faced negative impacts to independence). In response to this, the participants attempted to minimize perceived disability associated with the high fall risk label.

Guilt over perceived deficiencies has the potential to support negative and harmful beliefs and self-regulatory functions. Guilt has been associated with negative self-conscious emotions, including embarrassment, regret, and shame [34]. Guilt directs behavior and is often in response to negative or positive evaluations of the self, which may impact cooperative behaviors [35]. In order to effectively deal with these negative emotional responses, a high level of conscious self-awareness is needed as individuals must assess themselves in comparison with an ideal standard [34] which in Western societies are values of youth and health.

Hospitalization and changes in cognitive and physical functioning stimulated participants to confront the issue of mortality with the onset of Erikson' s last stage (integrity versus despair) often triggered by loss (i.e., loss of family and friends, health, career) and changes in roles [20]. The participants experiencing declines in health and functioning seemed to foster a renewed sense of purpose to emerge as they labored to remain

autonomous. Throughout the interviews, participants discussed their involvement in activities both past and present that brought meaning to their lives. When faced with challenges, participants often drew upon experiences that helped remind them of their resiliency and provide the skills needed to cope and thrive, utilizing these skills to help solve current problems.

However, it should be noted that the participants' dissociation with their high fall risk label demonstrates engagement in the process of pseudo integration. The participants described an inability to view high fall risk labels and preventative fall measures from diverse perspectives. This lack of self-awareness and distorted perception of reality impacts safety and the facilitation of wisdom. This is a strategic response to deflect a stigmatized identity that is believed to be salient. Erikson, et al. [24] discussed older adults who gave accounts of their lives that sounded too unmarred and inerrant. Elders who, knowingly or not, gave accounts of their lives that sounded too flawless suggested that they were "constructing a satisfactory overall view of the life cycle by denying those elements they find to be unacceptable" (Erikson, et al., p. 70). In doing this, the older adult presents a version of them self that is unwilling to examine difficulties and lacks self-awareness as they desire to be seen as strong and capable. This study supports previous research findings indicating that fall prevention messages are often rejected when the message is associated with a negative identity [36], with individual perception of health and ability providing an important source of identity and self-worth. However, in order to achieve ego integrity, the individual must strip away any false identities that his or her ego has created.

According to the Centers for Disease Control and Prevention [37], falls are considered to be one of the most preventable health problems in the United States. However, previous research has shown that hospital fall prevention programs often fail to produce optimal results. Previous findings suggest that a patient's complex medical conditions, inability to identify fall risk factors and overconfidence enable ineffectiveness [38]. The evaluation of preventative fall measures like fall risk labels are necessary to assist healthcare providers, older adults, and other key stakeholders in evaluating their impact and effectiveness.

Limitations

Limitations of this study should be considered when interpreting the results. First, a potential personal bias of the researcher and lack of objectivity in the research must be identified. To address this limitation, the researcher performed bracketing to identify and diminish personal biases. The study was also limited by the selection of a small number of participants. The initial sample size called for ten to fifteen participants; however, data saturation occurred at eight. Finally, the subjectivity of the participants' responses must be addressed. While participants who volunteer for research studies are more likely to share information freely due to the perception that their opinions and experiences matter, they may provide answers they feel are desired to the researcher [39]. The researcher employed member checking to help validate data; however, this process could not eliminate all potential for bias.

Conclusion

This study provided an in-depth look into how eight older adults described their personal experiences being labeled as a high fall risk. The findings of this study revealed a mixture of vulnerability and resiliency with a multitude of influences contributing to adaptation and independence. The beliefs and perceptions of the participants operated as coping mechanisms to health declines and other issues. Perceptions were not always medically accurate but were rational and inherently logical from the participants' subjective viewpoints serving as their objective reality and influencing acceptance or lack of acceptance of the high fall risk label and subsequent behaviors. This study has shown that older adults want to be seen for who they are as individuals, listened to, respected, and appreciated. Indications were made that health care providers were unable to adequately grasp and understand the feelings and needs of older adults concerning fall prevention. The information provided in this research may be beneficial to health care institutions, health care professionals, and the aging community as it examined the experiences of older adults who are given high-risk fall labels.

Current fall messages have negative connotations associated with them and could be seen as limiting or disregarding older adults. The interests and needs of older adults should be a central focus when working on fall prevention. Health care providers can work to keep the needs of older adults as the primary emphasis of their service by seeing, hearing, interacting, and treating each individual as the unique person they are. For fall prevention to be successful, it is essential to consider the personal narratives of the individuals that it targets [40].

Approaches to fall prevention often lack insight into the populations they serve, which greatly impacts their effectiveness. Ineffective evidence-based fall interventions divert and waste resources and may negatively impact older adults by worsening health outcomes and increasing fall rates. Continued efforts and collaboration are needed between health care professionals and older adults to help test preventative fall measures and interventions and modify unfavorable beliefs, providing individualized support that could help advance evidence bases and increase validity.

This research indicated that a resurgence of complex developmental stages continues to reoccur in later life. Changes in health facilitated the confrontations of previous developmental stages as older adults worked to confront challenges to their autonomy. The findings of this study may be useful to psychologists working in healthcare sectors as psychologists have increased opportunities to promote behaviorally oriented healthcare approaches [41]. Therefore, psychologists may use this information to advocate positive health behaviors, alter maladaptive behaviors, and promote enhanced community involvement and interactions.

This study provided tentative and initial findings that older adults negatively perceive high fall risk labels that challenge their identity. Increased research will continue to be needed exploring how older adults retain a sense of identity despite a variety of mental and physical challenges that research has shown older adults face [42]. Hospitalization and subsequent fall risk labeling may be promoting a shift in the young-old to face identity issues associated with the old-old as the young-old confront complex illnesses and declines in mental and physical.

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Appendix A

Following is a list of the 9 researcher-designed guiding questions:

1. How would you define a high fall risk?
2. What beliefs do you hold about being labeled as a high fall risk?
3. How did you feel when you were told that you were a high fall risk?
4. How did you view yourself prior to being labeled as a high fall risk?
5. How did you view yourself after being labeled as a high fall risk?
6. How would you describe your current perception of self?
7. Have you noticed a change in your behavior since being labeled as a high fall risk? If so, what changes have occurred?
8. Have you noticed a change in other's behavior or how others treat you since you were labeled as high fall risk? If so, what changes have occurred?
9. Is there anything that you would like to add or you feel that I am missing?