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RESEARCH ARTICLE

REVISED How community-dwelling older adults use positive coping strategies to manage fear of falling: a qualitative study using walking interviews

[version 3; peer review: 1 approved with reservations]
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Abstract

Background

Older adults often experience fear of falling (FoF). Falls and FoF impose significant costs on both individuals and the healthcare system. As a result, a wide range of interventions has been developed to prevent them, and much recent research has focused on evaluating the effectiveness of these interventions. However, evidence suggests that community-dwelling older adults also develop individual coping strategies, which remain understudied. This study aims to address this gap by identifying the coping strategies older adults develop and employ in their daily lives.

Methods

We conducted 13 walking interviews with older people residing in Canada. Our sample consisted of individuals living in an urban area, either with family members or alone. Participants were aged 55 and older and had experienced at least one fall in the past several years. We analyzed the data using reflexive thematic qualitative data analysis approach and identified six themes related to older adults' coping strategies. At the final stage, we conducted a co-occurrence analysis

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to explore the coping strategies that are interconnected.

Results

The analysis of the interview data identified positive individual coping strategies developed by older adults in their everyday lives. These strategies were classified into six main categories, including activity adaptation, social support, environmental modification, psychological resilience, health and wellness strategies, and use of supportive devices. We also found that older adults tend to combine multiple coping strategies. The most frequent co-occurrence is between activity adaptation and social support coping strategies, reflecting both individuals' personal agency and their reliance on social networks to prevent fear of falling and falls.

Conclusions

These findings suggest that seniors use a variety of coping strategies and often apply several of them simultaneously. The results can inform the development of devices and awareness campaigns aimed at reducing fear of falling and preventing falls.

Keywords
Falls, fear of falling, coping strategies, older adults, aging.



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REVISED **Amendments from Version 2**

The revised version includes statement addition in data section as Each coping strategy code was represented by a corresponding theme in ATLAS.ti. Theme co-occurrence analysis shows how often two themes were coded within the same quotation or in overlapping coded segments [40]. We used the theme co-occurrence analysis to examine co-occurrences between different coping strategies. Each cell in Table 3 shows how often two themes co-occurred, while groundedness (Gr) indicates the total number of quotations associated with each theme. We used these frequencies as an exploratory tool to identify commonly co-occurring coping strategies and then reviewed the corresponding quotations to better understand how these strategies were used together.

Any further responses from the reviewers can be found at the end of the article

Background

Preventing falls and reducing fear of falling among older adults is a key public health issue worldwide. Falls are one of the leading causes of injury[1] and unintentional injury deaths among older individuals,[2] with approximately 684,000 deaths globally each year.[2] Beyond actual falls, many older adults experience a fear of falls (FoF), defined as a psychological concern about falling and its potential consequences that may lead to activity limitation and avoidance.[3,4] Recent data suggest that nearly 50% of older adults worldwide often experience fear of falls.[5] This fear is strongly linked to poor health outcomes, including depressive symptoms,[6] lower life satisfaction,[7] and reduced physical activity.[8]

To address these adverse outcomes, various community-level interventions have been developed to prevent falls and reduce the fear of falling. Accordingly, much of the literature has focused on evaluating the effectiveness of these interventions. Within this field, existing studies offer key insights in three main directions. First, activity-related interventions consistently show the strongest effect.[9,10] Activities such as Pilates, yoga and Tai Chi significantly reduce the fear of falling, especially when supervised by instructors and offered in community settings rather than unsupervised or home-based programs.[11,12] Second, educational and awareness programs, including fall risk education and body awareness also help reduce FoF.[13] Older adults who fail to adequately assess their personal fall risk are more likely to experience falls.[14] Third, family involvement enhances intervention effectiveness. Educating family members and caregivers on fall prevention strategies supports older adults in managing FoF and preventing falls.[15]

While much of the existing research has focused on interventions, studies examining how community-dwelling older adults individually cope with the fear of falling remain scarce. Existing studies have predominantly explored coping among hospitalized older adults,[16–18] individuals in assisted-living facilities,[19] and older adults' caregivers,[20,21] with some research also examining the diversity of coping strategies among those who experience fear of falling and those who do not.[22] However, this field has largely overlooked community-dwelling older adults, who often individually develop coping strategies to manage fear of falling in everyday life.

This research aims to address this gap by identifying the coping strategies that community-dwelling seniors develop individually during their daily activities. To achieve this, the study employs the lens of the stress and coping model,[23] which posits that coping depends on personal appraisal, available resources, and contextual factors, ultimately serving to reduce stress. Coping involves both problem-focused strategies, aimed at addressing the problem itself, and emotion-focused strategies, dealing with managing emotional response, both of which contribute to sustaining individuals' well-being.

Methodologically, this study contributes to the fear of falling literature by employing walking interviews, a method that has rarely been used in this field. Although this method has been widely recognized as an effective tool for studying aging in place, its use in fear of falling research remains limited.[24,25] To the best of our knowledge, only one previous study has used walking interviews in this context.[26] Nevertheless, this method offers several important advantages for examining fear of falling among older adults. Conducting interviews as participants move through familiar environments can reduce the power imbalance between researchers and participants, thereby fostering greater rapport.[24,27] Allowing participants to choose the route and setting of the interview generates richer data by encouraging them to discuss aspects of their everyday environments and experiences that may not emerge during conventional sit-down interviews.[28]

Overall, this study is particularly important given the high prevalence of falls worldwide. In this context, a deeper understanding of the coping strategies developed and employed by older adults can provide valuable insights for designing technologies, guiding health care practitioners, and developing accessible awareness campaigns to effectively reduce falls and fear of falling, especially in settings with limited community support.

Data and methods

Data collection

This study is based on qualitative data obtained through walking interviews[27] with older adults. The study participants were asked to choose and engage in a routine daily activity of their preference. These daily activities ranged from gardening and washing utensils to grocery shopping and visiting a mall. While carrying out these activities, participants were asked questions about their experiences, the barriers they encountered, what could result in falls during those activities, and whether they experienced any fear during these daily activities. If so, they were asked why they experienced this fear and how they usually coped with it. We made sure that participants stayed focused on their activities, and the walking interviews were conducted in a conversational manner. This approach ensured that participants, rather than the researcher, remained in control of their narratives.

At the same time, participants took part in an observational study in which they wore eye-tracking glasses to capture where they were looking while engaged in the walking interviews. They also wore wrist devices that recorded biometric data, such as heart rate. These data are used in a separate research project[29] and may potentially be used for data triangulation.

Initially, 15 community-dwelling older adults participated in the study; however, only 13 provided explicit responses regarding fear of falling and coping strategies and were therefore included in the analysis. The average duration of the walking interviews was approximately 57 minutes (SD = 31.06). Since participants were free to select and perform any daily activities of their choice, the number and type of activities varied across participants, resulting in variation in the duration of the interviews.

Data collection took place between July and December 2023. Because data were collected during both the summer and winter in Toronto, participants performed different activities to account for seasonal and environmental differences. During the summer, some participants completed outdoor walking activities, whereas in the winter, activities were conducted primarily indoors.

Older adults were recruited through the Jane and Finch Family Centre in the Jane and Finch neighborhood in Toronto, a marginalized community characterized by high population density, a large immigrant population, a high proportion of visible minorities, and social and economic deprivation.[30] Study participants were selected using purposive sampling. To be eligible, respondents had to be 55 years of age or older and have experienced a previous fall. For the purposes of this study, older adults were operationally defined as adults aged 55 years and older. Although Canadian demographic and public-health reporting commonly use a threshold of 65 years, some Canadian community-based programs use 55 years to define older adults or seniors.[31–33] This threshold was appropriate for the present community-based study because falls and fear of falling are documented among adults aged 55 years and older.[34–36]

Study participants

There was a total of 13 study participants, most of whom were female (84.6%), had a high school education (46.2%), and resided in the Jane and Finch neighborhood in Toronto, an urban area in Ontario. The majority of participants were in the 55–64 (41.7%) and 70–79 (41.7%) age groups. In terms of living arrangements, over half lived with family members (53.8%). Almost all participants reported having various chronic diseases, such as arthritis, hypertension, and diabetes. According to the 16-item Falls Efficacy Scale-International (FES-I), most study participants scored above 23, indicating a high level of concern about falling.[37] A detailed description of the participants is presented in Table 1.

Data analysis

The qualitative data derived from the walking interviews were transcribed verbatim by a research team member with a sociological background. Data were analyzed using reflexive thematic analysis as proposed by Braun and Clarke,[38] with the support of ATLAS.ti Version 25.0.1.

The analysis followed the six phases of reflexive thematic analysis. First, the researchers familiarized themselves with the data by listening to the interview recordings and repeatedly reading the transcripts while recording preliminary analytic observations and reflecting on patterns relevant to the research questions. Second, an inductive coding approach was used to generate initial codes directly from the interview transcripts. Throughout this process, the researchers engaged in ongoing reflexive discussions about their interpretations of the data, using these conversations to deepen and refine the developing analysis rather than to achieve coding consensus. Third, the researchers examined relationships among the codes to identify patterns and develop initial themes and subthemes. Fourth, these themes were reviewed and refined by returning to the coded data and the complete dataset to ensure that they accurately represented participants' ideas. Fifth, the themes were clearly defined and named. Finally, the themes were fully developed and described in relation to the

Table 1. Socio-demographic characteristics of the study participants.

# Study Participant	Age group	Gender	Highest degree of education	Living arrangement	Chronic disease	Falls Efficacy Scale (FES-I) Score
1	65–69	Female	Less than high school	Alone	Diabetes, arthritis	31 (high concern)
2	55–64	Female	Less than high school	Alone	Diabetes, asthma	53 (high concern)
3	70–79	Female	Less than high school	Alone	Diabetes, arthritis	28 (high concern)
4	65–69	Female	High school	With a husband	Diabetes	61 (high concern)
5	*	Female	High school	With a husband	No chronic disease	35 (high concern)
6	70–79	Female	High school	Alone	Hypertension, arthritis	53 (high concern)
7	55–64	Female	High school	Alone	Hypertension, arthritis	51 (high concern)
8	70–79	Female	High school	With a son	Arthritis	43 (high concern)
9	70–79	Female	Less than high school	Alone	Diabetes, arthritis	43 (high concern)
10	55–64	Male	Graduate school	With a wife	Hypertension	26 (high concern)
11	55–64	Female	Graduate school	With a husband, and a son	Hypertension, diabetes	27 (high concern)
12	70–79	Male	High school	With a wife	Hypertension, heart attach angina	46 (high concern)
13	55–64	Female	College/ University	With 2 sons and a husband	Hypertension	*

*These data are not disclosed in accordance with the study participants' preferences.

research questions and study aims. Although these phases are presented sequentially, the analysis was iterative, with researchers moving back and forth between the data, codes, and developing themes throughout the analytic process. Consistent with reflexive thematic analysis, the researchers viewed the analysis as an interpretive process shaped by ongoing reflexive engagement with the data.

Additionally, we conducted a co-occurrence analysis of codes[39] in ATLAS.ti to identify coping strategies that are interconnected and used together by older adults. Each coping strategy code was represented by a corresponding theme in ATLAS.ti. Theme co-occurrence analysis shows how often two themes were coded within the same quotation or in overlapping coded segments.[40] We used the theme co-occurrence analysis to examine co-occurrences between different coping strategies. Each cell in Table 3 shows how often two themes co-occurred, while groundedness (Gr) indicates the total number of quotations associated with each theme. We used these frequencies as an exploratory tool to identify commonly co-occurring coping strategies and then reviewed the corresponding quotations to better understand how these strategies were used together.

Results

The analysis generated 51 codes organized into six themes: activity adaptation, social support, environmental modification, psychological resilience, health and wellness strategies, and the use of supportive devices. These themes represent different ways participants responded to perceived fall risk in everyday life. Some strategies involved modifying activities or environments, whereas others relied on social relationships, emotional coping, health practices, or supportive technologies. Activity adaptation generated the highest number of coded quotations (n = 97), followed by social support (n = 54) and environmental modification (n = 37). Psychological resilience (n = 36), health and wellness strategies,[25] and the use of supportive devices (n = 22) were represented by fewer coded quotations. These frequencies indicate the relative

Table 2. Descriptive statistics of derived themes.

Theme of coping strategies	Quotes (n)	Codes (n)
Activity adaptation	97	17
Social support	54	7
Environmental modification	37	6
Psychological resilience	36	14
Health and wellness	25	3
Use of supportive devices	22	4

prominence of themes in the coded dataset and should not be interpreted as the proportion of participants who used each strategy. Table 2 provides a summary of the coded quotations and codes associated with each theme.

Activity adaptation

Activity adaptation was the most prominent theme in the coded data. Participants described changing the pace, sequence, duration, or physical demands of everyday activities in response to fatigue, pain, balance concerns, or anticipated fall risk. Common adaptations included moving more slowly, dividing tasks into smaller steps, taking breaks, avoiding heavy lifting, and asking others to complete activities perceived as unsafe.

These adaptations did not always involve withdrawing from activity. In many accounts, participants modified how an activity was performed so that they could continue engaging in it while reducing perceived risk. The degree of adaptation varied across participants. Some retained responsibility for the activity by pacing themselves or incorporating rest periods, whereas others delegated specific tasks when they judged the physical demands to be too high. One participant described interrupting household activities when fatigue increased:

'Yeah, I feel tired. Like especially when I'm washing the dishes. It takes one hour for me to wash the dishes and clean. Yeah, so after this, washing the dishes, I feel tired, somewhat tired, so then I take some rest, go and sit down and take some rest and then come back again, start cooking.' (Participant 13: Female, aged 55–64, lives with her husband and two sons, and has a history of hypertension)

This account illustrates how participants adjusted the timing and sequence of everyday tasks in response to perceived physical limits. Across the data, activity adaptation functioned as a practical approach to managing risk while continuing daily routines.

Social support

Social support was another prominent coping strategy. Participants described relying on family members, friends, and community networks for practical assistance with household tasks, grocery shopping, cooking, cleaning, and other everyday activities. Social support also included emotional reassurance and the knowledge that help was available when needed.

For some participants, receiving assistance allowed them to avoid tasks that they or healthcare professionals considered unsafe. One participant described how her daughter helped with physically demanding household activities:

'Doctors taught me to vacuum. They stopped me to do the mopping. So when my daughter was living with me, she used to do it for me. So now she's gone. I do it myself. Sometimes she comes and she helps me.' (Participant 2: Female, aged 55–64, lives alone and has some history of diabetes and asthma)

Participants also described social support as reciprocal rather than one-directional. Some continued to provide help to relatives, friends, or neighbours, positioning themselves as active contributors within their relationships and communities. One participant explained:

'[Her friend] She lives over this building. Sometimes, two times a week, I cook for her, carry food. But I am doing it because I want to help her.' (Participant 4: Female, aged 65–69, lives with her husband, and has a history of diabetes)

These accounts suggest that social support involved both receiving assistance and maintaining reciprocal relationships. The theme therefore reflects not only practical help but also participants' continued involvement in social and community life.

Environmental modification

Participants also described modifying their physical environments to reduce hazards and make everyday activities feel safer. These changes ranged from more permanent modifications, such as installing grab bars or handrails, to routine practices such as turning on lights, checking for wet floors, and removing obstacles.

Participants frequently described monitoring their surroundings and making small adjustments before beginning an activity. One participant explained:

'Maybe I'm a little bit careful. I put the lights on, make sure that the floors are not wet where I am walking around. Otherwise, I have a fall while doing this activity' (Participant 10: Male, aged 55–64, lives with his wife and has a history of hypertension)

Others introduced movable items intended to improve stability in frequently used areas. One participant noted:

'I just got these mats here. I put them not to slide on the barefoot. I don't want the next fall.' (Participant 9: Female, aged 70–79, lives alone, and has a history of diabetes and arthritis)

These accounts show that participants did not treat the home environment as fixed. Instead, they actively assessed and modified their surroundings in response to perceived hazards. Environmental modification therefore functioned as an ongoing form of risk management embedded in everyday routines.

Psychological resilience

Psychological resilience referred to the ways participants managed the emotional and cognitive dimensions of fear of falling. Participants described maintaining a positive outlook, avoiding excessive focus on possible falls, accepting changes associated with ageing or health, and drawing emotional strength from faith. Several participants emphasized the importance of not allowing fear to dominate their daily thoughts. One participant explained:

'I try not to think about that. I just try to think positive every day. I wake up in the morning. I try to stay positive in doing whatever I have to do for the day. But you cannot think 'Oh, this morning I'm gonna fall'. No, you don't think that way. We always try to think positive.' (Participant 12: Male, aged 70–79, lives with wife and has a history of hypertension and heart attack angina)

For some participants, religious faith provided an additional source of emotional support. One participant reflected:

'That is life. Since my daughter passed away. But thank God, God be with me. God, be with me. We are talking. But God doesn't leave me. I'm happy.?' (Participant 6: Female, aged 70–79, lives alone, and has a history of hypertension and arthritis)

The data suggest that psychological resilience was expressed through several related but distinct strategies, including optimism, acceptance, attentional redirection, and faith. These strategies appeared to help participants manage the emotional burden associated with health challenges and concerns about falling.

Health and wellness strategies

Participants described health and wellness practices as another way of responding to fall-related concerns. Walking, stretching, and light exercise were commonly discussed as ways of maintaining movement, reducing discomfort, and supporting mobility.

Participants also described adapting these practices to environmental conditions. For example, some continued walking indoors during winter rather than discontinuing physical activity altogether. One participant explained:

'I go on walk every day. Yeah, every day. The hallway is my first walk. When I wake in the morning at eight o'clock. Before I just have breakfast. I just walk the hallway like that and to this end like 10 times go and come' (Participant 4: Female, aged 65–69, lives with her husband and has a history of diabetes)

Healthy eating was also recognized as important, but participants indicated that this strategy was not always easy to sustain. Financial constraints limited some participants' ability to follow dietary recommendations:

'My doctor recommends measuring my blood pressure and having a balanced diet, but it's sometimes hard to follow because of the high food prices.' (Participant 5: Female, age is not disclosed, lives with a husband and has no history of chronic disease)

This theme highlights a distinction between knowing which health practices may be beneficial and having the resources or circumstances needed to sustain them. Participants' use of health and wellness strategies was therefore shaped by both personal effort and external constraints, including weather and food costs.

Using supportive devices

Participants described using several types of supportive devices to reduce fall risk and increase their sense of safety during everyday activities. These included non-slip footwear, mobility aids such as walkers, and communication technologies such as smartwatches.

The devices served different functions. Footwear and mobility aids provided physical stability, whereas communication technologies offered access to assistance and reassurance, particularly for participants who lived alone. One participant described the role of a smartwatch purchased by her daughter:

When you live alone, you have to be careful, right? If I get hurt, what can I do? My daughter bought me that Apple Watch she said, 'Mommy, we're here all the time. I can know if something is wrong with you'. (Participant 2: Female, aged 55–64, lives alone and has a history of diabetes and asthma)

This account shows that supportive devices were not used only for physical assistance. Some technologies also connected participants to family members and provided reassurance that help could be accessed in an emergency.

Co-occurrence analysis of coping strategies

To explore how coping strategy themes co-occurred within participants' narratives, we conducted a theme co-occurrence analysis in ATLAS.ti. The analysis showed that activity adaptation most frequently co-occurred with social support indicating that participants often described modifying their daily activities while simultaneously relying on assistance from family members or friends to manage their fear of falling. These co-occurrences were identified across four participants, indicating that this combination of coping strategies recurred across multiple accounts. In addition, activity adaptation frequently co-occurred with environmental modification, health and wellness, and psychological resilience, illustrating that participants often combined behavioural adaptations with changes to their environment, health-promoting practices, and psychological coping strategies. Environmental modification also co-occurred with use of supportive devices, indicating that participants commonly used multiple practical strategies to enhance safety and reduce fall risk. The complete co-occurrence matrix is presented in Table 3.

Table 3. The results of co-occurrence analysis.

	Activity adaptation Gr = 97	Use of supportive devices Gr = 22	Environmental modification Gr = 37	Health and wellness Gr = 25	Psychological resilience Gr = 36	Social support Gr = 54
○ **Activity adaptation** Gr = 97	0	1	3	3	3	5
○ **Use of supportive devices** Gr = 22	1	0	3	0	0	1
○ **Environmental modification** Gr = 37	3	3	0	0	2	1
○ **Health and wellness** Gr = 25	3	0	0	0	2	1
○ **Psychological resilience** Gr = 36	3	0	2	2	0	2
○ **Social support** Gr = 54	5	1	1	1	2	0

Discussion

This study identified coping strategies that community-dwelling older adults develop individually to mitigate the fear of falling while performing their routine activities. The findings indicate that seniors tend to use the strategies across the following domains: activity adaptation, social support, environmental modification, psychological resilience, health and wellness strategies, and the use of supportive devices. The research also shows that older adults often employ multiple coping strategies simultaneously. The most common combination involves activity adaptation and social support, reflecting both individuals' personal agency and their reliance on social networks.

Our findings provide a more nuanced and contextualized understanding of fear of falling (FoF) and the coping strategies employed by older adults, extending previous research. Specifically, our findings support the "protective effect" described by Lee and Tak,[41] who argue that moderate fear can enhance task concentration and promote safer behavior. Our study illustrates how this protective effect is manifested through the use of active coping strategies, such as adapting daily activities and modifying the home environment to reduce fall risk. Furthermore, our findings are consistent with Ellmers et al.,[42] who suggest that perceived control is the key mechanism determining whether concerns about falling lead to adaptive behaviors or avoidance. The coping strategies identified in our study such as breaking tasks into smaller steps and proactively identifying environmental hazards reflect older adults' sense of personal agency and internal locus of control. Next, consistent with Jiang et al.,[43] our findings demonstrate that older adults actively employ a range of adaptive coping strategies, to mitigate the fear of falling. Our study extends this evidence by capturing these strategies within participants' everyday routines through walking interviews, providing a richer understanding of how coping strategies are developed and implemented in daily life.

Furthermore, this research provides important findings regarding the coping strategies of seniors, which align with previous studies, particularly in terms of activity adaptation,[17,18] environmental modifications,[18,44] psychological resilience,[19] social support.[22] However, it adds to the literature several crucial findings. First, while previous research shows that family, friends, and community support are central to social support coping strategies, this study reveals that seniors are not only recipients of assistance but also active providers, exercising agency in helping family and friends. Second, the research demonstrates that health and wellness strategies are also important for mitigating the fear of falling among seniors, although some strategies, such as maintaining a healthy diet, may be constrained by financial capacities. This finding requires further exploration, particularly in terms of how socioeconomic background conditions fear of falls and the employment of various coping strategies. Third, the study highlights the growing interest of older adults in using devices to mitigate the fear of falling. Seniors often use devices such as smartwatches to stay in touch with family, which has important implications for the further development of technologies tailored to fall prevention among the elderly.

Next, older adults tend to combine multiple coping strategies simultaneously. In particular, this research found that the most frequent co-occurrence was between social support and activity adaptation showing that older adults commonly rely on both practical assistance from others and behavioral adaptations to reduce their fear of falling. This finding contributes theoretically to coping and stress theory[23] in the context of older adults' coping. While individually developed activity adaptations reflect problem-focused coping, social support reflects both problem-focused and emotion-focused coping, as seniors mentioned two dimensions: assistance with activities and emotional comfort. Moreover, this finding has important practical implications, suggesting that interventions, devices, or awareness campaigns for community-dwelling older adults should address both their individual agency and their social networks when targeting the fear of falling.

A strength of this study is that it is among the first studies on fear of falling to collect data using walking interviews. This approach enabled participants to build rapport with the researcher while engaging in their everyday activities. It also allowed participants to navigate their familiar environments and reflect on their fear of falling in the context in which it is experienced. As a result, participants were able to discuss their feelings and coping strategies while performing daily tasks, providing richer and more contextualized insights than traditional semi-structured interviews, which rely on participants recalling past experiences and emotions. Additionally, this is one of the first studies to employ co-occurrence analysis to identify strategies that seniors use simultaneously.

Despite its strengths, the study also has several limitations that should be acknowledged. The sample consisted primarily of older adults living in urban area. Consequently, the findings may not be generalizable to older adults residing in rural settings. Future research should therefore examine coping strategies among rural populations, as their daily activities and environmental contexts may differ substantially from those of their urban counterparts.

Building on the results of this study, future research should further explore several key directions. First, it would be valuable to further examine the use of devices as a coping strategy that seniors employ in their everyday lives.

Additionally, future studies should continue investigating how different coping strategies are used in combination, as this approach can provide a more nuanced understanding of seniors' behavioral responses. Another promising area for future inquiry is the role of socioeconomic background in shaping both the fear of falling and the adoption of coping strategies. Exploring these dimensions would deepen understanding of the complexity of fall-related experiences among older adults.

Conclusions

This study provides insights into how community-dwelling older adults develop and employ coping strategies to mitigate their fear of falling in everyday life. Furthermore, these findings can inform awareness campaigns, community interventions, technology design, and policy measures aimed at preventing both the fear of falling and actual falls among older adults.

Ethics and consent

Ethical approval for this study was obtained from the Research Ethics Board of York University (Toronto, Canada; approval number e2022–204). Written informed consent for participation and publication was obtained from all study participants.

Data and software availability

The dataset of this study is not publicly available due to the privacy concern of participants. Access to the data may be granted for research purposes upon reasonable request. Requests should be directed to Dr. Shital Desai at desais@yorku.ca. Access will be reviewed on a case-by-case basis and is subject to ethical approval and data-use conditions.

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Open Peer Review

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Version 2

Reviewer Report 18 August 2026

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Toby Ellmers
[1] Imperial College London Department of Brain Sciences (Ringgold ID: 216517), London, England, UK
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My final recommendation is to provide further methodological clarification regarding the "co-occurrence" analysis. Subject to this revision, I have no additional comments.

Competing Interests: No competing interests were disclosed.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 30 Sep 2026

Valeriia Yakushko

Thank you for this comment. We have added methodological clarification regarding the co-occurrence analysis.

Competing Interests: No competing interests were disclosed.

Version 1

Reviewer Report 10 March 2026

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Toby Ellmers
[1] Imperial College London Department of Brain Sciences (Ringgold ID: 216517), London, England, UK
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- It would be useful to somehow in the title indicate that this isn't just a standard qualitative study, whereby semi structured interviews are performed – but rather a type of think-aloud paradigm, as this is very novel. As far as I am aware, this has only been done before in young adults exposed to a fear evoking balance paradigm (e.g., Zaback et al. (2016)) – but still this was immediately retrospective. Relatedly, Ellmers et al. (2020) asked older adult fallers (and non fallers) to retrospectively describe thought processes and strategies to avoid falling during high risk scenarios. Although it might be useful to mention these studies in your Introduction/Discussion, your study is very novel and I feel the title (but actually the Introduction overall) can better emphasise the novelty of your approach.
- Please provide more detailed analysis of the actual tasks that participants performed during the verbal report protocols. Were the tasks and the environments performed in standardized across participants? Or did these differ? What specific questions were asked to participants (and at what point in the task)? Were follow up prompts used? If the experimenter wanted further clarification, did they ask this during the task or after?
- Although I applaud the authors for adopting such a novel approach, I am concerned that by asking participants these types of questions during the tasks themselves would have altered how they performed the task – and potentially the responses then provided. For instance, performance may have become more conscious (e.g. Uiga et al. 2019, 2020, Wong et al. 2008).
- How did the experimenter also avoid the verbal reports protocol becoming a dual-task that disrupted the ongoing task?
- Can you please comment how for some people the protocol only lasted for 14 minutes, but for others over 2 hours? Did some people just perform less tasks? If so, why?
- It appears that the overall themes were derived inductively, based on an existing model. But was coding also performed inductively, or...?
- The thematic analysis methods used (if indeed adhering to the original 2006 Braun and Clarke paper) are outdated. Reflexive thematic analysis has now replaced the original thematic analysis (Braun & Clarke, 2019; Braun et al., 2023). Can the authors please comment on what type of thematic analysis was used?
- Given that data collection spanned summer and winter in Toronto, please comment on how the differing weather may have also affected the data collected (given that some participants would have been performing tasks outside in sunshine and others in ice/snow).
- The majority of the sample are younger than 65 (the typical cut-off for someone being deemed an "older adult", although that I appreciate that some countries view this as 60). I

am surprised that this sample experienced falls and fear of falling. Would the authors be able to comment on this point? The framing of the study however needs to also be addressed – instead you should write “middle-aged and older adults” throughout (including the title), as stating only older adults is misleading. In the Abstract it is written that participants were aged 55 and older, but Table 1 has a participant aged 45-54.

- Relatedly, Table 1 would have benefitted from additional demographic information, including: prior fall history, clinical measures of FoF/balance confidence (FES-I, ABC etc), clinical balance/gait measures (e.g., TUG, berg balance scale etc.). This is all important information to understand the sample and better interpret the findings.
- I felt that the Result section in places felt too sparse. I urge the authors to study some examples of Braun and Clarke’s empirical work whereby reflexive thematic analysis has been effectively used, so that further details and data can be presented to allow the reader to fully comprehend the themes presented.
- Many of the same findings/conclusions have been presented in other recent qualitative studies / qualitative meta-syntheses (Ellmers et al., 2022; Jiang et al., 2024; Lee & Tak, 2023). I feel that the results should be discussed within the context of this existing work.
- In the Discussion, you mention the sample coming from “marginalized” backgrounds. But this is not described anywhere in the Methods. Please clarify.

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Is the work clearly and accurately presented and does it engage with the current literature?

Partly

Is the study design appropriate and is the work technically sound?

Yes

Are sufficient details of methods and analysis provided to allow replication by others?
Partly

Are all the source data and materials underlying the results available?
No

If applicable, is the statistical analysis and its interpretation appropriate?
Not applicable

Are the conclusions drawn adequately supported by the results?
Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Falls prevention; fear of falling; qualitative research.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 15 Jul 2026

Valeriia Yakushko

1. Thank you for this valuable suggestion. In the revised manuscript, we more explicitly describe the use of walking interviews and emphasize the novelty of this methodological approach. As recommended, we have also revised the title to explicitly indicate that the study employed walking interviews.

2. Thank you for this helpful comment. We have expanded the Methods section to provide a more detailed description of the walking interviews and the activities performed by participants. During the walking interviews, participants were invited to choose an everyday activity they wished to engage in. Consequently, neither the tasks nor the environments were standardized across participants. The activities varied and included, for example, gardening, washing dishes, grocery shopping, and visiting a shopping mall with friends. The interviews followed a conversational format, with questions focusing on participants' experiences while performing the activity, perceived barriers, situations that could increase their risk of falling, whether they experienced fear of falling during the activity, and the strategies they used to cope with that fear. We also clarify in the revised manuscript that follow-up prompts were used as needed to encourage participants to elaborate on their experiences.

3. This is a valid concern, and we were aware of this possibility. To minimize its impact, we ensured that participants remained focused on performing their activities while the walking interviews were conducted in a natural, conversational manner, consistent with the

principles of walking interviews. During the interviews, participants primarily narrated past experiences and described how they had coped with situations involving fear of falling or an increased risk of falls.

4. The conversational nature of the walking interviews helped minimize dual-task interference by allowing participants to remain in control of the conversation and pace of the interview. Rather than asking continuous or structured questions during task performance, the researcher followed participants' narratives and used prompts only when appropriate, enabling participants to lead the conversation and reflect on their daily experiences.

5. Thank you for this comment. Participants were free to select and perform the everyday activities they wished to demonstrate during the walking interview. Consequently, both the number and type of activities varied across participants, resulting in protocol durations ranging from 14 minutes to over 2 hours. To better characterize the sample and avoid potential confusion, we have revised the manuscript to report the mean duration and standard deviation of the walking interviews, rather than only the range.

6. Thank you for this comment. The coding was conducted inductively, consistent with the principles of reflexive thematic analysis. To clarify this process, we have revised the Methods section to provide a more explicit description of each step of the data analysis.

7. Thank you for this important comment. We used reflexive thematic analysis following the guidance of Braun and Clarke (2019) and Braun et al. (2023). In the revised manuscript, we have clarified this in the Methods section and explicitly described the analytical procedures to reflect the principles of reflexive thematic analysis.

8. Thank you for this comment. Because data collection took place during both summer and winter in Toronto, the activities performed by participants naturally varied with the season. During the summer, some participants chose to engage in outdoor activities, whereas during the winter, all participants selected indoor activities. As a result, participants were able to choose activities that reflected their usual daily routines under the prevailing seasonal conditions, thereby minimizing the influence of weather on their participation.

9. Thank you for raising this important point. We have addressed this issue in the revised manuscript. For the purposes of this study, older adults were operationally defined as community-dwelling adults aged 55 years and older. We acknowledge that age thresholds for older adulthood vary across institutional and disciplinary contexts. Although Canadian demographic and public health reporting commonly defines older adults as individuals aged 65 years and older, some Canadian community-based programs use a threshold of 55 years. We considered this threshold appropriate because previous research has shown that falls and fear of falling are also prevalent among adults aged 55 years and older. Regarding the participant categorized as 45-54 years in Table 1, this was a typographical error. After reviewing the original study documentation, we confirmed that this participant did not belong to this age group and chose not to disclose her age. We have corrected Table 1 accordingly.

10. Thank you for this helpful suggestion. In addition to the participant characteristics already reported, all participants completed the 16-item Falls Efficacy Scale–International (FES-I). We have added the FES-I scores to Table 1 in the revised manuscript. We have also clarified that all participants had experienced at least one previous fall prior to their participation in the study.

11. Thank you for this valuable suggestion. We have revised and expanded the Results section to provide a richer and more detailed description of each theme. Specifically, we strengthened the analytical interpretation, and provided more contextual detail to better demonstrate how the themes were developed from the data. We believe these revisions make the findings clearer and more consistent with the principles of reflexive thematic analysis.

12. Thank you for this helpful suggestion. We have revised the Discussion section to discuss our findings in the context of the existing literature. Specifically, we incorporated and discussed the studies by Ellmers et al. (2022), Jiang et al. (2024), and Lee and Tak (2023), highlighting how our findings align with and extend previous research.

13. Thank you for this comment. In the revised manuscript, we have added a more detailed description of the study neighbourhood in the Methods section. We have also revised the limitations section to acknowledge that the findings should be interpreted within the context of the specific neighbourhood and participant population included in this study.

Competing Interests: No competing interests were disclosed.

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