**‘FEAR OF FALLS’ – ADDRESSING THE ‘ELEPHANT IN THE ROOM’ FOR MOBILITY AMONG OLDER PEOPLE**

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**Highlights**

* Fear of falls in older adults is common and an independent risk factor for frailty and falls
* Geriatric depression and anxiety disorders can lead to fear of falls in many individuals
* Addressing sensory deficits, reducing polypharmacy, creating age-friendly environments and psychosocial support – are vital to reducing fear of falls
* A holistic and multi-disciplinary approach is necessary

**The problem?**

Mobility and ‘transportation’ is not only an essential activity of daily living(ADL), but a loss of mobility has been associated with reduction in well-being and happiness in all individuals, irrespective of age.

According to the World Health Organization, falls are the second leading cause of accidental or unintentional injury deaths worldwide. Among older adults, fear of falling is prevalent and can have a profound impact on their quality of life. This fear often stems from the potential consequences of a fall, such as injury, loss of independence, or even death.

Sadly, according to some studies, 2-39% of older persons who has no history of fall suffers from ‘fear of fall’ (FOF). The prevalence increases to 40-70% among those with a history of fall. Most authors define FOF or ‘ptophobia’ as a nervous anticipation of falling. It often leads to avoidance of various household activities, decreased sense of self-efficacy, and fearfulness in carrying out actions that the person is otherwise physically capable of. FOF has been associated with higher risk for falls in future, increase in frailty, decreased social activity and isolation, higher possibility of nursing home admission, and poorer quality of life (QOL).

**The correlates**

While most of the times, the exact onset of FOF cannot be elicited, the factors that contribute to its occurrence are: previous incidence of fall, unsteadiness due to various physical conditions and diminished health, frailty, visual impairments, having poor social and emotional support, environmental hazards and a chronic sedentary lifestyle. A comorbid moderate to severe depressive disorder or anxiety disorder has also been shown to contribute significantly to older adults developing FOF. We also need to keep in mind that almost all the factors that act as contributors or risk factors for FOF, can also be an outcome of the same, thus making it a vicious cycle of gradually increasing dysfunction. It is not unusual to find patients who are completely bed-bound and avoiding even going to the bathroom for passage of stool and urine.

Often, ‘fear of falls’ becomes the signature presenting symptom in late-life depression and anxiety disorders, even though in such cases, actual falls and gait imbalance may be minimal. However, the ‘fear’ itself can be extremely crippling – leading to restriction of movements, frailty, fatigue, body pains and isolation. At times, this fear may be the result of elder abuse (physical or psychological/neglect).

**What can be done?**

Patients with FOF might present to any of the clinical specialties with a varied possibility of presenting a complaint. At times, the patient or the informant might not report FOF directly, but it comes across during the evaluation of the patient’s daily routine. Thus, to get an idea about the presence and extent of FOF in older patients, the clinician must be proactive and inquisitive. An assessment should include the person’s recent pattern of activity - over days, months, years, presence of history of falls (with or without major injury), past treatment and rehabilitation, current living situation and family/caregiver availability, extent of mobility both in the home and in the community, specific activities that trigger FOF or anxiety, a comprehensive review of medications the person in currently taking(possibly from different specialists and physicians), pre-existing diagnosis and treatment sought for psychiatric disorders like depression or anxiety.

Objectively, the patient should be assessed for: any gross neuro-deficit, difficulty in maintaining balance, the extent of their mobility like sitting down on and getting up from a chair and a bed, walking indoors, walking outdoors, climbing up and down stairs, walking to and from bathroom, and any use of aid like sticks, walkers etc. The strength of the trunk and limbs, along with their bulk and tone, needs to be noted. The patient’s reported level of anxiety, as well as monitoring the objective evidence of anxiety while mobilisation during examination, is important to understand the severity of the problem. Also, assessing the cognition associated with the triggers that lead to FOF needs to be explored in a non-judgemental and non-demeaning manner. Fear of Falling Avoidance Behaviour Questionnaire and Falls Efficacy Scale International are instruments that can be used for this assessment.

The management of FOF can be challenging, and generally, there is no ‘one size fits all’ approach. Also, caregivers and family members play an important role in home-based care that is important for recovering from FOF. The interventions need to be individualised, and all the factors contributing to FOF need to be addressed.

**Addressing the Fear of Falls:**

Addressing the fear of falls requires a multifaceted approach encompassing physical, psychological, and environmental interventions.

1. **Physical Exercise:** Regular physical activity, including strength and balance exercises, can improve muscle strength, flexibility, and coordination, reducing the risk of falls and instilling confidence in older adults.
2. **Education and Awareness:** Providing information about fall prevention strategies, risk factors, and the importance of maintaining mobility can empower older adults to take proactive steps to reduce their risk of falls and manage their fear.
3. **Home Modifications:** Assessing and modifying the home environment to minimize hazards, such as installing grab bars, improving lighting, and removing clutter, can enhance safety and alleviate anxiety about falling at home.
4. **De-prescribing:** Reviewing and adjusting medications, particularly those that may cause dizziness, sedation, or impaired balance, can help reduce the risk of falls and improve overall well-being. In an era of polypharmacy, the art of ‘de-prescribing’ is vital in geriatric pharmacology where every pill can add to a burden. At times, a once added medication tends to become a lifelong asset. Also an older person may be on multiple prescriptions, often repetitive. Hence, a careful and periodic review of the entire medication list with careful deletions is important.
5. **Vision and Hearing Screening:** Regular vision and hearing screenings can detect sensory impairments that may contribute to falls and enable appropriate interventions, such as corrective lenses or hearing aids.
6. **Psychological Support:** Cognitive-behavioral therapies, relaxation techniques, and mindfulness practices can help older adults manage anxiety, build resilience, and develop coping strategies to overcome their fear of falls.
7. **Social Support:** Encouraging social engagement, participation in group activities, and support networks can combat social isolation and loneliness, promoting mental and emotional well-being and inter-generational bonds

Fall prevention is an integral component of the Comprehensive Geriatric Assessment (CGA). Equal weightage needs to be given to the ‘fear of falls’ addressal as well, as it’s an independent risk factor for actual falls carrying a significant psychological component.

While research is being undertaken in this area, certain gaps remain in the current literature. The lack of a consensus definition and measurement of FOF leads to heterogeneity in the existing research. Standardisation of measurement and evaluation of persons with FOF is necessary to bridge this gap. Also, more large scale qualitative and quantitative studies need to be taken to clarify the relationships between FOF and cognitive, psychological, social, and environmental factors. As clinicians, we need to make ourselves aware of how crippling this phenomenon can be, and actively ensuring help for the same should be a routine practice while providing healthcare to the older adult population.

Promoting healthy aging invariably involves age-friendly communities, freedom of movement, and ease of mobility. Addressing older people's fear of falls can go a long way toward restoring their self-esteem, dignity, and quality of life.

**Conflict of interest:** None

**References**

1. MacKay S, Ebert P, Harbidge C, Hogan DB. Fear of falling in older adults: a scoping review of recent literature. Canadian geriatrics journal. 2021 Dec;24(4):379. Available:<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8629501/> (accessed 10.11.2022)
2. Nagai K, Ikutomo H, Tagomori K, Miura N, Tsuboyama T, Masuhara K. Fear of falling restricts activities of daily living after total hip arthroplasty: A one-year longitudinal study. Clinical gerontologist. 2018 Aug 8;41(4):308-14.
3. Iaboni, A., & Flint, A. J. (2013). The complex interplay of depression and falls in older adults: a clinical review. *The American journal of geriatric psychiatry : official journal of the American Association for Geriatric Psychiatry*, *21*(5), 484–492. <https://doi.org/10.1016/j.jagp.2013.01.008>
4. Bernabei R, Venturiero V, Tarsitani P, Gambassi G. The comprehensive geriatric assessment: when, where, how. Critical reviews in oncology/hematology. 2000 Jan 1;33(1):45-56.
5. Schoene D, Heller C, Aung YN, Sieber CC, Kemmler W, Freiberger E. A systematic review on the influence of fear of falling on quality of life in older people: is there a role for falls?. Clinical interventions in aging. 2019 Apr 24:701-19

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