Fear of Falling

Since the identification of the post-fall syndrome[1] and use of the term "ptophobia" (the phobic reaction to standing or walking)[2] in the early 1980s, fear of falling (FOF) has gained recognition as a health problem of older adults. In an attempt to measure this entity, various definitions have evolved. Tinetti and Powell[3] described FOF as an ongoing concern about falling that ultimately limits the performance of daily activities. Other authors[4,5] have referred to FOF as a patient's loss of confidence in his or her balance abilities. Still other authors[6] defined FOF as a general concept that described low fall-related efficacy (low confidence at avoiding falls) and being afraid of falling. Subjects in one study[7] indicated they did not describe themselves as being "afraid of falling," but rather were "worried" about falling.

In the early phase of research, FOF was largely believed to be a consequence of falling. Researchers discussed FOF as resulting from the psychological trauma of the fall, leading to reduced activity and subsequent losses in physical capabilities.[2,8–10] Recent research, however, has revealed FOF in those who have not fallen[4,11,12] and, furthermore, has uncovered a relationship to physical, psychological, and functional changes in older adults.[6] Ongoing studies are focusing on the causes of FOF, dispelling misconceptions (eg, FOF being a result of the normal aging process), and identifying the interventions that address FOF most effectively. The researchers, however, agree that FOF is multifactorial in etiology,[12,13] and they suggest that FOF may be a more pervasive and serious problem than falls in older adults[6,13] and thus deserves attention.

The purpose of this update is to increase the reader's awareness of the current findings about FOF, including its prevalence among the growing older adult population in the United States, how it is measured, the relationships of FOF to other conditions, and the interventions that are being used to address this problem. The need for further research in the areas of measurement and intervention will be discussed.

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Fear of falling is known to be multifactorial with, at a minimum, physical, psychological, and functional influences.

Prevalence

Fear of falling, to some degree, has been reported to occur in 12% to 65% of older adults (those in the sixth decade of age or older) who live independently in the community and do not have a history of falling.[9,12,14–17] In those who have fallen, FOF is reported to exist in 29%[17] to 92%[18] of older adults. A 30% prevalence has been noted in subjects who were 65 years of age and older and were hospitalized (inpatient wards were selected that had a high number of elderly patients, not a particular pathology)[6] and a 47% prevalence in older adults who experienced dizziness.[19] The prevalence of FOF was consistently higher among women than men.[5,13–15,20] The researchers, however, suggested that there was likely underreporting of FOF among men due to the perceived stigma attached to the reporting of their fears.[5,13] Increasing age was correlated with FOF in studies that compared age groups (>58 years of age) with degree of FOF,[14,15,20] although increasing age was not correlated in 2 studies that used the mean age of the groups for analysis.[12,17]

The variability in the prevalence of FOF is likely due to the various definitions and instruments used to measure FOF. Lower prevalence was present when a dichotomous response ("no" versus some degree of fear) was required to answer the question "are you afraid of falling?"[20] Increased prevalence was evident when a response indicating a degree of fear was expected (eg, "very afraid," "somewhat afraid" or "moderately fearful").[6,12,14,16,17] The highest prevalence was noted when FOF was assessed relative to an activity, such as "going out when it is slippery."[9] The suggestion has been made that these prevalence figures are at least a slight underestimation of the prevalence of FOF among community-dwelling older adults, because those with the greatest fear probably did not agree to participate in the studies[5,11] or they feared possible institutionalization.[6] These ranges reflect large numbers of older adults and a pervasive health care problem.

Measurement Tools

The tools that have been developed over the past 2 decades to measure FOF use different definitions and premises. The simple question "are you afraid of falling?"[3,5,21] was used initially in research studies with a "yes/no" or "fear/no fear" response format,[11,13,21,22] and this format has the advantages of being straightforward and easy to generate prevalence estimates. This measure was later criticized for its limited ability to detect variability in degrees of fear[12,17] and because it may express a generalized state of fear that does not directly reflect FOF.[12] Various authors[12,13,23] have expanded the answer choices to this question to provide a hierarchy of responses (eg, "not at all afraid," "slightly afraid," "somewhat afraid," "very

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Table 1.
Falls Efficacy Scale and Various Modifications[a]

Tool	No. of Subjects	Reliability	Fall-Risk Threshold Scores	Comments
Falls Efficacy Scale (FES)[21]	18 older adults	.71 (mean age of subjects=79 y, SD=NA, range=65–91)	≤75 76–99 100[6]	
Modified Falls Efficacy Scale (MFES)[7,16]	216[7] older adults	NA	NA	Two additonal items added to the FES Revised scoring procedure with 1–4 rating scale
Falls Efficacy Scale Swedish Modification (FES[S])[28]	30 patients with stroke	.97[b] (mean age of subjects=65 y, SD=11, range=44–81)	NA	Includes easier items than the FES to accommodate those with cognitive, motor, and/or perceptual deficits
Expanded Falls Efficacy Scale[29]	179 older adults	.95 (mean age of subjects=77.6 y, SD=7.4, range=NA)	NA	Four outside activities added to FES Rating was on visual analog scale of 0%–100%
Balance Self-Perceptions Test[30]	105 older adults	NA	NA	Modification to FES with 20 basic ADL and IADL Rating scale of 1–5

[a]NA=not available, ADL=activities of daily living, IADL=instrumental activities of daily living.
[b] $P<.001$.

Table 2.
Psychometric Properties of Fear of Falling Measures[a]

Tool	No. of Older Adults	Reliability	Threshold Scores
Activities-Specific Balance Confidence Scale (ABC)[24]	60	.92[b]	≥80 50–80 <50[31]
Survey of Activities and Fear of Falling in the Elderly (SAFE)[9]	270	NA	NA
Perceived Control Over Falling[12]	392	NA	NA
Perceived Ability to Manage Falls and Falling[12]	392	NA	NA

[a] NA=not available.
[b] $P<.001$.

afraid") to better reflect the degree of fear. Others have continued to advocate use of the simple question only as a screen for FOF in community-dwelling older adults[11,24] or because of its ease of use with their specific population (ie, patients in nursing homes).[25]

Tinetti et al[21] developed the Falls Efficacy Scale (FES) to examine older adults, under the premise that FOF could be measured by looking at fall-related self-efficacy, or a person's self-confidence in his or her ability to avoid falling while performing everyday activities (eg, cleaning house, getting dressed, simple shopping). It is a 10-question scale, with questions such as "How confident are you that you can clean the house without falling?" Subjects rate each question on a scale of 1 to 10, and the scores are summed to give a total score between 0 and 100. Many authors have used this scale to quantify FOF or fall-related efficacy in community-dwelling older adults,[6,9,11,13,16,26,27] or they have modified it (MFES,[7] FES[S] for patients with stroke,[28] expanded FES,[29] Balance Self-Perceptions Test[30]) to meet the needs of their clients (Tab. 1). Because it measures only simple indoor activities, the FES is most usable with older adults who are homebound and have low mobility.[13,31]

Powell and Myers[24] developed the Activities-Specific Balance Confidence Scale (ABC) for older adults with higher functioning, using the same premise of fall-related self-efficacy as the FES. It is a 16-item questionnaire that asks the subject to rate his or her balance confidence on a visual analog scale (0–100), with a response to the question "How confident are you that you will not lose your balance or become unsteady while . . .?" Zero represents no confidence, and 100 indicates complete confidence in performing the activity. The authors chose activities and circumstances (eg, reach into cabinets versus reaching for something at eye level) that were more specific than those of the FES in an effort to decrease the inconsistency of individual interpretation. Activities performed outside of the home and of greater difficulty than the FES (eg, walking in a crowded mall, riding an escalator holding onto the railing) were also chosen because the FES tended to show a ceiling

effect with active older adults[3] (Tab. 2). The ABC was found to have greater responsiveness for older adults who had higher functioning than the FES (ABC: range=21%-90%; FES: range=1.9–3.9), although the FES was better for adults who were frail (ABC: range=5%-84%; FES: range [conversion to percentages]=44%-84%).[24] Both of these scales could be used to discriminate between low and high mobility in older adults who avoided activity because of their FOF; the ABC showed greater usefulness in discriminating between those who were fearful or were avoiding activity (FES: $\overline{X}$=43.4; ABC: $\overline{X}$=30.8) and those who were not fearful or were not avoiding activity (FES: $\overline{X}$=19.8; ABC: $\overline{X}$=74.0).[11]

Yet another measure, the Survey of Activities and Fear of Falling in the Elderly (SAFE),[9] was developed to assess FOF, using the premise that there are negative consequences to this fear, such as activity restriction or poor quality of life, that should be examined. This survey examines 11 activities of daily living (ADL), instrumental activities of daily living, mobility tasks, and social activities (eg, taking a shower, going to the store, taking public transportation, and going to movies or shows, respectively). Lachman et al[9] included exercise activities and social activities, because they felt that avoiding these activities might signal early onset of FOF. For each task, the subjects were asked the following questions:

1. Do you currently do it?

2. If you do the activity, how worried are you that you might fall?

3. If you do not do the activity, do you not do it because you are worried that you might fall?

4. If you do not do the activity because of worry, are there other reasons that you do not do it?

5. For those not worried, what are the reasons that you do not do the activity?

6. Compared with 5 years ago, would you say that you do it more/the same/less than you used to?

A 5-point (0–4) response system was used for each of these questions and then totaled to give an FOF score (Tab. 2). Lachman and colleagues' study of older adults showed that the SAFE could be used to differentiate between different degrees of fear and those who do or do not restrict their activity level (afraid/restricted activity: $\overline{X}$=1.27, afraid/no restriction: $\overline{X}$=0.66, not at all afraid: $\overline{X}$=0.24), suggesting that the SAFE was useful for examining FOF as it relates to activity restriction.[9] Correlation of data obtained with the SAFE with data obtained with the FES was noted ($r=-.76$).[9] In addition to the need to assess the reliability of measurements obtained with the SAFE, further research should examine the relationship and discrimination abilities of the SAFE and the ABC, because these tools are more similar to each other than to the FES and they address similar populations.

Lawrence et al[12] chose to further refine the premise of fall-related efficacy and developed 2 scales: Perceived Control Over Falling and Perceived Ability to Manage Falls and Falling. The scales were developed to differentiate a person's ability to control the environment, mobility, and his or her ability to prevent and manage falls.[12] Perceived Control Over Falling has 4 items that focus on control over the environment and the person's mobility and ability to do things to prevent falls (eg, "there are things I can do to keep myself from falling" or "falling is something I can control"). The scale's 5-point Likert-type response format ranges from "strongly disagree" to "strongly agree."

Perceived Ability to Manage Falls and Falling is a 5-item scale that assesses people's beliefs about managing falls, such as "finding a way to get up if they fall" or "protecting themselves if they do fall." A 4-point scale ranging from "not at all" to "very sure" is used (Tab. 2). Lawrence and colleagues' study demonstrated a lower level of FOF when the subjects had a higher perceived ability to manage falls, although they also found that FOF was a manifestation of a more generalized anxiety level, as measured by a Generalized Fearfulness Index (detailed in the report).[12] These findings raise important implications for the study of the causes of FOF and the interventions used to decrease the effects of FOF. Psychometric data relative to these tools, however, are needed.

Considerable effort has been made to construct user-friendly tools that measure the underlying nuances (contributing factors) of FOF. Because the causes of FOF are multifactorial, it may be difficult to develop an instrument that fully reflects a comprehensive view of FOF. Each of the tools described have strengths and weaknesses relative to the older adult population, although they have not been studied with a younger population or with a population that has very different activity performance (different performance level). Further study is needed to examine the reliability and validity of the measurements and to establish threshold scores for the population studied, and consideration needs to be given to using these measures with other populations.

Factors Associated With Fear of Falling

As research has evolved in the area of FOF, the original theory that FOF was a result of falls has been refuted. A relationship certainly exists between FOF and falls, because those people with a history of falling express a greater prevalence of FOF to the survey question "Are you afraid of falling?"[9,14] Howland et al[17] noted that the degree of FOF increased as a function of the number and seriousness of the falls experienced. In contrast, however, there is ample evidence that those people who have not fallen also report FOF.[4,5,11,12,16,19,32] Myers et al[11] found similar proportions of FOF (measured by the question "Are you afraid of falling?") in people who reported falling versus people who have not fallen (56% and 58%, respectively) among an ambulatory group of community-dwelling older adults. Comparable mean FES scores were produced in the same population using the FES, with mean FES scores of 84.9 in those who fell versus 88.1 in those who did not fall ($P \leq .0001$).[16]

Several studies have confirmed that FOF is associated with poorer health status[6,12,14,15,17,18] and functional decline.[20,25,26] Cumming et al[6] completed a prospective study over a 12-month period with older adults who had received medical intervention (inpatient, outpatient, or adult day care) at the beginning of the study. Baseline interviews were used to collect data on fall history, fall-related self-efficacy using the FES, and the assistance required to perform 10 ADL tasks. In addition to finding that those who had low fall-related self-efficacy tended to have poorer health (measured by a health-related quality-of-life measure, the Medical Outcomes Study 36-Item Short-Forum Health Survey [SF-36][33]), the researchers found that the poorer FES scores ($\leq$75) were associated with greater declines in the ability to perform ADL (.69 change in score) than higher FES scores (100) (.04 change in score).[6] These results confirmed those found previously in a prospective study by Arfken et al[20] that asked "At the present time, are you very fearful, somewhat fearful, or not fearful that you may fall?" In those community-dwelling older adults who were very fearful of falling, 91% reported at least one characteristic of frailty, 85% had impaired balance, and 22% described delay in getting up after a fall.[20]

Fear of falling consistently has been correlated to an increase in restriction of activity or activity curtailment.[14,16,17,26,34] The measures used to assess activity restriction due to FOF, however, are highly variable and, therefore, difficult to compare. Tinetti et al[16] assessed social activity participation with adaptations from the Established Populations for Epidemiologic Study of the Elderly interview[35] and physical activity using a modification of the Yale Physical Activity Survey.[36] Both of these instruments rely on self-report, although the scores were converted to ordinal measurements for analysis. Howland and colleagues[14,17] used self-report tools as well, although a smaller number of activities were investigated. Results of the study by Lachman et al,[9] which used the SAFE instrument, supplement these findings on activity restriction and raise further questions about the underlying reason for FOF. A goal of the SAFE instrument was to discern the reasons for avoidance of activities, suggesting that there may be reasons beyond FOF that contribute to activity restriction. Lachman and colleagues[9] found that the 2 activities most avoided because of FOF were "going out when it is slippery" and "reaching overhead." Reasons other than FOF (eg, personal preference, physical limitations, external constraint) for avoiding other activities, such as "taking a tub bath" or "walking several blocks outside," were considered. Lachman et al[9] suggested that there is evidence that people who experience FOF do not necessarily restrict their activities.

Psychological factors, specifically depression and anxiety, have been examined relative to FOF. Some researchers[12,15,17,19] have suggested that FOF may actually be an expression of generalized anxiety, comparable to other fears that plague older adults. The degree of fear among older adults was variable in these studies, with some adults having a reasonable response of FOF, whereas others exhibited an excessive, unrealistic fear response. Two studies[19,26] have correlated depression with FOF. These investigations showed that depression decreased the performance of automatic daily behaviors, which in turn decreased the positive reinforcement that comes to a person. Burker et al[19] identified that a decrease in positive reinforcement prompted a chain of events that led to increased focus on the person's self, increased need for assistance, decreased participation in pleasurable activities, and negative expectations. A correlation existed among depression and activity restriction, social withdrawal, and loss of independence.[22] In addition, fatigue often accompanies depression, which may make people less secure about their physical abilities and therefore fearful of falling.[19]

Consensus among the studies indicates that increased FOF is associated with decreased quality of life in older adults.[6,9,12,17,20,26] In studies by Cumming et al[6] and Lachman et al,[9] quality of life was assessed using the SF-36.[33] Both groups of investigators noted that, with increased fear (FES scores $\leq$75), the subscale scores of the SF-36 decreased, especially the physical function and bodily pain subscales, which declined the most.[6] Lachman et al[9] noted that greater FOF was also associated with lower quality of life in mental health and social and leisure pursuits. Often this decrease in quality of life was associated with a decrease in the amount of social interaction that the person experienced, leading to fewer social contacts with friends and family, social

isolation, depression, and anxiety.[9,14,17] It was unclear whether decreased quality of life led to FOF or whether FOF led to decreased quality of life.[9] Less well-known and well-tested quality-of-life measures were used in the other studies,[12,17,20] although the investigators' conclusions about the relationship of FOF to quality of life concur with the findings of Cumming et al and Lachman et al.

Recent research has compared fall-related self-efficacy versus FOF. Given that fall-related self-efficacy was a major premise for much of the early work on FOF, the terms were used interchangeably. Recently, however, the 2 entities have been evaluated separately. Self-efficacy, having a strong belief in one's self and perceived abilities, has been shown to be important for maintaining one's physical activity level and preventing functional decline.[31] Self-efficacy plays a definite role in FOF, although it is a different construct. It is concerned with what people think they can do, not their actual skill.[13] The role of self-efficacy becomes important in our society, where older people are often stereotyped as lacking independence and capabilities and frequently are offered aid when none is required. This may lead to a decreased sense of self and, in turn, lead to a reluctance to carry out normal activities even when the skills are available to perform these tasks.[13] When fall-related efficacy and FOF were compared, fall-related efficacy was an independent correlate of physical function and ADL performance, whereas FOF was not.[16,27] When elderly people who were highly active were compared with elderly people who were less active, there was no difference in fall-efficacy between the groups, although the highly active group reported less FOF.[13] These subtle differences are important for the future research on measurement of FOF and interventions for FOF.

Interventions for Fear of Falling

The factors that contribute to FOF seem to be multifactorial, similar to the causes of falls. A multidimensional approach to intervention to decrease FOF, is often recommended throughout the literature. Minimal research, however, has examined the interventions. The primary components of the interventions recommended include education, environmental safety considerations, discussion of risk-taking behaviors, assertiveness training, and physical fitness.[7,29,33] Myers et al[31] argued that building confidence or fall-related efficacy was crucial, and they suggested that it was as important as physical training in decreasing FOF.[24] Tennstedt et al[7] conducted the only randomized controlled trial examining FOF intervention with older adults and concluded that that cognitive-behavioral changes must occur for FOF to be reduced or inactivity to be reversed (ie, reverse the cycle or activity restrictions or increase participation in physical activities).

The goals of the education component of FOF intervention were to provide information and counseling on falls, fall-related injuries, and fear of falls; to instill confidence in the older adults' abilities and perceived control over falling; and to train them to move from self-defeating thoughts to motivating thoughts on controlling this fear.[7,32] The focus is to educate older adults on a realistic assessment of their self-concept of falls and risk for falls, which is complemented by strategies to increase their perceived control over the environment in order to reduce fall risk and to increase their physical activity and exercise.[7] Some authors included testimonials from those who had fallen and were discussing their fears, paired with advice from those who had appropriately overcome their FOF.[7,31] The need to instill confidence and perceived control of falls was considered critical,[31] including providing success in how to manage falls and gradual exposure to the feared circumstances or environment.[2,12]

Environmental modification to reduce fall risk was a standard component of the education programs, although the specifics were not detailed in reports of the studies.[7,31,32] Home safety checklists were provided to the older adults, with options presented for remedying the fall hazards.[32] In a recent home-based fall-risk–reduction program with rural older adults, the researchers completed a home assessment (before and after intervention) for the subject and control groups, providing them with appropriate safety modifications that should be made in the home to reduce the fall risk.[37] Both groups were noted to have a decrease in environmental hazards in the home, although the difference in the decrease of the number of hazards (intervention group: $\overline{X}$=14.21 [out of 40]; control group: $\overline{X}$=24.06 [out of 40]) was only significant for the intervention group (P=.002 when compared with the Bonferroni alpha=.10).[37] Providing older adults with information they could use to recognize and alter the environmental hazards that increase fall risk allowed them to take control over this aspect of their fear.[7]

Assertiveness training and discussion of risk-taking behaviors were critical components of this multidimensional approach, because the older adults needed to learn to ask for assistance when in a situation where they were fearful. They also needed to feel comfortable discussing their fear with family, friends, and health care providers. They could develop an appropriate support system to discuss their FOF, but they also had the opportunity to devise and carry out fall-prevention strategies.[7,32] Walker and Howland[32] noted that those who could talk about their FOF were less likely to restrict their activity level and that they remained active. Encouragement from friends and family to ask for assistance

and to discuss their FOF may have made the patients more at ease in participating in the FOF interventions.[7,32]

Maintaining or improving the physical fitness levels of older adults has been the hallmark of many current fall-risk reduction and fall-prevention programs, the effectiveness of which have been supported by research.[30] Individualized multidimensional exercise programs yielded significant improvements in balance measures ($P<.001$), mobility measures ($P<.011$), and decreased fall risk ($P<.001$).[30] This dimension of the intervention remained important in programs to reduce FOF. Most programs included education that emphasized the benefits of exercise to improve strength and balance, but then provided specific strengthening exercises for extremities, balance and coordination activities, and mobility tasks.[7,32] Tennstedt et al[7] and Lawrence et al[12] suggested that more attention should be paid to the skills in recovery from a fall and to management of the fall as part of the physical fitness program. Tennstedt et al[7] evaluated interventions for FOF, and they noted that the subject group of older adults increased levels of activity and had reduction in general physical dysfunction immediately after the intervention period, interventions that included physical fitness. A decrease in these effects was noted by the 6-month follow-up point; therefore, they suggested adding a booster session a few months after the intervention.

The results of multidimensional interventions for fall prevention have been mixed,[7] and those that have specifically addressed FOF have been limited in number.[7,26] The emphasis has been on physical interventions rather than behavioral change, although the literature suggests that FOF is far more complex than a physical problem. Success in decreasing FOF apparently depends at least in part on the ability to restore a person's confidence in his or her mobility. Reducing the risk of falling may not reduce FOF, because this fear is, to some degree, independent of the risk of falling.[5] Successful mobility in activities that people need to perform on a regular basis may build their confidence,[11] when combined with knowledge about falls and fall risks and the assertiveness to ask for assistance when they need it. Researchers have not compared the individual aspects of this multidimensional approach to treating FOF (ie, education versus physical fitness).

Further Research Needs

Most of the research on FOF completed thus far has been cross-sectional in nature; therefore, more longitudinal and prospective studies are needed. Research is difficult in this realm, because those potential subjects who are most fearful are those least likely to volunteer for studies. The samples used in previous research may underestimate the true effect of fall-related fear[22]; thus, creative sampling techniques are necessary.

Further research is needed in the area of measurement related to FOF. Fear of falling is known to be multifactorial with, at a minimum, physical, psychological, and functional influences. A complete understanding of the role of these factors is needed, including a clear delineation between fall-efficacy and FOF. The extent to which FOF is a protective mechanism versus a social dysfunction requires study.[14] The physical and psychological consequences of falling warrant further investigation, beyond the incidence of falls.[16] The prevalence of FOF in other populations must be determined, including various age groups and pathology-related groups. The ability to identify those at risk for developing FOF is also worthy of study,[25] because this may be the route for future preventative measures.

With the current instruments that are available, the reliability and validity of measurements obtained with the SAFE and the Perceived Control Over Falling and Perceived Ability to Manage Falls and Falling scales need to be established. The relationship and discrimination ability of the ABC versus the SAFE should be examined for further clarity (understanding of discerning between the underlying premises) in the constructs that the instruments assess. Threshold scores identifying mild versus severe degrees of FOF for these tools should also be determined for ease in use and communication among health care providers.

The interventions for FOF also require further study. The individual aspects of the multidimensional programs need to be studied and compared with randomized controlled trials, and long-term follow-up studies are a necessary part of these investigations. The role of vicarious experience in changing the activity levels of older adults is an area warranting study, in order to determine the underlying reasons for why older adults reduce their activity because of falls by other people.[14] Lachman et al[9] recommended the identification of strategies that foster a healthy degree of caution and risk taking (still performing activities) rather than an unhealthy level of fear (leading to restriction of activities). Investigation of the specific group of people who choose to engage in activities despite their fear would be helpful, as well as looking at whether changes in physical activity and self-efficacy actually bring about changes in balance and FOF.[13]

Conclusions

In the past 2 decades, much attention in research and the health care realm has focused appropriately on falls and fall prevention among older adults. As this research has evolved, FOF has emerged as an entity distinct from

falls. Fear of falling is claimed to have an average prevalence of 30% or more in older adults who do not have a history of falling, and it is double that in those older adults who have fallen. It has long-term negative consequences to the physical and functional well-being of older adults, to the degree that loss of independence is experienced with normally performed daily activities. The prevalence of FOF in other age and disease-related groups has not been thoroughly examined.

The factors contributing to FOF in older adults are numerous, although the exact causes remain unclear. Functional and physical decline and decreased quality of life are closely related to FOF, so that these factors may actually be causes of FOF or are caused by FOF. Specific measures based on a concise definition are needed, as further subtleties between fall-efficacy and FOF become evident. Multiple interventions have been recommended, with the optimal result being a cognitive-behavioral change in the older adult that results in bolstered self-confidence to perform daily activities.

Fear of falling needs to be assessed by health care providers as they work with older adults. Fear of falling should be viewed separate from falling, to be present in those who have not fallen, and as a pervasive health care concern in older adults. Prevention of this fear would be ideal, although, in lieu of this, education, dialogue, and further research with this population may bring us closer to a full understanding of the causes and effective interventions for FOF, regardless of the population.

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