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Understanding Disproportionate Fear of Falling in Older Adults: Implications for Intervention Development

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In this issue, Wetherell et al.¹ found preliminary evidence for a multifactorial intervention to reduce fear of falling and activity avoidance among older adults with disproportionate fear of falling. While these outcomes compare favorably to other interventions that have tried to reduce fear of falling,²⁻⁴ intervention effects eroded over a six-month follow-up period, raising questions about the sustainability of community-based interventions for adults with disproportionate fear. It is important to keep in mind that this study was designed as a pilot study with aims focused on feasibility and safety (as well as obtaining effect size estimates for a future trial). It was not powered to detect significant between-group differences. The sample size (N = 42) was based on the number of participants the authors thought they could enroll given the available time, rather than on a power analysis.

To target adults with disproportionate fear of falling, the authors developed the Activity, Balance, Learning, and Exposure (ABLE) intervention, an eight-week intervention integrating exercise, exposure therapy, cognitive restructuring, and a home safety evaluation, to reduce fear of falling and activity avoidance. An important approach is that the authors considered disproportionate fear of falling as a type of anxiety disorder, as manifested by high fear in the absence of relatively low risk of falls. Disproportionate fear can have a negative effect upon older adults' day-to-day lives, including unnecessary restriction of activities of daily living, which may lead to physical inactivity, mobility difficulties, frailty, and reduced quality of life. Individuals with disproportionate fear of falling in the absence of high fall risk likely require a different treatment approach from older adults at high fall risk. Therefore, the authors deliberately recruited participants whose fear exceeded their functional disability. Almost 70% of participants met criteria for a psychiatric disorder; of these, most had a pre-existing anxiety disorder.

A major strength of this study is that ABLE employed a novel mental health delivery model in which elements of cognitive behavioral therapy (CBT) were delivered by physical therapists in participants' homes. ABLE was feasible to implement, acceptable to participants, safe (i.e., it did not increase fall risk), and showed large effect sizes on fear of

falling ($d = 1.23$). The fact that the intervention was successfully delivered by physical therapists based in home healthcare agencies has important implications for ABLE's adoption into routine practice.

What modifications to ABLE are needed to maintain participant gains over a longer follow-up period? The authors speculate that “less emphasis should be devoted to fall prevention elements such as exercise and home safety [in this population] and more to the fear reduction elements of exposure and cognitive restructuring.” A related trial similarly suggests the value of a strong CBT approach, possibly by combining mixed-group and individually delivered CBT.⁴ Interestingly, the cognitive restructuring element of ABLE was less likely to be identified by participants as the most helpful component in the intervention. Treatment strategies that also address underlying anxiety may be more effective than other strategies in reducing fear of falling in this population of adults.

Another strategy for maintaining participant gains is to amend the fidelity monitoring plan to include multiple domains of intervention effort, including delivery, receipt, and enactment.⁵ The authors assessed delivery by videotaping and watching a sample of sessions so that feedback could be relayed back to physical therapists in weekly supervision calls. Greater attention to receipt and enactment might be valuable as well. Intervention *receipt* can be measured by reviewing notes/questions during intervention sessions to ensure participant comprehension and ability to use cognitive skills. Intervention *enactment* can be measured by tracking the number of times per week participants practice what they have learned.

The ABLE study is valuable for addressing a potentially remediable source of activity limitation when older adults overestimate their fall risk. Notably, the ongoing Strategies to Reduce Injuries and Develop Confidence in Elders (STRIDE) trial will allow another approach to this question.⁶ Participants are eligible for this multicomponent practice-based trial if they meet any of three fall risk criteria: have you fallen and hurt yourself in the past year, have you fallen two or more times in the past year, and are you afraid that you might fall because of balance or walking problems? A substantial portion of participants will likely be enrolled only because they meet the third criterion. They will receive non-psychological fall care management, and fall efficacy will be tracked as an outcome. Results from ABLE suggest this group may not benefit because the underlying anxiety disorder is not addressed, but it is also possible that comprehensive management of fall risk in itself can reduce anxiety and fear of falling.

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