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Addressing fear of falling in older adults: a public health implication and the emerging role of the BATHE technique

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Abstract

Fear of Falling (FOF) is a common and disabling geriatric syndrome with substantial consequences for physical function, mental health, and overall quality of life in older adults. Beyond its link to actual falls, FOF is associated with activity avoidance, reduced confidence, social withdrawal, depressive symptoms, and increased use of healthcare services, making it a significant public health issue. Although multifactorial interventions, such as exercise programmes, environmental modifications, and cognitive-behavioural strategies, have demonstrated effectiveness, the psychosocial aspects of FOF are often insufficiently addressed in routine care, particularly in low-resource and busy clinical settings. This narrative review explores FOF from a public health and psycho-social perspective, with particular emphasis on the emerging role of the BATHE technique (Background, Affect, Trouble, Handling, Empathy). BATHE technique is a brief, structured, person-centred approach that enables clinicians to explore patients' concerns, emotional responses, coping strategies, and support systems within routine consultations. The review synthesises literature on the epidemiology and public health impact of fear of FOF, the psychological mechanisms underlying fear-related avoidance behaviours, and the role of patient-centred communication in geriatric care. Evidence on the use of the BATHE technique in addressing anxiety, fear, and functional concerns is critically examined, highlighting its feasibility, acceptability, and potential relevance in geriatric and primary care settings. Overall, the BATHE technique appears to be a practical and inexpensive counselling strategy that promotes empathy, patient engagement, and adaptive coping. However, its effectiveness as a standalone intervention for reducing FOF has not been conclusively demonstrated, and existing evidence is limited by methodological weaknesses and a lack of long-term follow-up. Future robust studies are required to confirm its clinical effectiveness.

Key words: BATHE technique, fear of falling, low- and middle-income countries, older adults, public health.

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Introduction

The global demographic transition toward an ageing population has brought increased attention to geriatric health, particularly the prevention of falls and their psycho-social consequences.¹ Falls represent one of the leading causes of injury, disability, and mortality among older adults worldwide, with nearly one-third of individuals aged 65 years and above experiencing at least one fall annually.²⁻⁴ Beyond physical injuries, a significant yet often overlooked consequence of this phenomenon is the Fear of Falling (FOF), a pervasive and persistent psychological concern that affects both those who have fallen and those who have not.⁵

FOF is defined as a progressive concern about falling that leads individuals to avoid activities, they remain capable of performing.⁶ This fear, while initially protective, can become maladaptive, resulting in activity restriction, deconditioning, social isolation, loss of confidence, and diminished quality of life.^{6,7}

Studies estimate that between 20% and 60% of community-dwelling older adults experience FOF, with even higher rates among institutionalized populations and women.⁷ Despite its high prevalence, FOF remains underdiagnosed and undertreated in clinical and public health practice, especially in Low- and Middle-Income Countries (LMICs) where the ageing population is growing rapidly but geriatric care infrastructure remains weak.^{8,9}

Globally, interventions targeting FOF have largely focused on exercise-based and cognitive-behavioral approaches, aiming to improve balance, mobility, and confidence.^{10,11} However, these strategies often require specialized personnel, long-term commitment, and resources that may be unavailable in low-resource settings.¹⁰⁻¹² Moreover, the psychosocial dimensions of FOF, such as anxiety, loss of control, and perceived social judgment, are frequently neglected in biomedical fall-prevention programs.¹³ This gap emphasizes the need for accessible, person-centered interventions that integrate psychological and emotional care within rou-

tine clinical encounters. The BATHE counselling technique, an acronym for Background, Affect, Trouble, Handling, and Empathy, emerges as a promising model in this regard. Developed by Stuart and Lieberman,¹⁴ BATHE is a brief psychosocial intervention designed for use in busy clinical settings to enhance the therapeutic relationship and address emotional distress. By promoting empathy and self-reflection, BATHE empowers patients to express concerns, identify coping strategies, and regain confidence, mechanisms directly relevant to managing FOF.^{14,15} A randomized controlled trial by Pace *et al.*, 2017, found that the daily administration of the BATHE technique had strong effects on patients' likelihood of endorsing their medical care as "excellent".¹⁵ BATHE technique did not improve satisfaction by making patients feel more respected, informed, or attended to, rather, the effects on satisfaction were mediated by patients' perception that their physician showed "a genuine interest in me as a person".¹⁵

This review, therefore, aims to critically examine FOF as a global public health challenge, discuss its determinants and consequences, and explore the potential role of the BATHE technique as an innovative, feasible, and scalable intervention. In doing so, it highlights opportunities to strengthen geriatric mental health care and promote healthy ageing, particularly within resource-constrained environments such as Nigeria and other LMICs.

Global and the burden of fear of falling in older adults

FOF is a widespread public health concern affecting older adults across diverse cultural and socioeconomic contexts. The global prevalence of FOF was 49.6%, with reported rates ranging from 6.96% to 90.34%.¹⁶ Subgroup analysis showed higher prevalence in developing countries (53.4%) compared with developed countries (46.7%), and in patient populations (52.2%) compared with community-dwelling adults (48.4%).¹⁶ In institutionalized settings, such as nursing homes and assisted-living facilities, rates were higher, particularly among those with prior falls, chronic illnesses, or functional limitations.^{5,17} Women consistently report higher levels of FOF than men, possibly due to differences in physical strength, self-efficacy, and social role expectations regarding vulnerability and independence.¹⁸

Regional variation and determinants

In High-Income Countries (HICs), systematic fall-prevention programs and greater access to geriatric care have improved awareness and management of FOF. For instance, studies in Europe and North America report prevalence rates between 25%

and 40% among community-dwelling older adults, with lower rates among those engaged in structured physical activity programs.¹⁹⁻²¹ Conversely, evidence from LMICs remains limited but indicates higher and often underreported prevalence. An Ethiopian study found that over half (59.9%) of older adults in an urban city experienced moderate to severe FOF, with significant associations with advancing age, female gender, previous falls, and lower educational status.⁹ Similarly, research from America, Iran, Brazil, Nigeria, and South Africa confirms that social isolation, illiteracy, chronic illness and medications, the black population, poor quality of life, and environmental hazards substantially heighten FOF risk.²²⁻²⁵ Socioeconomic disparities further compound this burden. In many LMICs, inadequate housing infrastructure, poor lighting, and uneven walking surfaces increase the risk of both falls and FOF.^{24,25} Limited access to rehabilitation services and assistive devices also reduces recovery confidence after falls, reinforcing the cycle of fear and inactivity.^{26,27}

A neglected public health issue

FOF represents a major yet under-recognised public health challenge with wide-ranging health, psychosocial, and economic consequences. Beyond the immediate concern of falls, persistent FOF often leads to activity restriction and avoidance, which accelerates physical deconditioning, muscle weakness, and impaired balance. Paradoxically, these consequences increase the actual risk of future falls, reinforcing a vicious cycle of fear and physical decline.²⁸⁻³⁰ Psychologically, FOF is closely associated with depression, anxiety, and reduced self-efficacy, contributing to progressive loss of independence and deterioration in overall quality of life.³¹⁻³³ Socially, older adults affected by FOF frequently withdraw from outdoor, social, and communal activities, increasing the risk of loneliness, social isolation, and cognitive decline.³⁴

The burden of FOF and falls also extends to health systems and society at large. Fall-related injuries and hospitalisations account for billions of dollars in annual healthcare expenditure worldwide, with additional indirect costs arising from long-term care needs, rehabilitation services, and caregiver burden.^{1,3,35} As global populations continue to age, these costs are projected to rise substantially, particularly in LMICs where healthcare resources are already constrained.^{3,35}

Despite these far-reaching implications, FOF remains inadequately addressed in policy and practice. Most fall-prevention strategies prioritise physical rehabilitation and environmental modification, with limited attention to psychological factors.^{4,36} In primary care settings, routine screening for FOF is uncommon, and

Table 1. Practical application of the BATHE technique in primary care and care of older adults with Fear of Falling (FOF).

BATHE component	Key question(s)	Purpose of the component	Examples of issues explored
Background	"What is going on in your life that is making you worry about falling?"	To explore the context and situations contributing to fear of falling	Previous falls, decline in physical health, environmental hazards, stories from peers
Affect	"How do you feel about the possibility of falling?"	To identify emotional responses related to fear of falling	Anxiety, fear, helplessness, frustration
Trouble	"What is troubling you most about this fear of falling?"	To identify the most distressing aspect of the fear	Fear of injury, loss of independence, lack of help after a fall
Handling	"How are you handling the situation (fear of falling)?"	To assess current coping strategies and identify gaps	Avoidance of activities, use of walking aids, reliance on family support
Empathy	Empathic statements (e.g., "That sounds very difficult, and it is understandable to feel this way.")	To validate the participant's experience and strengthen the therapeutic alliance	Emotional validation and reassurance

many older adults hesitate to report fear due to stigma or fatalistic views of ageing.^{5,8} This neglect highlights the need for integrated, low-cost interventions that address both physical and emotional dimensions of fall prevention. Brief psychosocial approaches, such as the BATHE counselling technique, offer a practical and scalable option, aligning well with the psychological needs of older adults and holding promise for strengthening geriatric mental health and fall-prevention efforts.^{14,15,37}

Psychological and behavioral dimensions of the fear of falling

As illustrated in Figure 1, FOF reflects a complex interaction between cognitive, emotional, and behavioural processes. Cognitively, older adults with FOF often demonstrate catastrophic thinking, overestimating fall risk while underestimating their physical capabilities.³⁸⁻⁴⁰ Emotionally, FOF is closely linked to anxiety and depressive symptoms, generating physiological responses such as muscle stiffness and altered gait patterns that further increase fall risk.^{32,36,41} Behaviourally, FOF initiates a fear-avoidance cycle characterised by progressive activity restriction, deconditioning, and social withdrawal.^{34,42} This pattern mirrors behavioural mechanisms observed in chronic pain and anxiety disorders, where avoidance perpetuates both physical decline and psychological distress.⁴²⁻⁴⁴ These multidimensional effects highlight the need for interventions that address both emotional and functional aspects of fear.

The BATHE technique: conceptual framework

The BATHE technique is a structured, brief psychosocial intervention designed to address emotional distress within routine clinical encounters.⁴⁵ It comprises five steps: i) Background, exploring life context; ii) Affect, identifying emotional responses; iii) Trouble, clarifying the most distressing concern; iv) Handling, exploring coping strategies; v) Empathy, validating the patient's experience. The BATHE technique is not a substitute for psychotherapy but it serves as a communication-based intervention that fosters empathy, emotional expression, and problem-solving.^{14,45} Its brevity and adaptability make it particularly suitable for primary care and geriatric settings.

Relevance of the BATHE technique to the fear of falling

BATHE directly targets key psychological mechanisms underlying FOF. Through empathic listening and guided reflection, clinicians can help older adults articulate fears, reframe maladaptive beliefs, and strengthen coping strategies.^{14,15} The “Affect” and “Handling” components are especially relevant for addressing anxiety and low self-efficacy, central drivers of fear-related avoidance. BATHE also complements physical fall-prevention strategies by addressing emotional barriers to participation in exercise, rehabilitation, and mobility programmes.⁴⁶⁻⁴⁸ Its feasibility makes it particularly attractive in LMICs, where access to specialised mental health services is limited.^{8,26,27} As depicted in Figure 2, BATHE counselling is expected to affect FOF through these mechanisms: i) emotional expression, in exploring the emotional impact of FOF, older adults may experience a reduction in anxiety and mental distress; ii) cognitive restructuring, through guided discussions, the BATHE technique helps patients rethink their negative beliefs about falling, which reduces fear; iii) empowerment and self-efficacy, BATHE's emphasis on problem-solving and emotional support helps build confidence in older adults, encouraging them to engage in activities they may have previously avoided due to fear; iv) behavioral activation, as fear is reduced and confidence is restored, older adults may increase their participation in physical activities, thus improving their physical health and mobility.

Integrating the BATHE technique into geriatric and public health strategies

Integrating BATHE into fall-prevention programmes offers a low-cost, scalable approach to holistic care. BATHE aligns with the World Health Organization's (WHO) Healthy Ageing Framework, which emphasises person-centred, community-based interventions that promote functional ability and well-being.⁴⁹ Its suitability for task-shifting allows delivery by nurses, physiotherapists, and community health workers, expanding access to psychosocial support.^{9,37} Although empirical evidence on BATHE use for FOF in LMICs is limited, studies from other contexts demonstrate improvements in emotional well-being, treatment adherence,

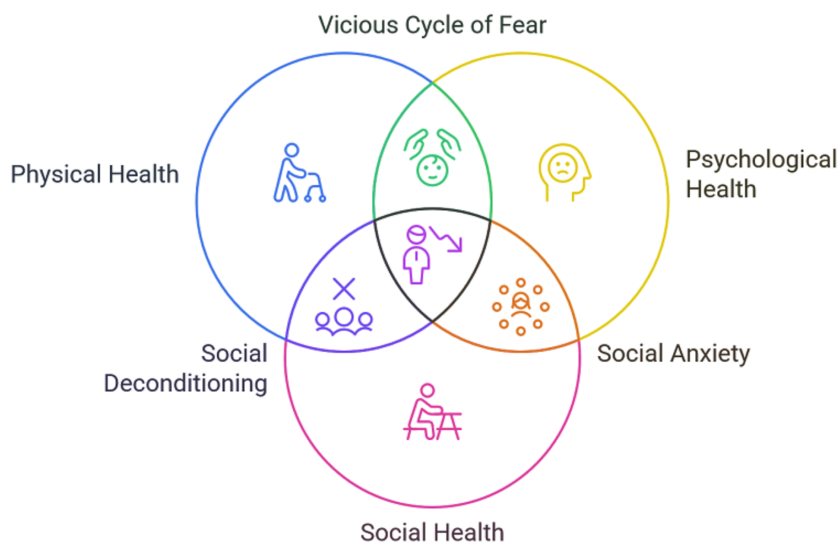


Figure 1. Interconnected impacts of the Fear of Falling (FOF).

and patient satisfaction.^{14,37,50-52} These findings support its adaptation for older adults experiencing FOF. Table 1 describes how the BATHE technique could be integrated into the care of older adults with FOF.

Limitations of the BATHE technique in primary care

Although the BATHE technique is a simple, patient-centred, and low-cost counselling approach, its implementation has several limitations. Globally, evidence supporting its effectiveness remains limited, with most studies characterised by small sample sizes, heterogeneous designs, and short follow-up periods. Its success also depends on clinicians’ communication skills and the availability of sufficient consultation time. In LMICs, additional challenges include high patient loads, workforce shortages, limited training in psychosocial care, cultural barriers to discussing emotional concerns, and weak referral systems. Furthermore, BATHE is a brief counselling tool and may be insufficient for patients with complex psychosocial or mental health conditions requiring comprehensive multidisciplinary care. Therefore, BATHE should be viewed as a complementary rather than a standalone intervention in primary care, and further implementation research is needed, particularly in LMICs.

Potential community-based application of the BATHE technique

Although no published study has directly evaluated the effectiveness of the BATHE technique in reducing FOF among community-dwelling older adults, its patient-centred and empathetic approach suggests potential value as part of community-based falls prevention. Existing evidence supports its role in improving psychological well-being, patient engagement, and doctor–patient communication across chronic disease settings.^{14,37,53,54} In community practice, BATHE could be integrated into home visits, primary healthcare outreach programmes, older persons’ clubs, and routine assessments by family physicians, nurses, and community health workers to identify psychosocial concerns, reinforce adaptive coping, and encourage adherence to falls prevention strategies. Given the multifactorial nature of FOF, BATHE should complement

established interventions such as exercise programmes, medication review, home hazard assessment, and multidisciplinary rehabilitation rather than serve as a standalone intervention. Further implementation studies, particularly in LMICs, are warranted.

Integrating BATHE into fall-prevention and mental health strategies

The dual challenge of falls and mental health in ageing populations

Globally, one in three adults aged 65 years and above experiences at least one fall annually, and the incidence is even higher in institutionalized or frail populations.^{3,4} Beyond physical injury, FOF contributes to psychological distress, social withdrawal, and functional decline, perpetuating a cycle of inactivity and frailty.^{3,6} In LMICs such as Nigeria, where healthcare systems often prioritize acute and infectious diseases, the mental health aspects of ageing, including anxiety, depression, and fear associated with falls, are frequently under-recognized.⁸ The integration of psychosocial approaches such as the BATHE technique into fall-prevention frameworks therefore presents a timely, low-cost opportunity to enhance holistic care.

The rationale for integration

Traditional fall-prevention programs often emphasize physical rehabilitation and environmental modifications, with limited focus on psychological determinants of fall risk. However, interventions that fail to address emotional factors may achieve limited long-term success.³⁶ BATHE offers a complementary approach by fostering self-awareness, coping strategies, and emotional resilience, essential for maintaining confidence and engagement in daily activities.^{15,45} Moreover, BATHE’s brevity and adaptability make it suitable for task-shifting to nurses, physiotherapists, and community health workers, a critical advantage in resource-constrained settings where mental health specialists are scarce.^{9,37} This aligns with the WHO Healthy Ageing Framework, which advocates for community-based, integrated, and person-centered models of care to promote functional ability and well-being in older adults.⁴⁹

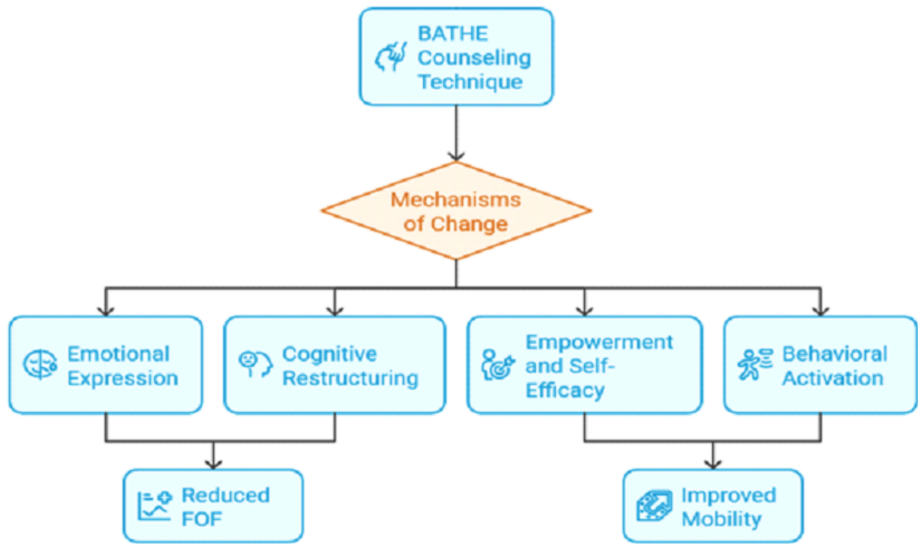


Figure 2. Conceptual framework on the effect of the BATHE technique on the Fear of Falling (FOF).

Lessons from emerging evidence in low- and middle-income countries

Although empirical studies on BATHE use in Africa are limited, its effectiveness in improving emotional adjustment, treatment adherence, and patient satisfaction in various primary care settings provides a strong rationale for adaptation.^{14,37} For example, studies in India and Iran have demonstrated that incorporating BATHE into routine geriatric consultations enhances psychological well-being, trust in clinicians, and compliance with lifestyle advice.⁵⁰⁻⁵² In the context of FOF, where anxiety and self-efficacy play central roles, these outcomes suggest that BATHE could improve confidence, mobility, and social participation among older adults. Moreover, as LMICs experience rapid demographic ageing, integrating BATHE within existing geriatric or rehabilitation programs could offer a scalable, culturally sensitive model for psychological support alongside physical therapy.

Research gaps and future directions for the BATHE technique in geriatric mental health and fall prevention

Limited empirical evidence linking the BATHE technique to fear of falling outcomes

Despite evidence that BATHE counselling improves psychological distress, patient satisfaction, and doctor–patient communication, no published study has directly examined its effect on FOF among older adults, to the best of our knowledge. Existing studies largely address general emotional well-being, anxiety, and depressive symptoms in populations with chronic pain, diabetes, or cardiovascular disease.^{14,37,54,55} This gap is notable because FOF encompasses both psychological and functional components, including anxiety, reduced self-efficacy, and activity avoidance. FOF is also shaped by multiple factors, such as prior falls, mobility impairment, environmental risks, and social isolation. Given its multifactorial nature, interventions integrating psychological support with physical rehabilitation may be particularly effective. BATHE, with its focus on empathy, validation, and patient-centred problem-solving, represents a theoretically promising yet empirically underexplored approach for addressing fear-related behaviours in older adults.

Limited research in low- and middle-income countries

Most evidence on BATHE originates from high-income settings with well-established primary care and mental health integration. In contrast, studies from LMICs, including Nigeria, are sparse despite the growing ageing population and the significant burden of falls.^{37,54,55} Older adults in these regions face unique barriers, such as limited access to rehabilitation, social stigma around mental health, and under-resourced healthcare systems, which may influence both FOF prevalence and response to interventions.^{8,37,53} Conducting context-specific research in LMICs is therefore essential to understand cultural attitudes toward falling, adapt BATHE for local use, and assess its feasibility when delivered by non-specialist healthcare providers through task-shifting.

Future research priorities

To address these knowledge gaps, future studies should: i) conduct randomized controlled trials comparing BATHE-based counselling to usual care or other psychosocial interventions for reducing FOF and improving mobility; ii) employ mixed-methods approaches to capture quantitative improvements (e.g., Falls Efficacy Scale scores) alongside qualitative narratives of confi-

dence and emotional well-being; iii) evaluate long-term outcomes on fall rates, physical performance, and quality of life; iv) explore adaptations of BATHE for culturally diverse and resource-limited settings through participatory co-design with healthcare workers and older adults; v) investigate cost-effectiveness and feasibility for integration into existing geriatric and primary care workflows.

Limitations

Since it is not a systematic review, the search and study selection for this narrative review were not exhaustive, increasing the risk of selection bias and the omission of relevant studies. The review relied on published literature, much of which used self-reported measures of FOF, making findings vulnerable to recall and reporting bias, particularly among older adults with cognitive impairment. In addition, most evidence originated from clinical or high-income country settings, potentially limiting relevance to low-resource or community contexts. Despite these limitations, the review provides a useful synthesis of current evidence, identifies important knowledge gaps, and offers a conceptual basis for future research and the integration of person-centred interventions, such as the BATHE technique, into geriatric and public health practice.

Conclusions

FOF is a prevalent, disabling, and under-recognised geriatric syndrome with profound physical, psychological, and social consequences. While existing interventions focus largely on physical risk factors, the BATHE technique offers a feasible, empathetic, and person-centred approach to addressing the psychological drivers of fear. Although empirical evidence remains limited, BATHE represents a promising adjunct to fall-prevention and geriatric mental health strategies, particularly in resource-constrained settings. Further research is needed to establish its effectiveness and guide integration into routine care.

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