

ORIGINAL ARTICLE: EPIDEMIOLOGY,
CLINICAL PRACTICE AND HEALTH**Relationship between fear of falling and mobility varies with visual function among older adults**Orna A Donoghue,¹ Harriet Ryan,³ Eoin Duggan,⁴ Ciaran Finucane,¹ George M Savva,¹ Hilary Cronin,¹ James Loughman^{5,6} and Rose Anne Kenny^{1,2}

¹The Irish Longitudinal Study on Ageing, ²Trinity College Institute of Neuroscience, Trinity College Dublin, ³School of Medicine, Royal College of Surgeons in Ireland, ⁴School of Medicine and Medical Sciences, University College Dublin, ⁵Department of Optometry, School of Physics, Dublin Institute of Technology, Dublin, Ireland; and ⁶African Vision Research Institute, Faculty of Sciences and Health, University of KwaZulu Natal, Durban, South Africa

Aim: The present study examined the association between vision, fear of falling and fear-related activity restriction, and assessed the effect of vision on the relationship between fear of falling and mobility, using data from a nationally representative sample of community-dwelling adults aged ≥ 50 years.

Methods: Participants ($n = 5003$) completed an interview and health assessment (including Timed Up-and-Go, vision and cognitive tests). Visual acuity and contrast sensitivity were assessed using an Early Treatment Diabetic Retinopathy Study logMAR chart and Functional Vision Analyzer, respectively. Participants self-reported their vision as excellent, very good, good, fair or poor. They were assigned to no fear of falling, fear without activity restriction and fear with activity restriction groups. Logistic regression models examined the relationship between vision, fear of falling and activity restriction. Linear regression models were used to examine the main and interaction effects of fear of falling, self-reported vision, visual acuity, and contrast sensitivity on mobility after adjusting for confounders.

Results: Poorer self-reported vision was independently associated with fear of falling and fear-related activity restriction ($P < 0.05$), but visual acuity and contrast sensitivity were not. Participants with the lowest visual acuity and contrast sensitivity levels, combined with fear-related activity restriction, had slower Timed Up-and-Go than those in the highest visual performance quartiles ($P < 0.05$).

Conclusions: Participants' perceptions of visual function were related to fear of falling and activity restriction, but this was not explained by other visual factors measured here. However, poorer visual acuity and contrast sensitivity did moderate the relationship between fear-related activity restriction and mobility, highlighting the importance of a comprehensive vision assessment especially in individuals with fear of falling. **Geriatr Gerontol Int 2013; ••: ••–••.**

Keywords: accidental falls, aged, contrast sensitivity, gait, locomotion.

Introduction

Fear of falling (FOF) has been defined as "a lasting concern about falling that leads to an individual avoiding activities that he/she remains capable of performing".¹ It affects up to 30% of community-dwelling older adults,^{2,3} and occurs in those with and without a history

of falls. It is more common in females, and is independently associated with previous falls, depression, poor self-reported health, reduced social activity and impaired mobility.^{4–8} The consequences of fear-related activity restriction include a decline in physical and social function, which can increase the risk of mobility decline, falls and functional disability.^{9,10}

Visual impairment can include deficits in visual acuity (VA), contrast sensitivity (CS), visual field (VF) and depth perception (DP). Lower VA, CS and VF have been associated with poorer mobility in community-dwelling adults,^{11–16} whereas deficits in VA, CS, VF and DP have been associated with falls, especially recurrent falls.^{17–21}

Accepted for publication 8 September 2013.

Correspondence: Dr Orna Donoghue PhD, The Irish Longitudinal Study on Ageing (TILDA), Lincoln Gate, Trinity College Dublin, Dublin 2, Ireland. Email: odonogh@tcd.ie

1 Estimates of the effect of vision on FOF and activity
2 restriction have been mixed. No independent relation-
3 ship between self-reported visual impairment and FOF
4 or associated activity restriction was seen in community
5 representative samples;^{22,23} however, moderate and
6 severe self-reported visual impairments were independ-
7 ently associated with FOF-related activity restriction
8 among community-dwelling older adults in receipt of
9 home care services.²⁴ Deshpande *et al.* found that psy-
10 chophysically measured visual function, specifically CS
11 and VA, was not linked to FOF; however, reduced CS
12 was associated with FOF-related activity restriction
13 among those without depressive symptoms.²⁵ Finally,
14 longitudinal studies have shown that reduced VA pre-
15 dicted the development of FOF¹⁸ and mobility impair-
16 ment²⁶ after 5 years.

17 Currently, studies examining associations between
18 FOF, vision and mobility are limited. Both FOF and
19 poor vision have been associated with impaired mobil-
20 ity, but it is unclear how visual impairment and FOF
21 interact with respect to mobility impairment, and if so,
22 which components of vision are most important.
23 Understanding this would allow specific groups to be
24 identified and targeted for assessment and intervention.
25 Therefore, the aims of the present study were first, to
26 examine the role of vision (self-reported vision, VA and
27 CS) in FOF and FOF-related activity restriction, and
28 second, to examine the influence of vision in the rela-
29 tionship between FOF and mobility, using data from
30 a nationally representative sample of community-
31 dwelling adults aged 50 years and older.

32 **Methods**

33 **Study design**

34 The Irish Longitudinal Study on Aging (TILDA) is a
35 prospective cohort study of the social, economic and
36 health circumstances of community-dwelling older
37 adults in Ireland. Analysis is based on the first wave of
38 data, collected between October 2009 and July 2011.
39 The sampling frame is the Irish Geodirectory, a listing of
40 all residential addresses in the Republic of Ireland. A
41 clustered sample of addresses was chosen, and house-
42 hold residents aged ≥ 50 years and their spouses/
43 partners (of any age) were eligible to participate. Ethical
44 approval was obtained from the Trinity College Dublin
45 Research Ethics Committee, and participants provided
46 written informed consent.

47 The study design is described elsewhere.²⁷ Briefly,
48 data collection included: (i) a computer-assisted per-
49 sonal interview that included detailed questions on
50 sociodemographics, wealth, health, lifestyle, social
51 support and participation, use of health and social care,
52 and attitudes to aging; (ii) a self-completion question-
53 naire; and (iii) a detailed health assessment carried out

54 by research nurses including cognitive, cardiovascular,
55 mobility, strength, bone and vision tests. In total, 8175
56 individuals aged ≥ 50 years were interviewed, of whom
57 5037 attended the health center assessment (61.3%).
58 Inclusion criteria for this analysis was a Mini-Mental
59 State Examination (MMSE) score ≥ 18 , no history of
60 Parkinson's disease, Alzheimer's disease or dementia,
61 participation in a health center assessment, and comple-
62 tion of the FOF and activity restriction questions in the
63 interview ($n = 5003$).
64
65
66

67 **Outcome measures**

68 *Demographics and health*

69 Age, sex and highest level of education attained were
70 recorded. Primary, secondary and tertiary education
71 corresponded to ≤ 8 , 9–13 and ≥ 13 years of education,
72 respectively. Height and weight were measured, and
73 body mass index (BMI) was calculated. Participants self-
74 reported doctor-diagnosed chronic conditions from the
75 following: heart attack or heart failure or angina, stroke,
76 diabetes, chronic lung disease, asthma, arthritis, osteo-
77 porosis, cancer, peptic ulcer, hip fracture, hypertension
78 and high cholesterol. The number of medications was
79 also recorded. Depressive symptoms were assessed
80 using the 20-item Center for Epidemiological Studies
81 Depression (CES-D) scale, where a score of ≥ 16 repre-
82 sents clinically relevant depressive symptoms.²⁸
83

84 *Fear of falling and falls*

85 Fear of falling was assessed with the question "Are you
86 afraid of falling?". Those that answered "Yes" were
87 asked "Do you ever limit your activities, for example,
88 what you do or where you go, because you are afraid of
89 falling?". It should be noted that this latter question
90 might combine both physical and social activity limita-
91 tions. Similar questions have been used in previous
92 studies,^{3,23,29} and allowed participants to be classified
93 into three groups: (i) no FOF; (ii) FOF, but no activity
94 restrictions (FOF-NAR); and (iii) FOF with activity
95 restrictions (FOF-AR). Participants were also asked how
96 many times they had fallen in the previous year.
97

98 *Cognitive function*

99 Participants completed the MMSE,³⁰ which assesses
100 global cognition (maximum score 30). A letter fluency
101 task (list as many words as possible beginning with "F"
102 in 1 min) measured expressive language and executive
103 function,³¹ and a computer-based choice reaction time
104 test measured processing speed.³² In this test, partici-
105 pants depressed a button, released it in response to an
106 on-screen stimulus and pressed the appropriate target
107 button (this occurred approximately 100 times). The
108

1 mean time from appearance of the stimulus to pressing
2 this button was the choice reaction time. Both verbal
3 fluency and choice reaction time have been shown to be
4 independent predictors of Timed Up-and-Go (TUG)
5 performance.³³

6 *Physical function*

8 Maximum grip strength was the highest score from two
9 tests on each hand using a Baseline hydraulic hand
10 dynamometer (Fabrication Enterprises, White Plains,
11 NY, USA). Grip strength declines with age and indicates
12 overall strength.³⁴ Mobility was assessed with the TUG
13 test using a chair with armrests and seat height of
14 46 cm. Participants were asked to rise from the chair,
15 walk 3 m at normal pace, turn around, walk back and sit
16 down again.³⁵ Walking aids were allowed, and no
17 instructions were given about the use of participants'
18 arms. The time taken from the command "Go" to when
19 the participant sat with their back resting against the
20 back of the chair was recorded using a stopwatch.

21 *Vision*

22 Participants self-reported their vision as excellent, very
23 good, good, fair or poor;³⁶ one participant reported
24 being registered blind and was added to the poor vision
25 group. A history of cataracts and related surgery, glau-
26 coma and age related macular degeneration (ARMD)
27 was also recorded.

28 VA represents a high contrast letter recognition task,
29 and was assessed using an Early Treatment Diabetic
30 Retinopathy Study (ETDRS) logMAR chart (Precision
31 Vision, La Salle, IL, USA) at a viewing distance of
32 4 m.^{37,38} VA was measured psychophysically for both
33 eyes, using the habitual distance vision correction if
34 required. For statistical purposes, the best acuity value
35 measured from either eye was selected and converted
36 to a Visual Acuity Score (VAS).³⁸ This score inverts
37 the logMAR scale using the formula: $VAS = 100 -$
38 $50 \times \logMAR$, so that a VAS of 100 represents a
39 logMAR score of 0 or 20/20 vision. For each letter that
40 is read correctly using the ETDRS chart, there is a
41 corresponding 1-point increase in the VAS. This allows
42 a more intuitive interpretation of the acuity scores, as
43 higher values indicate better acuity. The VAS was sub-
44 sequently expressed in quartiles and deciles.

45 CS represents the ability to distinguish an object from
46 the background in varying size and contrast conditions.
47 It was measured in the eye with better VA using a
48 Functional Vision Analyser (Stereo Optical, Chicago,
49 IL, USA) under mesopic (3 cd/m²) background illumi-
50 nation conditions. Testing was then repeated for the
51 same background illumination conditions, but in
52 the presence of a radial glare source.³⁹ During the test,
53 the respondent viewed a Functional Acuity Contrast
54

Test (FACT), which comprised sinusoidal gratings pre-
55 sented as Gabor patches at five spatial frequencies of
56 1.5, 3, 6, 12 and 18 cycles per degree (cpd) respectively.
57 For each spatial frequency, a series of nine patches were
58 presented in order of decreasing contrast (0.15 log unit
59 or 50% loss of contrast between consecutive patches).
60 Respondents were instructed to indicate if the gratings
61 tilted to the left (+15°), right (-15°) or upright (0°),
62 moving from patch 1 to 9 for each spatial frequency
63 tested, in order of increasing frequency. The CS score
64 corresponds to the contrast of the last grating that was
65 accurately identified on each row.

66 Factor analysis was used to reduce the dimension of
67 the 10 CS scores (each of five frequencies in two glare
68 conditions). As the CS variables are based on ordinal
69 scores, factor analysis using a polychoric correlation
70 matrix was carried out. Two factors were identified and
71 retained based on their eigenvalues and amount of vari-
72 ance explained (69.2% in total). Oblique rotation using
73 the direct oblimin criterion suggested two factors cor-
74 responding to the contrast sensitivity at high spatial
75 frequencies (6, 12, 18 cpd) and low spatial frequencies
76 (1.5, 3, 6 cpd). CS at the middle spatial frequency
77 (6 cpd) loaded onto both factors (Table 1). No factor
78 separated the glare from the "no glare" condition. Two
79 factor scores were derived for each individual corre-
80 sponding to their "high frequency" and "low frequency"
81 CS. Each factor score was divided into quartiles and
82 deciles for use as independent variables in regression
83 analyses.
84

85 *Statistical analysis*

86 Statistical tests were carried out using Stata v12
87 (StataCorp LP, College Station, TX, USA). All analyses
88 were weighted with respect to age, sex and education to
89 the Quarterly National Household Survey (2010) to
90 ensure that data were nationally representative. Data
91 were further weighted by health status (self-reported
92 health, disability status) and sociodemographic factors
93 (age, education) to account for those who did not attend
94 a health assessment. Baseline characteristics of each
95 group were compared using regression analysis and
96 χ^2 -tests.

97 Logistic regression analysis was used to examine the
98 relationship of vision with FOF and FOF-related activity
99 restriction. VA, CS factors 1 and 2 (all expressed as
100 deciles), and self-reported vision were entered into sepa-
101 rate models, which also included the effects of age, sex
102 and education.

103 Linear regression was then used to examine the asso-
104 ciations between FOF groups and TUG before and after
105 adjusting for age, sex, education, BMI, chronic condi-
106 tions, medications, history of falls in the previous year,
107 CES-D score, letter fluency, choice reaction time,
108 maximum grip strength and doctor-diagnosed cataracts
109

Table 1 Rotated factor loadings and unique variance for each contrast sensitivity variable

	Factor 1 (high spatial frequencies)	Factor 2 (low spatial frequencies)	Unique variance
CS (no glare)			
1.5 cpd	-0.1555	0.7598	0.5312
3 cpd	0.088	0.7823	0.3029
6 cpd	0.4526	0.472	0.3324
12 cpd	0.839	0.0079	0.2885
18 cpd	0.6489	-0.1213	0.6526
CS (glare)			
1.5 cpd	-0.0798	0.78	0.4551
3 cpd	0.1751	0.7176	0.3133
6 cpd	0.5783	0.3742	0.2825
12 cpd	0.8757	-0.0286	0.2604
18 cpd	0.6793	0.025	0.5189

High loadings (≥ 0.3) are shown in bold. cpd, cycles per degree; CS, contrast sensitivity.

(treated or untreated), glaucoma and ARMD. TUG was not normally distributed and was therefore log transformed for analysis.

Next, the visual variables (self-reported vision and quartiles of VA, high and low frequency CS) were added to the regression models separately and simultaneously to assess the independent effect of each aspect of visual function on mobility, and to explore whether visual impairment mediated any of the relationship between FOF and mobility.

Finally, moderation effects were examined by adding interaction terms between FOF and each vision variable to the regression models. Marginal mean TUG times from these models were plotted to graphically explore these interactions after adjusting for all covariates.

Complete data was available for 4498 participants (89.9%), and complete case analysis was used for multivariate analyses. Significance level was set at $P < 0.05$.

Results

Baseline characteristics of the no FOF ($n = 3974$), FOF-NAR ($n = 727$) and FOF-AR ($n = 302$) groups are provided in Table 2. Both FOF groups had more participants aged ≥ 75 years, were more likely to be female, have greater comorbidities and poorer physical health, mental health, cognitive function, and visual function than the no FOF group ($P < 0.001$). Most pronounced differences were observed in the FOF-AR group.

Psychophysical measures of vision (deciles of VA and CS) were not associated with FOF after adjusting for

age, sex and education ($P > 0.05$; Fig. 1). However, there was a statistically significant worsening of FOF with poorer self-reported vision. This was particularly marked among those who rated their vision as “fair” or “poor” ($P < 0.05$). An identical relationship was observed for FOF-related activity restriction.

Both FOF groups had slower TUG times than the no FOF group in univariate and multivariate analysis ($P < 0.001$; models 1 and 2, Table 3). The exponent of additive coefficients for log(TUG) can be interpreted as multiplicative coefficients for TUG, and so the coefficients in Table 3 correspond to those in the FOF-NAR group completing TUG 3.8% more slowly than those without FOF, whereas those with FOF-related activity restriction completed TUG 13.7% more slowly.

Poorer self-reported vision was independently associated with slower TUG after adjusting for all covariates ($P < 0.05$), whereas VA and CS had no independent effect on TUG performance (results not shown). Similar effects were observed when all psychophysical and self-reported vision variables were entered simultaneously (model 3, Table 3). However, adjusting for these vision variables had little effect on the FOF coefficients, and therefore did not explain the relationship between FOF, activity restriction and mobility.

Interaction effects for FOF with VA, high frequency and low frequency CS were statistically significant in the FOF-AR group ($P < 0.001$), but interaction effects with self-reported vision were not (Fig. 2). Specifically, marginal interaction plots adjusting for covariates show that individuals with FOF-related activity restriction who were in the lowest quartile of VA and CS had slower TUG than those in the highest quartiles ($P < 0.05$).

Fear of falling, vision and mobility

Table 2 Baseline characteristics of no fear of falling, fear of falling with activity restriction and fear of falling with no activity restriction groups

	no FOF (n = 3974) Mean ± SD / n (%)	FOF-NAR (n = 727) Mean ± SD / n (%)	FOF-AR (n = 302) Mean ± SD / n (%)	Total (n = 5003) Mean ± SD / n (%)
Age (years)				
50–64	2657 (64.1)	396 (46.9)	159 (43.8)	3212 (59.8)
65–74	1016 (22.8)	217 (23.4)***	98 (25.6)***	1331 (23.1)
≥75	301 (13.1)	114 (29.7)	45 (30.6)	460 (17.1)
Sex (female)	1938 (45.3)	557 (76.1)***	218 (71.4)***	2713 (52.2)
Education (%)				
Primary	805 (33.7)	190 (45.9)	94 (51.9)	1089 (37.0)
Secondary	1675 (45.8)	300 (39.5)***	117 (35.5)***	2092 (44.0)
Tertiary	1492 (20.5)	237 (14.6)	91 (12.6)	1820 (19.0)
BMI (kg/m ²)	28.54 ± 4.78	29.10 ± 5.51*	29.49 ± 5.86*	28.70 ± 5.00
Chronic conditions				
1 condition	1199 (29.4)	189 (23.9)	49 (13.6)	1437 (27.3)
2 conditions	881 (22.5)	192 (24.3)***	75 (21.1)***	1148 (22.7)
≥3 conditions	859 (23.4)	234 (38.6)	143 (56.0)	1236 (28.3)
Medications	1.23 ± 1.08	1.71 ± 1.04***	2.08 ± 1.01***	1.37 ± 1.10
History of falls (%)				
1 fall	467 (11.8)	133 (16.8)	52 (18.2)	652 (13.1)
≥ 2 falls	205 (5.4)	86 (11.9)***	49 (14.3)***	340 (7.1)
Depressive symptoms	5.06 ± 6.34	7.93 ± 8.47***	10.94 ± 10.21***	5.96 ± 7.29
MMSE	28.37 ± 1.87	28.13 ± 2.05	27.72 ± 1.99***	28.28 ± 1.92
Letter fluency	11.53 ± 5.00	10.62 ± 4.61***	10.79 ± 5.03*	11.33 ± 4.96
Choice reaction time (ms)	825 ± 280	907 ± 370***	935 ± 320***	846 ± 301
Max grip strength (kg)	28.65 ± 9.95	21.83 ± 8.24***	21.17 ± 9.12***	26.99 ± 10.09
TUG (s)	8.58 ± 1.81	9.72 ± 2.57***	11.41 ± 5.05***	8.97 ± 2.46
Cataracts – with surgery (%)	160 (4.9)	53 (12.8)	28 (13.1)	241 (6.8)
Cataracts – no surgery (%)	126 (4.2)	48 (7.1)***	18 (7.1)***	192 (4.9)
Glaucoma (%)	71 (1.9)	21 (3.5)	13 (5.3)**	105 (2.4)
ARMD (%)	57 (1.7)	22 (3.4)*	5 (1.2)	84 (2.0)
Self-reported vision (%)				
Excellent	894 (19.7)	121 (14.7)	48 (11.3)	1063 (18.2)
Very good	1522 (37.8)	287 (36.7)	100 (29.0)	1909 (37.0)
Good	1273 (33.4)	255 (36.3)	104 (35.5)***	1632 (34.1)
Fair	252 (7.6)	53 (9.7)	39 (15.9)	344 (8.6)
Poor	33 (1.4)	11 (2.6)	11 (8.3)	55 (2.1)
VA (VAS)	96 ± 10	95 ± 10*	93 ± 9***	96 ± 10
CS (no glare)				
1.5 cpd	36.4 ± 19.9	34.9 ± 21.1	34.0 ± 20.8	36.0 ± 20.2
3 cpd	67.2 ± 32.0	62.7 ± 31.3**	58.6 ± 34.3**	65.9 ± 32.2
6 cpd	31.9 ± 25.6	28.0 ± 24.5**	26.1 ± 25.8**	30.8 ± 25.5
12 cpd	6.6 ± 9.6	5.0 ± 9.1***	5.2 ± 14.1	6.2 ± 9.9
18 cpd	0.8 ± 2.7	0.6 ± 2.0*	0.2 ± 1.1***	0.7 ± 2.5
CS (glare)				
1.5 cpd	38.2 ± 19.1	35.4 ± 18.1**	33.9 ± 19.6**	37.5 ± 19.0
3 cpd	69.4 ± 32.8	63.9 ± 32.1**	57.1 ± 33.8***	67.6 ± 33.0
6 cpd	32.2 ± 25.1	28.7 ± 25.4**	24.3 ± 22.5***	31.1 ± 25.1
12 cpd	6.8 ± 10.2	5.6 ± 9.5**	4.2 ± 7.6***	6.5 ± 9.9
18 cpd	0.8 ± 2.7	0.6 ± 2.8*	0.2 ± 1.0***	0.7 ± 2.6

P* < 0.05; *P* < 0.01; ****P* < 0.001. Prevalence is weighted by age, sex and education to the Quarterly National Household Survey (2010) to ensure that data were nationally representative and further weighted by health status and sociodemographic factors to account for those who did not attend a health assessment. Regression analysis for continuous variables; chi squared analysis for categorical variables. No fear of falling (FOF) group was compared to the fear of falling with no activity restriction (FOF-NAR) group and the fear of falling with activity restriction (FOF-AR) group. ARMD, age-related macular degeneration; BMI, body mass index; cpd, cycles per degree; CS, contrast sensitivity; FOF, fear of falling; MMSE, Mini-Mental State Examination; SD, standard deviation; TUG, Timed Up-and-Go; VA, visual acuity; VAS, visual acuity scale.

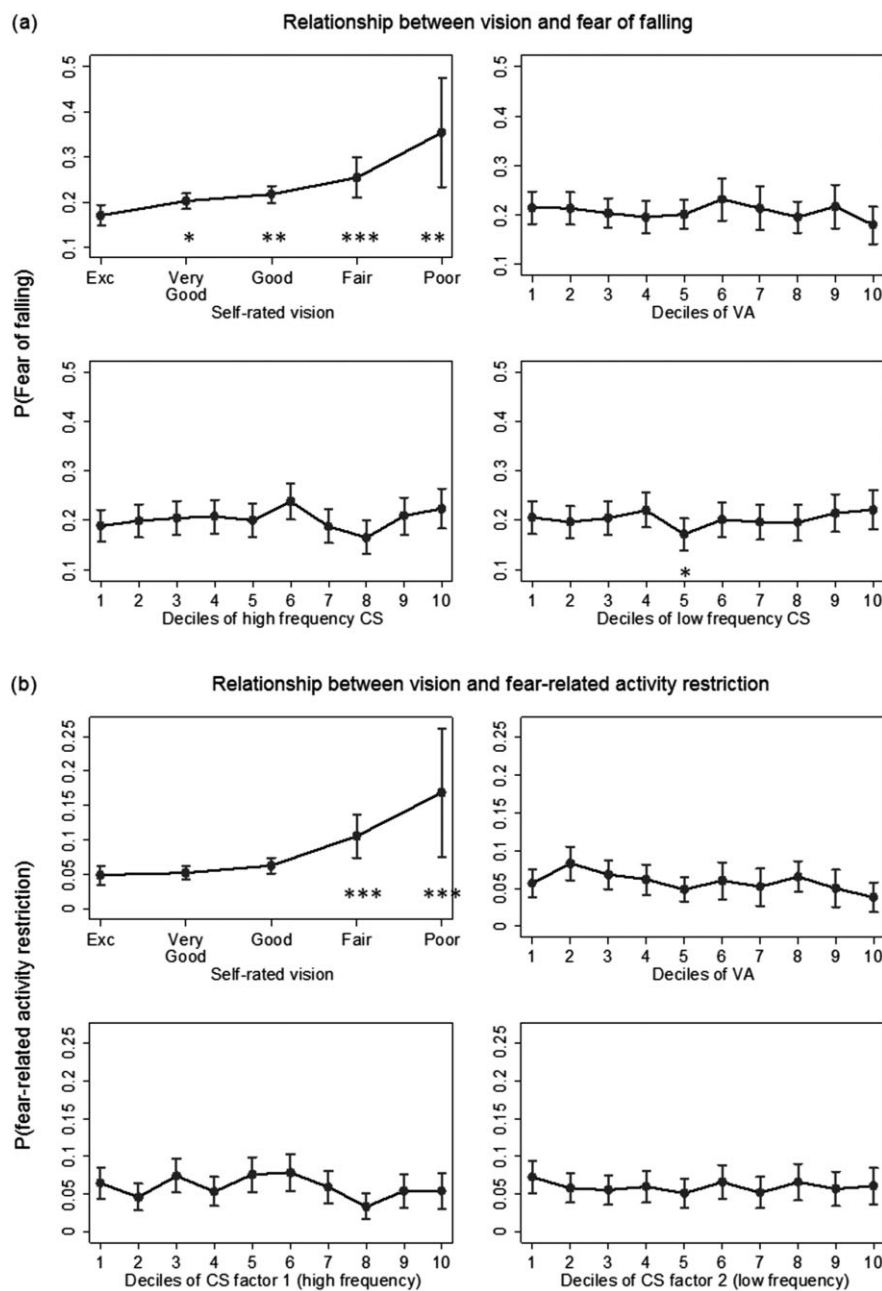


Figure 1 Relationship between (a) vision and fear of falling; (b) vision and fear-related activity restriction. Lowest deciles reflect lowest level of contrast sensitivity (CS) and visual acuity (VA) performance. Logistic regression analysis adjusted for age, sex and education. * $P < 0.05$; ** $P < 0.01$; *** $P < 0.001$ (indicates a category that is a significant predictor of the outcome relative to the highest level of visual function). P(fear of falling), probability of reporting fear of falling; P(fear-related activity restriction), probability of reporting fear-related activity restriction.

Discussion

The findings of the current study show that poorer self-reported vision was independently associated with FOF and FOF-related activity restriction, but that psychophysically measured vision (VA, CS) was not. FOF and self-reported vision were also linked to mobility impairment, but mesopic and photopic vision did not explain much of the relationship between FOF and mobility. These findings show that although participants' perceptions of visual function are related to FOF and activity restriction, other visual (e.g. DP, VF, eye disease) or non-visual factors (e.g. cognitive processing)

could be important determinants of self-reported vision.

However, reduced psychophysical visual function was associated with slower TUG in the FOF-related activity restriction group, illustrating the moderating effect of psychophysical vision on the relationship between FOF and mobility. FOF is associated with poorer function across multiple domains (physical, psychological, cognitive), and this is more pronounced in those with activity restriction. It is possible that reduced vision compounds the existing deficits in this group, resulting in greater mobility impairment. Viljainen *et al.* reported that when multiple self-reported sensory deficits

Fear of falling, vision and mobility

Table 3 Univariate and multivariate linear regression showing relationship between fear of falling, vision and log(Timed Up-and-Go) after adjusting for covariates

log(TUG)	Model 1 β (95% CI)	Model 2 β (95% CI)	Model 3 β (95% CI)
No FOF	Reference	Reference	Reference
FOF-NAR	0.113 (0.086, 0.141)***	0.037 (0.017, 0.058)***	0.034 (0.012, 0.055)**
FOF-AR	0.237 (0.183, 0.290)***	0.128 (0.084, 0.172)***	0.115 (0.073, 0.158)***
Self-reported vision			
Excellent	–	–	Reference
Very good	–	–	0.014 (–0.001, 0.029)
Good	–	–	0.017 (0.001, 0.033)*
Fair	–	–	0.040 (0.009, 0.071)*
Poor	–	–	0.097 (0.020, 0.175)*
VA (VAS)			
Lowest (20–93)	–	–	–0.018 (–0.038, 0.002)
2 nd quartile (94–99)	–	–	–0.012 (–0.029, 0.004)
3 rd quartile (100–103)	–	–	–0.021 (–0.038, –0.004)*
Highest (104–115)	–	–	Reference
CS factor 1 (high frequencies)			
Lowest (–1.44 to –0.75)	–	–	0.002 (–0.023, 0.029)
2 nd quartile (–0.75 to –0.17)	–	–	–0.005 (–0.027, 0.017)
3 rd quartile (–0.17 to 0.54)	–	–	–0.014 (–0.031, 0.003)
Highest (0.54 to 7.80)	–	–	Reference
CS factor 2 (low frequencies)			
Lowest (–2.29 to –0.64)	–	–	0.007 (–0.020, 0.034)
2 nd quartile (–0.64 to –0.17)	–	–	0.012 (–0.010, 0.034)
3 rd quartile (–0.17 to –0.61)	–	–	0.009 (–0.010, 0.027)
Highest (0.61 to –3.85)	–	–	Reference

P* < 0.05; *P* < 0.01; ****P* < 0.001. Model 1: Unadjusted linear regression. Model 2: Linear regression adjusted for age, sex, body mass index, education, medications, chronic conditions, history of falls, depressive symptoms, choice reaction time, word fluency, maximum grip strength, history of cataracts (treated or untreated), glaucoma, age related macular degeneration. Model 3: all vision variables entered simultaneously and adjusted as for Model 1. β, coefficient; CI, confidence intervals; cpd, cycles per degree; CS, contrast sensitivity; FOF, fear of falling; FOF-AR, fear of falling with activity restriction; FOF-NAR, fear of falling with no activity restriction; TUG, Timed Up-and-Go; VA, visual acuity; VAS, visual acuity scale.

combined with FOF, there is an increased risk of developing walking difficulties.⁴⁰

The ability to maintain dynamic postural stability requires an interaction between the sensory and motor systems. TUG involves transfers, turning and walking, and therefore requires muscle strength and balance; therefore, it was speculated that vision might play a more important role in this task compared with straight line walking. In challenging balance situations, an individual relies on the visual system, particularly CS and DP, to gain information about body positions, movements and the environment to maintain stability.⁴¹ CS might also reflect the ability to detect and recognise objects in the environment, and see ground level obstacles more accurately.⁴² Visual functions, such as VA and CS, decrease with age^{43,44} as do cognitive processes such as executive function, processing speed and visual attention.^{45,46} Similar cognitive deficits have been observed in recurrent fallers, and could reflect a difficulty in coordination of the

visual, cognitive and motor aspects required to negotiate the everyday environment.⁴⁷ If an individual with reduced vision, especially CS, does not detect all of the environmental and body position information available, this might predispose them to cautious gait and/or a greater risk of falling. If a vision deficit is combined with FOF or other age-related factors, such as increased risk of osteoporosis, low muscle tone, poorer muscle strength, slow reaction times and postural instability, the risk of mobility impairment, falls and injury could be amplified even further.

Owsley *et al.* found that age and CS at 6 cpd were the best predictors of the ability to detect and identify real-world targets, such as faces, signs and objects.⁴⁸ Although the present results suggest that CS at both high and low frequencies are important for mobility, we are unaware of any research that has identified which spatial frequencies relate most closely to specific environmental objects that might affect mobility.

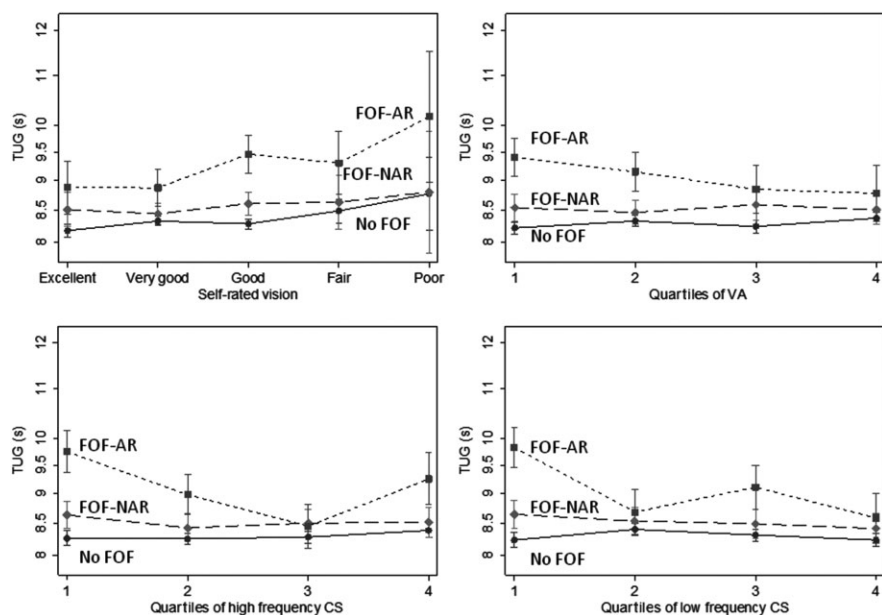


Figure 2 Interaction effects between fear of falling (FOF) and each vision variable with respect to their effect on functional mobility (measured by Timed Up-and-Go [TUG] time). Lowest quartiles reflect lowest level of CS and VA performance. Linear regression analysis adjusted for age, sex, body mass index, education, medications, chronic conditions, history of falls, depressive symptoms, choice reaction time, word fluency, maximum grip strength, history of cataracts (treated or untreated), glaucoma, age related macular degeneration. cpd, cycles per degree; CS, contrast sensitivity; FOF-AR, fear of falling with activity restriction; FOF-NAR, fear of falling with no activity restriction; VA, visual acuity.

The main strength of the present study was the detailed, psychophysical measures of CS and VA obtained in a large, nationally representative population. However, the study also had some limitations. Given the restraints inherent in a multidisciplinary study of this size (e.g. participant time, cost), a fully comprehensive assessment within each domain was not feasible. Therefore, measures of visual function, such as VF and DP, along with other aspects of sensory function were not obtained, although they have been associated with FOF, falls and mobility in previous research, and therefore might have added to the analysis. Also, only those who attended a health assessment center were included, making the results directly applicable to community-dwelling adults, but not those who are housebound or resident in nursing homes and other facilities. These individuals are likely to have greater mobility limitations and to be in poorer health, so the relationship between FOF, vision and mobility might be different in this group. Finally, CS was tested under mesopic conditions, so the CS results are only directly applicable to low light conditions.

VA is the most commonly measured visual function, but it might not be the best indicator of functional vision. Everyday living involves low contrast conditions, suboptimal lighting and sources of glare, so including CS measurement could provide a more comprehensive visual assessment. Individual variations in CS have direct implications for older adults in terms of environmental modifications (floor surfaces, lighting), behaviors (switching on lights especially at night) and treatment of conditions associated with poor CS (e.g. cataract). Although reduced vision does not affect the mobility of those with no FOF or FOF without activity

restriction, it does make those with FOF-related activity restriction more cautious, as evidenced by slower TUG. Reduced vision and FOF can lead to a self-imposed activity restriction, which can lead to social isolation, mobility limitations, loss of independence and increased fall risk. Therefore, the results of the present study suggest that clinicians should consider a comprehensive vision assessment including VA and CS, particularly in individuals with FOF, to prevent this transition to reduced activity.

Acknowledgments

This work was supported by the Irish Government; Irish Life plc and the Atlantic Philanthropies.

Disclosure statement

The authors declare no conflict of interest.

References

- 1 Tinetti ME, Powell L. Fear of falling and low self-efficacy: a case of dependence in elderly persons. *J Gerontol* 1993; **48**: 35–38.
- 2 Friedman SM, Munoz B, West SK, Rubin GS, Fried LP. Falls and fear of falling: which comes first? A longitudinal prediction model suggests strategies for primary and secondary prevention. *J Am Geriatr Soc* 2002; **50**: 1329–1335.
- 3 Rochat S, Büla CJ, Martin E *et al.* What is the relationship between fear of falling and gait in well-functioning older persons aged 65 to 70 years? *Arch Phys Med Rehabil* 2010; **91**: 879–884.

Fear of falling, vision and mobility

- 1 4 Arfken CL, Lach HW, Birge SJ, Miller JP. The prevalence and correlates of fear of falling in elderly persons living in the community. *Am J Public Health* 1994; **84**: 565–570.
- 2
- 3
- 4 5 Austin N, Devine A, Dick I, Prince R, Bruce D. Fear of falling in older women: a longitudinal study of incidence, persistence, and predictors. *J Am Geriatr Soc* 2007; **55**: 1598–1603.
- 5
- 6
- 7
- 8 6 Scheffer AC, Schuurmans MJ, van Dijk N, van der Hooft T, de Rooij SE. Fear of falling: measurement strategy, prevalence, risk factors and consequences among older persons. *Age Ageing* 2008; **37**: 19–24.
- 9
- 10
- 11
- 12 7 Vellas BJ, Wayne SJ, Romero LJ, Baumgartner RN, Garry PJ. Fear of falling and restriction of mobility in elderly fallers. *Age Ageing* 1997; **26**: 189–193.
- 13
- 14
- 15 8 Zijlstra GAR, van Haastregt JCM, van Eijk JTM, van Rossum E, Stalenhoef PA, Kempen GJ. Prevalence and correlates of fear of falling, and associated avoidance of activity in the general population of community-living older people. *Age Ageing* 2007; **36**: 304–309.
- 16
- 17
- 18 9 Delbaere K, Crombez G, Vanderstraeten G, Willems T, Cambier D. Fear-related avoidance of activities, falls and physical frailty. A prospective community-based cohort study. *Age Ageing* 2004; **33**: 368–373.
- 19
- 20
- 21 10 Deshpande N, Metter EJ, Lauretani F, Bandinelli S, Guralnik J, Ferrucci L. Activity restriction induced by fear of falling and objective and subjective measures of physical function: a prospective cohort study. *J Am Geriatr Soc* 2008; **56**: 615–620.
- 22
- 23
- 24
- 25 11 Klein BE, Klein R, Lee KE, Cruickshanks KJ. Performance-based and self-assessed measures of visual function as related to history of falls, hip fractures, and measured gait time. The Beaver Dam Eye Study. *Ophthalmology* 1998; **105**: 160–164.
- 26
- 27
- 28
- 29 12 Kwan MM-S, Lin S-I, Chen C-H, Close JCT, Lord SR. Sensorimotor function, balance abilities and pain influence Timed Up and Go performance in older community-living people. *Ageing Clin Exp Res* 2011; **23**: 196–201.
- 30
- 31
- 32 13 Luiz LC, Rebelatto JR, Coimbra AMV, Ricci NA. Association between visual deficit and clinical-functional characteristics among community-dwelling older adults (Associação entre déficit visual e aspectos clínico-funcionais em idosos da comunidade). *Rev Bras* 2009; **13**: 444–450.
- 33
- 34
- 35 14 West CG, Gildengorin G, Haegerstrom-Portnoy G, Schneck ME, Lott L, Brabyn JA. Is vision function related to physical functional ability in older adults? *J Am Geriatr Soc* 2002; **50**: 136–145.
- 36
- 37
- 38 15 West SK, Rubin GS, Broman AT, Munoz B, Bandeen-Roche K, Turano K. How does visual impairment affect performance on tasks of everyday life? The SEE Project. Salisbury Eye Evaluation. *Arch Ophthalmol* 2002; **120**: 774–780.
- 39
- 40
- 41 16 Laitinen A, Sainio P, Koskinen S, Rudanko S-L, Laatikainen L, Aromaa A. The association between visual acuity and functional limitations: findings from a nationally representative population survey. *Ophthalmic Epidemiol* 2007; **14**: 333–342.
- 42
- 43
- 44 17 Freeman EE, Muñoz B, Rubin G, West SK. Visual field loss increases the risk of falls in older adults: the salisbury eye evaluation. *Invest Ophthalmol Vis Sci* 2007; **48**: 4445–4450.
- 45
- 46
- 47 18 Klein BEK, Moss SE, Klein R, Lee KE, Cruickshanks KJ. Associations of visual function with physical outcomes and limitations 5 years later in an older population: the Beaver Dam eye study. *Ophthalmology* 2003; **110**: 644–650.
- 48
- 49
- 50 19 Kuang T-M, Tsai S-Y, Hsu W-M, Cheng C-Y, Liu J-H, Chou P. Visual impairment and falls in the elderly: the shihpai eye study. *J Chin Med Assoc* 2008; **71**: 467–472.
- 51
- 52
- 53
- 54
- 55
- 56
- 57
- 58
- 59
- 60
- 61
- 62
- 63
- 64
- 65
- 66
- 67
- 20 Lord SR, Dayhew J. Visual risk factors for falls in older people. *J Am Geriatr Soc* 2001; **49**: 508–515.
- 68
- 69
- 70 21 Rossat A, Fantino B, Nitenberg C *et al*. Risk factors for falling in community-dwelling older adults: which of them are associated with the recurrence of falls? *J Nutr Health Aging* 2010; **14**: 787–791.
- 71
- 72
- 73 22 Howland J, Lachman ME, Peterson EW, Cote J, Kasten L, Jette A. Covariates of fear of falling and associated activity curtailment. *Gerontologist* 1998; **28**: 549–555.
- 74
- 75
- 76 23 Kempen G, van Haastregt J, McKee K, Delbaere K, Zijlstra GR. Socio-demographic, health-related and psychosocial correlates of fear of falling and avoidance of activity in community-living older persons who avoid activity due to fear of falling. *BMC Public Health* 2009; **9**: 170.
- 77
- 78
- 79 24 Fletcher PC, Hirdes JP. Restriction in activity associated with fear of falling among community-based seniors using home care services. *Age Ageing* 2004; **33**: 273–279.
- 80
- 81
- 82 25 Deshpande N, Metter EJ, Bandinelli S, Lauretani F, Windham BG, Ferrucci L. Psychological, physical, and sensory correlates of fear of falling and consequent activity restriction in the elderly: the InCHIANTI study. *Am J Phys Med Rehabil* 2008; **87**: 354–362.
- 83
- 84
- 85 26 Sakari R, Era P, Rantanen T, Leskinen E, Laukkanen P, Heikkinen E. Mobility performance and its sensory, psychomotor and musculoskeletal determinants from age 75 to age 80. *Ageing Clin Exp Res* 2010; **22**: 47–53.
- 86
- 87
- 88 27 Kearney PM, Cronin H, O'Regan C *et al*. Cohort profile: the irish longitudinal study on ageing. *Int J Epidemiol* 2011; **40**: 877–884.
- 89
- 90
- 91 28 Beekman ATF, Deeg DJH, van Limbeek J, Braam AW, de Vries MZ, van Tilburg W. Criterion validity of the Center for Epidemiologic Studies Depression scale (CES-D): results from a community-based sample of older subjects in the Netherlands. *Psychol Med* 1997; **27**: 231–235.
- 92
- 93
- 94 29 Reelick MF, van Iersel MB, Kessels RPC, Rikkert MGMO. The influence of fear of falling on gait and balance in older people. *Age Ageing* 2009; **38**: 435–440.
- 95
- 96
- 97 30 Folstein MF, Folstein SE, McHugh PR. "Mini-mental state". A practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res* 1975; **12**: 189–198.
- 98
- 99
- 100 31 Lezak MD, Howieson DB, Loring DW. *Neuropsychological Assessment*, 4th edn. New York: Oxford University Press, 2004.
- 101
- 102 32 Standardising JAR. Chronometry. *Clocking the Mind: Mental Chronometry and Individual Differences*. Amsterdam: Elsevier, 2006; 237–246.
- 103
- 104 33 Donoghue OA, Horgan NF, Savva GM, Cronin H, O'Regan C, Kenny RA. Association between timed up-and-go and memory, executive function, and processing speed. *J Am Geriatr Soc* 2012; **60**: 1681–1686.
- 105
- 106 34 Rantanen T, Guralnik JM, Foley D *et al*. Midlife hand grip strength as a predictor of old age disability. *JAMA* 1999; **281**: 558–560.
- 107
- 108
- 109 35 Podsiadlo D, Richardson S. The timed "Up & Go": a test of basic functional mobility for frail elderly persons. *J Am Geriatr Soc* 1991; **39**: 142–148.
- 110
- 111 36 Klein BEK, Klein R, Lee KE, Cruickshanks KJ. Associations of performance-based and self-reported measures of visual function: the Beaver Dam Eye Study. *Ophthalmic Epidemiol* 1999; **6**: 49–60.
- 112
- 113 37 Ferris FL, Kassoff A, Bresnick GH, Bailey I. New visual acuity charts for clinical research. *Am J Ophthalmol* 1982; **94**: 91–96.
- 114
- 115 38 Colenbrander A. Visual standards, aspects and range of vision loss with emphasis on population surveys. *Report prepared for the International Council of Ophthalmology at the 29th International Congress of Ophthalmology*. Sydney, 2002.
- 116
- 117
- 118
- 119
- 120
- 121
- 122
- 123
- 124
- 125
- 126
- 127
- 128
- 129
- 130
- 131
- 132
- 133
- 134

OA Donoghue *et al.*

- 1 39 Hohberger B, Laemmer R, Adler W, Juenemann AG, Horn 15
2 FK. Measuring contrast sensitivity in normal subjects with 16
3 OPTEC 6500: influence of age and glare. *Graefes Arch Clin* 17
4 *Exp Ophthalmol* 2007; **245**: 1805–1814. 18
5 40 Viljanen A, Kulmala J, Rantakokko M, Koskenvuo M, 19
6 Kaprio J, Rantanen T. Fear of falling and coexisting sensory 20
7 difficulties as predictors of mobility decline in older 21
8 women. *J Gerontol A Biol Sci Med Sci* 2012; **67**: 1230–1237. 22
9 41 Lord SR, Menz HB. Visual contributions to postural sta- 23
10 bility in older adults. *Gerontology* 2000; **46**: 306–310. 24
11 42 Dhital A, Pey T, Stanford MR. Visual loss and falls: a 25
12 review. *Eye* 2010; **24**: 1437–1446. 26
13 43 Owsley C, Sekuler R, Siemsen D. Contrast sensitivity 27
14 throughout adulthood. *Vision Res* 1983; **23**: 689–699. 28
- 44 Glass JM. Visual function and cognitive aging: differential 15
16 role of contrast sensitivity in verbal versus spatial tasks. 16
17 *Psychol Aging* 2007; **22**: 233–238. 17
18 45 Salthouse TA. The processing-speed theory of adult 18
19 age differences in cognition. *Psychol Rev* 1996; **103**: 403– 19
20 428. 20
21 46 Madden DJ. Aging and visual attention. *Curr Dir Psychol Sci* 21
22 2007; **16**: 70–74. 22
23 47 Anstey KJ, Wood J, Kerr G, Caldwell H, Lord SR. Different 23
24 cognitive profiles for single compared with recurrent fallers 24
25 without dementia. *Neuropsychology* 2009; **23**: 500–508. 25
26 48 Owsley C, Sloane ME. Contrast sensitivity, acuity, and the 26
27 perception of “real-world” targets. *Br J Ophthalmol* 1987; **71**: 27
28 791–796. 28