

Thinking Out Loud: What Older Adults Say About Triggers for Physical Activity

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This study analyzed older women's (age 57-92, $N = 32$) descriptions of motivating triggers for physical activity. Among active women, activity was triggered by situations such as declining fitness levels, low bone density, more free time, fears about inadequate health care leading to self-care, expectations for reduced aches and pains, awareness of new community programs, and public reports of the health benefits. Semiactive women had doubts about the appropriateness of being active. Inactive people also experienced triggers but seemed firmly committed to a less active lifestyle by reminding themselves that retirement requires no commitments, exercise is not needed if you are healthy, exercise is not appropriate if you are ill, being very busy is a substitute activity, and serving others is less selfish. The findings suggest that active-living interventions might be more effectively aimed at semiactive seniors who seem positively disposed to participating but need help to get started or to stay involved.

Key Words: exercise, health, aging, motivation, cognitive beliefs

Conspicuous differences are visible in how people are aging (Teague & MacNeil, 1992), and "we can now be certain that inactivity contributes to health problems and that modern life is becoming increasingly sedentary" (Sallis & Owen, 1999, p. xvi). Only about 40% of Americans are adequately active (30-60 min of moderate physical activity every day), a number that diminishes even more in the older age groups (U.S. Department of Health and Human Services, 1997). Although active and healthy seniors are becoming more visible throughout the world, some estimates suggest that only 38% of all women age 19 and over are participating in regular physical activity (McGinnis, 1992). The National Advisory Council on Aging reported that "people can work hard to retain their functional capacities and activity in the community quite effectively until they reach advanced old age" (1996, p. 17), but it is less clear why so many of them do not. So although the Centers for Disease Control and Prevention and the American College of Sports Medicine (1998) have consensus on major issues related to physical activity and health (Pate et al., 1995), little is known about why some adults are highly active but most fail to get involved.

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In old age, "taking it easy" is socially endorsed and even expected, even though "the attribution of passivity to the old is no longer valid as a cultural image" (McPherson, 1994, p. 336). Many people believe that there is little they should do about aging-related declines and little they can do about their health. Many older people might be talking themselves out of active leisure pursuits, thinking that retirement is a time of less responsibility and personal choices. Indeed, 65% of older adults perceive the amount of activity they are doing as "just right," with adults over age 75 least likely to have intentions to do more (Alberta Centre for Well-Being, 1996). Many older adults say they are "too old" to participate because they see few of their peers in active pursuits (O'Brien Cousins & Janzen, 1998). Given the recent media attention to active living and healthy aging, research that explores how people get involved in physical activity would be a helpful line of questioning.

To date, little is known about what triggers people to be more active, but self-referent thinking about becoming more active is thought to begin with a triggering event. This "cue to act" might function as a wake-up call that brings attention to an active-living opportunity or a health threat for the individual. Bandura (1997) notes that "experienced symptoms, media communications, and social prompts serve as cues that trigger the decisional process for health-related action" (p. 283). Burgess and O'Brien Cousins (1998) reported that a sedentary 80-year-old woman, described as being "in a downward spiral" of accumulating health problems, reached a critical moment of reckoning with her mortality and sought help from a fitness professional. Her story suggests that she was able to reinstate her quality of life and extend her life by about 5 years through daily walking and mobility exercises, but we do not know whether her "trigger" was a single, defining realization or a slower coalescing process. Other research pertinent to older adults' triggers for physical activity suggests that older women recall this shift in thinking very clearly and that it was a defining moment that changed their activity behavior forever (O'Brien Cousins & Keating, 1995).

Theoretical Linkages

Much of the contemporary research on active-living behavior among older adults is guided by theory in social psychology that views people's lifestyles as being influenced by cultural knowledge and values, internalized beliefs, and ongoing experiences with physical activity itself (Bandura, 1997). Reinforced by new scientific evidence that links regular physical activity to a wide array of physical and mental benefits, Bandura (1997) notes that such knowledge "creates the precondition for change. Perceived physical threats provide the motive for health action" (p. 283).

Weinstein (1993) has noted the conceptual similarities of several "competing" theories of health-protective behavior. Indeed, one area of overlap is a cross-theoretical construct related to "cues" or "triggers" that shift people's thinking or behavior closer to the target behavior (regular involvement in physical activity). Such shifts in thinking are central to processes of motivating people to move from stage to stage (i.e., precontemplation to contemplation) in the stages-of-behavior-change model (Marcus, Pinto, Simkin, Audrain, & Taylor, 1994). The theory of planned behavior (Ajzen, 1991) explains how people move "from intentions to

actions” and proposes that a person’s intention to perform a behavior is the central determinant of behavior because “it captures certain motivational factors such as how hard one is willing to try” (Courneya, 1995, p. 81), but in the current study, the goal was to understand what leads an individual to think about forming intentions in the first place.

Health-psychology theory suggests that people think about taking action for their health once they are triggered by a health threat or cued by someone or something in their environment. Describing the essence of triggers is difficult because most behavioral theories deal with cognitive processing once triggered. Elements akin to triggering events are found in the health-belief model of Rosenstock, Strecher, and Becker (1988; health motive, perceived threat), in Bandura’s (1977) social-cognitive theory (environmental cues and cues to act), and in Weinstein’s (1988) precaution-adoption process (recognition of a health hazard). King et al. (1992) thoroughly reviewed determinants and interventions related to adult physical activity, but triggers, per se, were not mentioned; one explanation is that cues to act and motivational triggers have not received much attention in the research to date. For the purpose of this study, triggers are operationalized as opportunities, threats, or life events that shift people’s thinking relative to physical activity.

Social-cognitive theory supports the idea that when opportunities or threats act as triggers to think about one’s goals to live a long and healthy life, older people might seriously consider becoming more physically active if they (a) *value* physical activity as a meaningful strategy to obtain their goals such as control over specific health threats; (b) recognize that in their families, physicians, activity leaders, and friends, there are sources of *support* and encouragement; (c) have *positive expectations* that exercise, physical activity, and sport will do them more good than harm; and (d) believe that the required physical skills and competencies to be mobilized are well within their current capabilities (*efficacy*; O’Brien Cousins, 1998). But little is known about whether perceived health threats, social opportunities, and environmental cues are potential triggers for being more active in later life. Cues to become more physically active have simply not received much attention from social scientists. Referring to exercise motivation, Rejeski (1981) states, “quite frankly from the standpoint of understanding participant behavior, knowing what people *think* they are doing may well be more important than knowing what they *are* doing” (p. 304).

Thus, contextualizing cognitive beliefs—that is, identifying “who thinks what”—is an important first step in understanding how to target messages and programs effectively. In addition, health and fitness professionals want to know if there are social contexts and environmental cues that are effective in mobilizing older adults. For example, age stereotyping has been implicated as an important social barrier because several studies have found a diminishing gradient by chronological age of social support for physical activity (Hayslip, Weigand, Weinberg, Richardson, & Jackson, 1996; O’Brien Cousins, 1995), with Chogahara, O’Brien Cousins, and Wankel (1998) providing a review on how social influences provide positive or negative cues to late-life physical activity behavior. Other work suggests that social roles such as spousal and parental status can affect the type of barriers and opportunities that older people have for physical activity (Branigan & O’Brien Cousins, 1995; Janzen & O’Brien Cousins, 1995).

The Utility of Narrative Data

Interview data, although rarely used in the study of older adult exercise, have the potential to focus on the beliefs of older adults; dialogue with seniors vividly exposes some of the knowledge, values, beliefs, and ongoing life experiences that motivate or undermine older adult participation in physical activity. For example, 3 women born in 1900 and earlier shed light on the broader social forces affecting the physical activity opportunities of girls a century ago (O'Brien Cousins & Vertinsky, 1995). Their stories attest to their success in adapting to a century of evolving medical advice; by late life, all 3 women (of very different means and backgrounds) were exercising daily on their own with stretches and strength movements taught to them by nurses.

In a previous study with a similar life-course approach, O'Brien Cousins and Keating (1995) led focus groups with active and inactive older women to explore the hypothesis that unique life circumstances and opportunities would cue aging women differently for involvement in physical activity. Instead, they found evidence that there are several fairly universal stages or turning points in the life cycle that triggered women into reconsidering their lifestyle behavior, but active women found ways to take advantage of those turning points, whereas less active women interpreted them as cues to reduce activity.

Qualitative data are rarely used to help us understand what older adults think about physical activity, and given the heterogeneity in activity behavior, it makes sense to document the kinds of triggers that people think lead them into or out of physical activity participation. Qualitative data provide a new perspective and can overcome some of the liabilities that statistics present when nonlinear relationships are found for theoretically important predictors of active living. For example, both poor health and good health have been reported as important reasons to not be active (O'Brien Cousins, 1998); elderly women on four or more prescription medications were almost as physically active (1800 kcal/week) as were women with no health problems at all. Moreover, for older people, indicators that health or performance are declining might represent a "moment of reckoning or turning point [that] can be interpreted as the time to take life easier, or the time to take action" (O'Brien Cousins, 1998, p. 219). With statistics, these bipolar decisions that depend on people's interpretations of good health and poor health are not easily gleaned from quantitative studies; health would likely be eliminated as a key determinant of exercise if it were nonlinear and violated mathematical assumptions. In addition, age stereotypes, gender, and changing social roles are worth examining relative to beliefs about physical activity (Vertinsky & O'Brien Cousins, 1996).

Hayslip et al. (1996) advocated for more qualitative research after they developed and investigated the reliability and validity of several scales assessing constructs derived from the health-belief model. In comparing 86 younger adults age 19–31 with older adults age 60–91, they noted that older people pursued less diverse physical activities and reported less support from others regarding their exercise and health habits. They concluded their findings by inviting future research in the form of qualitative studies of older adults' beliefs about physical activity. That is, we might ask older adults what constitutes meaningful physical activity, what factors would make them more active, what they perceive to be the benefits of and barriers to such activity, and what specific cues influence their decisions to participate in activities that they value (Hayslip et al.).

Purpose

The aim of this study was to animate current theory by listening to seniors "think aloud" about physical activity; more precisely, the goal was to better understand how currently active seniors might have been triggered into active living and how currently semiactive or inactive seniors experience and interpret cues for physical activity. The trigger construct represented a line of questioning related to shifts in thinking that are described in several social-cognitive theories (environmental cues, cues to act, social influences, perceived health threats, perceived susceptibility to illness, hazard recognition). The paucity of research exploring the internal dialogue of sedentary older adults, as compared with those who are involved in active recreation, is a noticeable void given current theoretical understanding. If triggers to thinking about and taking action are primary but complex issues leading to physical activity behavior, then rich description becomes vital to the goals of the current study, which were to (a) enrich current theoretical understanding with the kinds of triggers that mobilize older people into physical activity, (b) be attentive to differences in the self-referent discourse and cognitive understanding of active and inactive older people as they think about opportunities and threats to health and physical activity, and (c) explore the possibility that less active people might simply have not been triggered into thinking about physical activity. Hypothetically, older people might experience life stages in a variety of ways, and if and when triggered to think about their choices, they might either talk themselves into, or out of, a physically active lifestyle.

Methods

The approach of this study was to enrich information about a current theoretical construct; as such, the work might be considered more structured than some qualitative studies are, falling in line with some of the strategies of survey-data analysis (Silverman, 1995). But Silverman has addressed "the need to avoid making a choice between the many polarities current in theory in methodology" (p. vii) while at the same time rejecting the notion that "anything goes." The intent behind the current study was not theory construction but theory validation, animation, and enrichment. Philosophically, however, the "think aloud" approach also falls in line with interactionism and inductive reasoning, in which interviewees are viewed as experiencing subjects who actively construct their social worlds (Fonteyn, Kuipers, & Grobe, 1993); the primary issue was to generate data that provide authentic insight into people's experiences (Selltiz, Jahoda, Deutsch, & Cook, 1964).

A university human ethics review board approved the use of guided interviews with willing volunteers on a large campus during Spring Session for Seniors, when 400 adults age 55 and older pay tuition fees and attend academic classes. Formal interviews lasting 60–90 min were initially conducted with 41 participants on a number of different issues on older adults' physical activity as part of a larger study. This article provides only the data involving women's triggers for physical activity, because the small sample of 9 participating men provided insufficient data to be included (Morse, 2000). Two graduate-student research assistants were employed, trained, and equipped with audiotape recorders to conduct the interviews at scheduled times in unused classrooms that were convenient for the volunteers. Research assistants first approached professors and instructors for permission to

introduce the study to their classes and then handed out sign-up sheets so that volunteers could be contacted for follow-up interviews.

The research assistants were educated in exercise gerontology, with interests in health psychology and field research. Our goal as a research team was to establish rapport with sensitivity and without judgment in order to gain access to the words and lived experiences of generally healthy and well-educated older adults who would be willing to share their thoughts about active living. In order to illuminate the breadth of human thinking about physical activity, social diversity was sought (active and inactive, of varying ages). The interviews were semistructured in design, beginning with the following:

This study is exploring the beliefs older people hold about their health and well-being. You do not have to answer any questions that make you feel uncomfortable. Please ask me to explain anything that you do not understand. There are no right and wrong answers—Only your opinion is what is important. I would like to tape your answers. Is that O.K.? [Tape machine turned on with permission.] Previous research indicates that as people get older, they often cut back on their previous physical activities. Some older people are actually quite athletic, and others are quite sedentary. We are interested in why some older people slow down more than others do. Could you tell me a little bit about yourself in this regard?

After this introductory section was read, and the individual's activity level was better known to the interviewer, the protocol became semistructured. If the participant reported being less active, the interview was guided by questions that were appropriate for low-active adults. For example, "Is there an activity that you sometimes wish you did more often?" and "What would motivate you to do this activity more often?" For more active respondents, the questions were similar, but worded, "What kinds of activities do you do?" and "What motivates you to do these activities?" Researchers were encouraged to open up conversation and expand on related lines of questioning on various kinds of activity participation and any and all motives for, or barriers to, taking part.

Validation of the method and meaning behind qualitative data is an important concern in any kind of research. Given the nature of the semistructured method framed by behavioral theory, and given the advice of Silverman (1995) in analyzing questions about opinions, beliefs, or attitudes, no formal interpersonal cross-checking of statements was undertaken. Kvale (1996) identifies two approaches that researchers can use to ensure validation of qualitative data: multiple interpretation or validation by example. In this study, rich examples of seniors' voices are used to demonstrate the nature of cues and triggers and how they were interpreted by the respondents. In this way, the link that I make between the voices of older adults and current theory is open to public critique and review.

Thirty-two women, average age 70.2 years, were interviewed during Spring Session for Seniors at a major university in western Canada. The volunteer sample included 20 women who were considered currently and regularly physically active. *Active* was operationally defined as someone who had planned activity every week at levels close to national recommendations (30 min of exercise most days of the

week; Active Living Coalition for Older Adults, 1999). Eight women were self-proclaimed to be "inactive," operationalized as not currently or regularly involved in physical activity, and 4 respondents were "semiactive," operationalized as inadequately active or participating in sporadic, irregular, or unplanned activity. Full interviews were obtained; no one was excluded for cognitive problems. Educational level was not assessed, but seniors taking university courses tend to be healthier, more active, and more highly educated. Readers should also note that these seniors were primarily White and middle-class.

Verbatim transcriptions of each interview were sorted by activity level and then into two age groups (10 women under 70 and 10 women over 70) for currently active women to provide some social-contextual organization. Each transcription was individually analyzed by the principal investigator for specific commentary on opportunities, threats, or general events that might have triggered people into thinking about their current activity level. Transcripts were analyzed in their entirety for all dialogue relevant to shifts in thinking or actual behavior change for physical activity; passages about triggers were highlighted and compiled. For the purpose of this report, the selection of respondents' comments was intended to capture the diversity of thinking that led to shifting motives for physical activity. The data are presented so that respondents often speak for themselves about cues and triggers for physical activity.

Listening to the Voices of Older Adults

Following are the findings of this study, beginning with the younger active respondents.

YOUNGER ACTIVE WOMEN AGE 55–67

At 55, the youngest active woman had not experienced any health problems, but her husband's heart attack was mentioned as a cue to pay more attention to food choices. "I guess it was a wake-up call to remind you once again of the importance of a good diet." Other women had "got away from fitness for a lot of years" while they had young children and "didn't do anything at all except chase them around." Younger active women claimed they were triggered to activity or reinforced to maintain their previous level of activity by the following:

- Recognizing their increasing age and declining fitness level. "Oh my God, 40! What am I going to do [about my level of fitness]?"
- Bone-density tests showing suboptimal bone strength.
- Widowhood leaving no family around and little to do.
- Realizing that habitual activity was the essence of their life.
- Finding that health care was becoming less reliable and self-care was becoming more important; there is a lot of published literature on the role of exercise in disease prevention, and "the last thing that one wants to be is . . . is to allow yourself, either mentally or physically or spiritually in any way to disintegrate."

- Noticing that the community was offering fitness classes specifically designed for seniors. "It just caught my eye . . . a special introductory program with equipment for the seniors, and it wasn't very expensive."
- Discovering that aches, pains, and joint problems were relieved with regular mobility activity. "Because if I don't I will seize up even more than I am now."

A 66-year-old woman used an active-living approach; she integrated physical activity quite well into her daily living, especially after learning of a hereditary disease in her sister that matched symptoms that she had been experiencing. Thus, her trigger was an increased sense of susceptibility to this disease that made short-term benefits with weight control and management of the disease more relevant. "It's something that you can't help, but you help yourself by doing activity."

An active 65-year-old was seeking help to ascertain whether she was doing the right kind of activities given her health conditions. "I can't find anyone who will tell me exactly what I should or shouldn't do. Maybe I shouldn't be doing what I'm doing even." Some active women had been so active for so long that it had become part of their identity. One woman, raised in northern Europe, claimed she had been active all her life (age 64):

Well, if I sit in a rocking chair I would die! To me that would not be. . . . I've been active all my life and when I told my children I was going to retire, they said, "Well, what are you going to do then?" I said, "I'm going to be lazy," and they didn't believe me for a minute. I'm on the go all the time. I don't believe in being a couch potato. That's not for me. Never was.

But another very active 65-year-old woman, a former athlete, had encountered serious health problems, and the experience was devastating:

I had nipples retracting and I could feel it pulling later on, you know. Oh, I was in shock. And "Why me?" I was angry. I had done all the right things in life, you know! How does this happen? The doctor said it was just the roll of the dice.

This particular woman was shaken in her resolve to pursue active living alongside her battle with cancer; she had to battle with the disappointment that exercise had not protected her.

I was doing lots of things . . . but it still came on. So I thought, well, I'm going to keep up my swimming and exercise and walking and the whole bit. Keep my joints oiled up! Because I firmly believe in what you don't use, you lose.

Thus, a very active woman was triggered to question her activity level because of her disappointment when physical fitness failed to protect her from a life-threatening disease.

OLDER ACTIVE WOMEN AGE 71-92

Active older women expressed a number of health conditions that prompted them to take part in physical activity. After a series of heart attacks, a 76-year-old woman reported,

He [the doctor] gave me 5 years. But it was almost a frightening thing. I had to do something. I had to have some kind of exercise. I could only walk for a block and a half and I was getting very depressed about this situation. But because I liked the water, that's why I started. And I found that I was so much better, and my outlook was so much better.

A 76-year-old widow felt that she had to keep herself "quite active" for the sake of her family. "Well, I'm single now, and I have a family that I sort of feel responsible for, to keep myself in good health, and besides you have a better chance to enjoy life."

At age 87, one woman reported a childhood trigger for physical activity; she claimed that she had always felt inferior to her older siblings in appearance, so she was "determined to be ahead physically, athletically, and also scholastically. It was a selfish reason." Now in a lodge for seniors, she is motivated to "get some fresh air and a feeling that I can still move." She was also affected by the lack of physical activity around her:

Well, in a place like this, there aren't many people who are active. They do exercises in the morning with an instructor, and I don't 'cause I am used to doing my own exercises. I do exercises in the bath, and sometimes I sit outside and do deep breathing and mild exercises. And I go for a short walk.

At 92, an active women reported how she experienced cues to quit being active when she joined an exercise program with people in their 60s:

I couldn't keep up with anybody, and that's why I didn't keep it up. I was the oldest one in the class and I was there for 3 weeks. I felt despondent and discouraged with myself. No one expected me to do it. The teacher was very appreciative of what I could do, because some people were doing seven rounds of the oval and I was going five. She said "You are expecting too much of yourself." But that's it, I'm just too old and I shouldn't expect myself to do that. I'll just do what I can.

SEMIACTIVE WOMEN

Semiactive women talked about encountering health problems that triggered them to think about being more active, but not necessarily into committing themselves. Thinking about being more active "has never really bothered me until I started having medical problems and then I thought *maybe* I should be out walking or *maybe* I should be out doing other things." Although this 65-year-old woman had a family with a history of heart disease and knew that physical activity could help combat these problems, she was still not motivated—"not enough to get on a program and really stick with it."

At age 66, another woman reported she currently did

nothing structured. I am quite content to continue what I am doing. . . . A thing that really got me to change my lifestyle was when I was diagnosed with diabetes, Type II, in 1979. So I had to change my diet, and I became more

interested in exercise. I always knew that exercise was good, but I think that I was more determined to exercise on a regular basis.

Now 20 years after the diabetes diagnosis, her initial interest in the health role of physical activity had apparently waned.

INACTIVE WOMEN

Among inactive women, triggers were indeed evident. One woman's trigger had built up slowly over time, and she was seriously preparing to become more active. At age 66, with increased intentions to be more active, she was being cued to do something to deal with her visual impairment.

Well, my sight is gradually going. Its getting worse and worse so I'm going for a dog, in the fall . . . whenever they decide to send one to me. I'll be more active. I'll be able to get out more and into the community, because now it's dangerous for me to cross streets. And with a guide dog, you're more secure. Nobody is going to attack you when you've got a monstrous dog.

Having an accident could trigger an abrupt change leading to an inactive lifestyle. For example, a 66-year-old active woman recovering from a fall had recently become inactive. "Most of my exercise is walking, but I haven't really done a lot of that in the past 4 years because I fell 4 years ago and hurt my leg really badly." Although her injury was severe, she was able to ride an indoor bike at home and walk two or three blocks, "but I am not faithful about doing it every day."

A health threat as big as a heart attack doesn't necessarily act as a trigger for an inactive individual, even when one's cardiac physician prescribes exercise. A reason given by a 73-year-old woman for not being physically active was that she was "very active" socially with volunteer work, continuing on with the volunteer service activities of her previous years:

I don't do very much. I had a heart attack and I'm supposed to be walking, but I am in no regular routine. I am as active as I was when I was 40, which is in all my organizations and my home and my flower garden. I am continuously helping other people. It's the same activity level that I had to work at 40.

Therefore, the comfort of her habitual lifestyle, even if it was not fully balanced for her own physical needs, was maintained because she is "always on the go" and "seldom feels tired." In her mind, social service was less selfish and overruled time spent on self-care. What was appropriate for her middle years seemed to be highly appropriate now that she was so much older.

Asked what might trigger her into being more active, a 73-year-old woman replied,

I don't think anything. Because really, the opportunity is there, it's close, my kids who swim keep impressing on me that this is what I should be doing. I could go to the warm pool at the Glenrose if I wanted to. I don't have any reason other than just inertia. Just inertia! That's all.

When the interviewer suggested that she might just have other things to do that were more worthwhile, she replied,

See if you can get anything more out of me than just being, you know, liking to put the seat of the pants to the seat of the chair! I'm just too lazy! I mean, perfectly honestly, it's too comfortable to sit and do my needlepoint and to read prodigiously than it is to get my shoes on and get out the back door, walk up the lane and go to Coronation Pool. I could go any day of the week if I wanted to.

Another woman, 77, explained her inactivity as overshadowed by her other good health behaviors:

Exercise and nutrition are much better together than either one of them apart. But I must admit much emphasis on the nutritional part. Probably due to the fact that I paint, you know, because I love it so much, then I've got the housework to do, and you kind of forget about exercise.

Another 77-year-old woman provided an interesting glimpse into her lifestyle and made a case for the active and even athletic side of doing "women's work":

In the winter, I get up and help make breakfast for one son living at home. And some days I start a batch of bread, . . . then while the bread is setting, I throw in a load of laundry, and tidy up the kitchen and just fill in time until the hour is up. Then its time to punch the bread again.

At age 80, a sedentary woman explained,

I don't have any ritual [regular activity] at all. I would think that the most activity that I do is that I live in a walk-up apartment, so every time I go out of the door, I am up and down three flights of stairs. And I am up and down those stairs two to four times a day, so it's actually the most physical activity that I have.

Asked if there was something she would like to do, she said "No because I couldn't. Heck, it isn't a very nice word, but I probably couldn't take it."

Discussion

This study explored the ways that older people might be triggered to think about being more physically active and ways that they talk themselves out of taking action, or ways that they do, indeed, adjust their lifestyles for physical activity. By virtue of the sampling strategy, the seniors in this study were probably well educated, on higher income, and generally vital older adults involved in lifelong learning; these are the voices of 32 women diverse in activity level and self-referent thinking about physical activity. The first aim of this study was to enrich and animate a cross-theoretical construct called a trigger or cues to act. In brief, these seniors presented a broad variety of triggers for late-life physical activity—cues that were generated

from abrupt life changes such as an accident or sudden health concern or were slow to coalesce as problems mounted. Some triggers could be considered positive cues, arising from new opportunities or having more leisure time. Negative triggers were prevalent, however; social isolation caused by widowhood or divorce, getting out of shape and increasing body weight, and experiencing a health problem were examples of negative events that got people thinking about doing more physical activity.

The preponderance of data from active women supported the four social-cognitive themes mentioned earlier. In summary, things that prompted elderly women to become more active were (a) a nursing background or health knowledge that was convincing that keeping active would lead to more successful aging (value in obtaining a goal), (b) learning how to do exercises in months of therapy after a serious car accident (support, efficacy), (c) having experienced benefits such as rapid healing and reduced pain with physiotherapy after surgery (positive expectations), (d) a need to find balance in how to spend one's free time (value in obtaining a goal), (e) wanting to travel and have the energy and fitness to explore international destinations (value and positive expectancies), and (f) wanting to control body size and weight ("When I started approaching 200 [lb], you start to want to do something about it"; value and positive expectancies).

A second goal of the study was to explore and compare the triggers of inactive and active older adults. Unique to some active women was mention of lifelong involvement and habitual participation that made triggers, or shifts in thinking, irrelevant to their unwavering motivation. Some active individuals were newly active and had recently increased their physical activity because they were cued by life changes presenting them with new threats or opportunities, but active individuals who were habitually active expressed a stable determination to stay active. There were two exceptions to this strong commitment to staying active. One woman, shaken by breast cancer, and the oldest woman, at 92 years of age, expressed doubts about what was appropriate activity for them.

In contrast, semiactive people viewed life changes as reasons to reduce activity. In listening to them thinking out loud, it seemed that they were talking themselves out of participating. Although often very knowledgeable and positive about physical activity benefits, they also conjured up many reasons that they should not take part. When potential triggers were mentioned, they seemed to waver in their thinking with concerns and self-doubts that moderated their positive thinking. Although irregular exercisers, in their uncertainty, procrastinated, regular exercisers seemed to bolster themselves with strong and positive reasons that their commitment to active living made sense.

Semiactive people made confusing and contradictory comments about triggers; on one hand, they agreed that exercise would be necessary if they ran into health problems, but on the other hand, they believed that you needed good health to be active. They felt fine the way they were, were hopeful that they would not run into serious health problems, and thus more active living was not necessary. Having more time in retirement was not seen by semiactive women as an opportunity to get more involved. Semiactive women were knowledgeable about the benefits of being active in late life but wavered in their resolve to commit to anything regular. In comparison, inactive individuals were also committed to their lifestyle, but it did not

include plans for physical activity. They sounded resigned to being older and used their retirement lifestyle to excuse themselves from activities that would schedule their time and commit their energy.

A third aim of the study was to explore the possibility that inactive people might not have been adequately triggered into thinking about becoming more active. This hypothesis did *not* seem to apply to the more sedentary adults in this study, who on a number of occasions mentioned important triggers that were similar to those of their more active peers. They acknowledged that regular exercise could lead to health benefits but chose to bypass life's opportunities or accepted warning signs of forthcoming health problems. They had a sedentary pattern of life that was well established and described the inertia they felt in thinking about what it would take to change that. Physical activity was not a matter of life and death, and paying attention to nutrition seemed to be a higher priority.

Inactive adults inferred that loyal exercisers were "perfect" and they were not; they used the word *lazy* to describe themselves but described other ways that they were good citizens in society. Indirectly, they saw self-sacrifice for helping others as more important than looking after themselves, even after having a heart attack. They "kind of forgot about exercise" because it was low on their list of things to do each day. Thus, inactive women evidently did experience health triggers and cues to act but seemed convinced that their current lifestyle was justified because (a) retirement requires no commitments, (b) exercise is not needed if you are healthy, (c) being active is not appropriate if you are ill, (d) being busy is a substitute activity, and (e) serving others is less selfish. Targeting inactive individuals such as these women would appear to be a difficult enterprise for health promoters, at least until further shifts in their thinking might occur. Such shifts might require major deterioration in health to the point at which exercise would become essential to their recovery; however, by that time, it might be too late.

Starting rehabilitating exercise after a cardiac event is a painful irony that has a huge social price. The kind of thinking that 1 elderly woman volunteered to me after a public talk was "I hope I don't ever have a stroke, because then I would *have* to exercise." Waiting for illness to act as a trigger shows that passive age stereotyping still abounds in various ways—from inadequate advocacy for active living by family, physicians, and friends (Chogahara et al., 1998; O'Brien Cousins, 1995) to reactive health and social policies that help people once they are ill but do little to prevent illness in the first place (Vertinsky & O'Brien Cousins, 1996). Healthier older people on fixed incomes experience few social incentives to find the money, effort, and time to improve their health and prevent disease, whereas unwell elderly receive many free services once they are sick. A fitness assessment is a low-risk, personal purchase for a healthy senior, whereas the only opportunity to run on a treadmill with full medical supervision is provided free to high-risk heart-attack patients. With these kinds of mixed messages, it is not surprising that seniors are confused about which approach is best for them.

Once seniors experience the physical, social, and mental health benefits firsthand, however, their confidence can measurably increase, and they soon realize the personal improvements to their quality of life (Myers, 1999). Therefore, a better understanding of how to help older people get started and stay involved long enough to reap the benefits of suitable and enjoyable physical activity has the potential to

mobilize thousands of older people, improve their prospects for healthier aging, and have a positive economic impact on lifelong productivity. It is becoming clear that we need to know how to trigger interest in physical activity *before* health problems arise.

A number of research initiatives are critical to sort this out. First, we need to better understand the depth of thinking that goes into decisions about being active or not. If older people already have their minds made up to not participate, trying to move them from contemplation to action will prove to be a wasteful health-promotion effort. Second, more research is needed on how personal changes in health are interpreted by older adults and how good health and poor health complicate the decision-making process. This study supports the notion that health difficulties do act as an important trigger to lifestyle change for some people but not all. New opportunities for active living, such as having more time in retirement or active companionship, seem to help people get started.

Further research is needed to identify the cues that active people use to stay active. The questions in this study did not capture that information, other than that some people were active out of habit. Future studies might explore the processes of trigger formation by monitoring how triggers evolve over weeks, months, and years. This study adds strength to current theory that health threats do act as important triggers, but not always in favor of motivation for physical activity. In this study, worsening health was interpreted differently among older people, prompting one individual to cease physical activity and prompting another to increase hers. In support of this finding, Ewart et al. (1986) noted that when cardiac symptoms arise, some people are frightened into exercising whereas others are afraid to do anything physical. Such examples remind researchers that relationships are not always simple and bring awareness to the complexities behind motivational determinants for physical activity.

Weinstein (1988) proposed a five-stage precaution-adoption process as a way of explaining how people reacted to the discovery of radon gas leaking into their homes. When confronted with this health threat, Weinstein proposed that people were triggered to adopt precautions to remove or reduce the threat. This model has merit but seems to represent a reactive "threat" model rather than an "incentive" model. There is evidence in the current study that not all triggers are negative, or even health threats. Some people, who are positively disposed to a health behavior such as being more active, might simply need more encouragement, more reminders, more help to get started, and more reinforcement along the way. People can turn life events into barriers or opportunities for physical activity, depending on their health information, habitual patterns, self-schemata with active living, and new experiences.

Implications for Exercise Counselors and Fitness Leaders

A final note is warranted, given the findings of this study. Exercise counselors and fitness leaders of seniors must gain an appreciation of how much motivation has been garnered by their clients to join their programs. By the time older adults end up in a walking program, tai chi, line dancing, or a fitness class, they might have had to overcome years of personal inertia and a lifetime of social barriers to active living

and finally talked themselves into showing up. By questioning them, perhaps over coffee after class, program leaders could benefit from knowing their clients' motives better. The information they obtain, either informally or in a more structured evaluation, can lead to a number of important adjustments in how programs are conducted (Myers, 1999). Finding out what triggers clients to try a program is likely to open up a colorful discussion about their beliefs about locus of control, the values they hold for certain kinds of activities, beliefs about which benefits are expected, worries about risks, thoughts about personal capability, dialogue about who is discouraging or encouraging them, their aspirations for health and fitness, and their challenges in getting started. Something has triggered these older adults to ignore the stereotypes and take up more active living, and the challenge facing researchers and practitioners is to find out what that particular trigger might be. Knowing the trigger can lead us to better appreciate the range of motivation that inspires active living among older adults.

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