Looking for More than Weight Loss and Fitness Gain: Psychosocial Dimensions among Older Women in a Primary-Care Exercise-Referral Program

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Looking for more than weight loss and fitness gain: Psycho-social dimensions among older women in a primary health care exercise referral scheme

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Abstract

There has been increasing interest in the promotion of health enhancing exercise within primary care services. One popular approach in the UK has been through General Practitioner exercise referral schemes. In these schemes mostly sedentary patients are referred from the primary health care setting to an exercise programme within a local authority operated leisure centre in the community. However, it is not clear how referred older women assimilate such a referral system into cognitive processes associated with physical activity involvement. This interpretivist study adopted unstructured interviewing and life story technique to embrace subjectivity and contextuality in an attempt to capture the complex processes, and to explore both common and diverse experience. The study explored referred older women's accounts of their past and current experiences of physical activity and their perception of what blocks or motivates them to being active. Fifteen newly referred older women (between 50 and 80 years old) were interviewed at various points during their prescribed 10-week exercise programme. The findings highlight the importance of psycho-social dimensions and informal networks within the processes of referral.

Introduction

There is consensus that exercise in later life brings physiological and psychological benefits (ACSM, 1998; Emery & Blumenthal, 1990; Hagberg, 1994; Shephard, 1997; US Surgeon General, 1996). With a growing population of older people there has been greater effort to promote physical activity among older people as a cost-effective approach to enhancing quality of life and reducing dependence on health and social care resources (Kickbusch, 1996).

Around sixty percent of the middle-aged and elderly may be classified as sedentary in the UK (Skelton, Young, Walker, & Hoinville, 1999). It is necessary to not only understand why older people fall into the cycle of increasing disuse, but also how such people respond when given the opportunity to change activity levels. There has been considerable literature written on the former (Skelton et al. 1999) but not the latter. King, Rejeski, and Buchner (1998) also highlighted the need for further understanding of such psycho-social processes involved in interventions to increase physical activity among older people. By understanding such cognitive and social processes health professionals and services can optimise strategies to facilitate change among older people.

In an attempt to promote physical activity in the United Kingdom several hundred primary health care groups in collaboration with leisure services have developed exercise referral schemes (Fox, Biddle, Edwards, & Bowler, 1997; Riddoch, Puig-Ribera, & Cooper, 1998; Taylor, 1999). In such schemes, typically a patient is identified by a member of the primary care team (usually the general practitioner) and given a referral card indicating various physical or mental indices (e.g., overweight, elevated blood pressure, low levels of fitness, depression). Upon presentation of the card at the leisure centre, an initial appointment is arranged. At the

initial appointment further screening is undertaken including an interview regarding past exercise history and the design of a tailored exercise programme of 20 sessions over a 10-week period, for example. Patients pay a subsidised rate each time they attend the leisure centre. Exercise instructors are available to offer advice, support, and encouragement during the programme. Mid-check and end-check assessments are also undertaken with the final evaluation being returned to the general practitioner (GP). Some exercise referral programmes take place in the form of group sessions. The scheme in the current investigation operates on a turn-up-and-use basis (from 11am-5pm, Monday-Friday) alongside typically younger and active leisure centre users.

Riddoch et al., (1998) provided a comprehensive review that suggested long-term increases in activity were not guaranteed and psycho-social outcomes rather than physical changes may be more likely (Talbot & Taylor, 1998; Taylor, 1997; Taylor, Doust, & Webborn, 1998). This prompted the Department of Health in the UK to publish a National Quality Assurance Framework (NQAF) to guide best practice in GP exercise referral schemes (Department of Health, 2001). The guidelines emphasize the importance of using appropriate behavior change strategies to facilitate both physiological and psycho-social benefits for patients. However, there has been little written on the psycho-social dimensions and emerging social networks in such referral schemes.

If GP exercise referral schemes are to be truly client-centred and broadly focused on all dimensions of health and well-being then further information is needed on the ways in which patients experience such schemes. Fox (1997) and Drew (1996) suggested individual responses to the conditions of exercise and exercise settings will vary and it is necessary to use case studies and a range of qualitative techniques to

sufficiently unravel the mechanisms involved in behavior change. There has been a trend towards universal and positivistic accounts of motivation, examining traits or cognitions that rarely predict more than 30% of the variability in exercise behavior (Biddle & Mutrie, 1992). There is a need to understand the cultural and social processes and individual interpretations associated with aging in a specific social context (Chogahara & Yamaguchi, 1998; McPherson, 1994). The older population must not be viewed as a homogeneous age cohort. For example, older people may experience different life events from younger people but not every older person experiences or attaches the same meaning to events that may impact on (their) physical activity levels.

We recognized that approximately two-thirds of referrals were women. Previous work (Sports Council/Health Education Authority, 1992) identified that older women more often label themselves as 'not the sporty kind'. We were keen to explore whether such statistics from national surveys had any relevance to individual interpretations and interactions with health and leisure professionals. The decision to progressively focus on this group was to capture the influence of a variety of events that may have impacted on the current experiences within the referral process.

The objectives of this paper are to provide some insight into the cultural and social processes of a GP exercise referral scheme that are experienced by older women. Through an interpretivist approach the study attempted to capture the essence of the referral experience from the older women's perspectives. The intention was to learn more about what the exercise experience, in an unfamiliar environment (a leisure centre), means to these older women, and how this medicalized approach to promoting physical activity is perceived. Another objective was to highlight the strength of qualitative and narrative methods particularly in allowing the older

participants voices to be heard. The qualitative methods adopted offer a contextuality which a positivistic approach cannot.

In terms of selection of the exercise referral scheme and centre, the one chosen at Hailsham, East Sussex, UK, is one of the largest and most advanced schemes. It has been in operation for over ten years with approximately eight new patients entering each week. The referral scheme has been widely used as a model throughout the UK after workshops were held for leisure and health professionals in the early 1990's. In a broader sense, there are interactions between health professionals and patients globally with respect to promoting physical activity. The context may vary but the resulting interpretation of such interactions and subsequent attempts to change physical activity levels, by older women, provides the reader with opportunities to extract meaning from the voices heard in the present paper. Although generalizability is not a core issue in this work, qualitative researchers may refer to its transferability (Guba & Lincoln, 1989; Kvale, 1995). For example, the findings in the current study may be applied to other similar contexts in which they were first derived (Henwood & Pidgeon, 1992). However, the subjectivity and contextuality embraced in this study allow for insights that tap into both common and diverse experience. In this way "rich and dense grounded theory, which is contextually sensitive at diverse levels of abstraction, will in itself suggest its own sphere of relevance and application" (Henwood & Pidgeon, p.109).

In an extensive debate on validity in qualitative inquiry, Sparkes (1998) discussed the problem of establishing trustworthiness in a world of multiple realities and ways of knowing. In moving away from the parallel perspective and objective criteria, Manning (1997) developed the notion of authenticity as the way forward in addressing validity and credibility. Authenticity is seen as an open array of choices

rather than a list of prescriptions and involves " a set of criteria (i.e., fairness, ontological authenticity, educative authenticity, catalytic authenticity and tactical authenticity…which commits the researcher to a set of actions (e.g., balance of perspectives, learning by the researcher and respondents, shared knowledge, and social action" (Manning, in Sparkes, 1998, p. 378)"

Lincoln (1993) sees authenticity in a way that the text is faithful to the story lines of the respondents but also conveyed the 'feeling tone' of the lives. This is best achieved when the reader is invited into a vicarious experience of the participants' lives being described. Lincoln (1993) also emphasized that the reader should come away from such texts with a richer insight into the lives being described.

Methods

A cohort of newly referred, older women (50-80 years) were followed through the process of referral and the exercise programme attempting to capture the individual processes of adjustment to the programme as they occurred. A holistic picture of the participants' life in terms of their physical activity patterns and physical self-perceptions was sought.

The approach of the current study falls under the interpretivist paradigm. The fundamental purpose of the interpretivist approach is rooted in the improved understanding of the individual. In terms of ontology, Sparkes (1992) proposes that for interpretivists, "There can be no seperation of mind and object since the two are inextricably linked together- the knower and the process of knowing cannot be separated from what is known" (p. 34). In other words, the individual according to his or her interpretation of events and experiences constructs reality. Interpretism

embraces subjective assumptions about the nature of lived experiences (Patton,1990; Holstein & Gubrium, 1998).

The current study adopted a number of techniques including unstructured interviewing (Denzin & Lincoln, 1994; 1998), and life story (Bruner, 1987; Sparkes, 1994a). The importance of the life story is that, "It preserves the complexity of human action with its interrelationship of temporal sequence, human motivation and chance happenings, and changing interpersonal and environmental contexts"(Polkinghorne, 1995, p. 7).

The intention of this study was to place current behaviors and perceptions in the context of other life experiences and perspectives that relate to physical activity. The research is situated in a climate that embraces a range of post-structural and post-modern thinking and theorizing (Sparkes, 1994b; Nicolson, 1991; Fahlberg, Fahlberg, & Gates, 1992). In this climate, a multi-layered approach is embraced (involving interviews and observation) because of the potential for different perspectives, richness, and depth to emerge.

When using unstructured interviewing and life-story techniques the purpose is to gain an in-depth understanding of the perceptions of exercise and the referral process of older women in the present study. Sparkes (1994b) claims that it is only through the comprehension of an individual's subjective experience that it becomes possible to understand the person in his or her present context. Such knowledge may then enhance the theoretical understanding of exercise behavior and highlight the needs of the older individual for more successful exercise referral and health promotion programmes.

An 'opportunistic' sampling strategy was adopted in the current study. Opportunistic sampling refers to a process whereby researchers find informants who

provide them with their data (Burgess, 1995). The sampling strategy was also based on theoretical sampling. Theoretical sampling is a technique used to guide the data collection and generate theory (Strauss & Corbin, 1998). Through theoretical sampling the researcher is able to build and broaden theoretical insight in the ongoing process of data collection and analysis. Such sampling involves choosing people to interview with a view to finding things that might challenge the emerging theory. In this way, preliminary data is coded and analyzed and then a decision is made (based on the findings) about what or where to collect next. The emerging themes and theory guide further data collection. The criterion for judging when to stop sampling is the theme's theoretical saturation (Burgess, 1995). At saturation no additional data are being found to broaden a theme. As the researcher sees similar instances over and over again, he or she can be confident that a theme is saturated. As such, it was deemed impossible to decide a priori how many individuals must be included in the study to understand physical activity participation in this older age group. Within the GP exercise referral scheme fifteen older women were followed through the exercise programme at which point saturation was reached.

Location of the researcher.

In acknowledging the role of "researcher as instrument", Sparkes (1992) argues that the role of the researcher and his or her interpersonal skills are crucial in the interpretivist paradigm. He claims that the researcher is the primary research tool, "Interpretive research is an intensely interactive and personal process of engagement that relies on the social skills and creative capacities of the researcher rather than a set of technical competencies" (p. 35). Janesick (1994) reminds us not to get preoccupied with the method to the exclusion of the actual product.

Interview Procedure

The interviews were conducted privately in the cafeteria during a visit to the leisure centre for an exercise session. A brief explanation was provided stating the authors' interests in wanting to follow them through their exercise programme, and, our independence from the leisure centre and the exercise referral scheme. At the beginning of each interview, the participants were advised that the discussion would be tape-recorded. Consent was obtained for the tape recording of interviews and anonymity was assured. The initial 20-40 minute interview sought to gain a rapport with the patient, to explore the process of referral, and to find out about perceptions of past and potential physical activity levels. Follow-up interviews at mid- (after 5 weeks) and end points (after 10 weeks) of the exercise programme centred on participants' progress and confirmation of initial data.

Data Analysis

The unstructured interviews were audiotaped and transcribed verbatim. The first step in the analysis process was to read through the transcriptions carefully and attach codes to text segments. By allowing sufficient time to go over the data carefully the researcher opens up possibilities for uncovering the meaning in participants' lives (Janesick, 1998). Secondly, inductive inference was used to create categories (Cote, Salmela, & Baria, 1993). In this process there were no predetermined categories before data collection. As such the important dimensions of the interviews emerged from the analysis. In this way categories were generated from the data. This process of sorting information was undertaken by using NUD-IST (Nonnumerical, Unstructured, Data-Indexing, Searching, and Theorising) qualitative software (QSR NUD-IST, 1996). By using NUD-IST each interview was analysed by attaching codes to each line or section. The names of the codes were either grounded in the

participant's language or the creative, interpretative powers of the researcher (Henwood & Pidgeon, 1992). Theoretical saturation was reached when the categorizing of new data fitted neatly into the current themes without the emergence of new categories (Strauss & Corbin, 1998).

The Meaning of an Exercise Referral Scheme for Older Women

The following six psycho-social dimensions emerged from the analysis: informal networks & processes of referral, perceptions of control and accountability, sources of beliefs regarding exercise, life-stages & support networks, social support in the gym setting, and, ageism & social norms. These will be discussed separately though there is interaction and overlap between them. Pseudonyms are used throughout to ensure anonymity for those talking.

Informal Networks and Processes of Referral

Although referral schemes provide GP's with the opportunity to promote physical activity, the sample in the present study appeared to be entering through a self-initiation process or use of informal networks. Over 80% of referrals appeared to initiate the idea for referral with their GP. This is a new and interesting finding which undermines the critique by others that such schemes fail to match the intervention to a participants' readiness to change. It would appear that patients entering the scheme tend to have thought about changing their activity levels. The current data shows an informal network in operation whereby referred women advocate exercise in the community. In short, it appears that particular events, circumstances, and relationships and friendships, acquaintances and kin seem to provide vicarious experiences, and/or, positive reinforcement or critical incidents and triggers to change. Anne, 68 years old,

tells her story of why she decided to ask her GP for a referral to the exercise programme:

'I think it was just talking generally to people in the swimming pool. I think that there was a women I spoke to one day who had recently lost her husband and she was saying how she needed to get out and her brother said come swimming, lets join a gym and so forth…. So it's really why I thought I think I'll join a gym after speaking to that lady. She seemed to be quite happy with it and said they're a nice crowd and friendly'.

This background information provides rich understanding of the participant's decision to join the exercise programme which could not be gained by other approaches. Allen (1996) commented on the significance of these network relationships "These relationships matter at a personal level, also more widely in terms of social organisation…these ties are the cement which binds together the bricks of social structure"(p. 117). To reinforce the importance of the informal networks, there are others who self-initiated referrals as a result of recommendations and successes "A friend of mine was referred. I thought I'd do the same"(Paula, age 56). "A friend recommended I go to the doctor who put me onto the scheme"(Joyce, age 80). Shirley, age 68, decided to try the exercise referral programme following recommendations from acquaintances that exercise may help lower her high blood pressure: "Oh well I've met other people who've said well it brings it down" (Shirley, age 68).

In addition to the importance of 'others' and vicarious experiences in both sources of beliefs and encouragement and reinforcement, the self-initiators also displayed a quest for advice and support and confidence from their GP. Maureen, age 52, had been diagnosed with emphysema when she sought her GP's advice regarding

the benefit of the exercise programme “I had a word with them and asked if this sort of thing would help”.

Perceptions of Control and the Referral Process

A participant’s understanding of the role of the GP in the referral process may dictate how the scheme and adoption of an exercise programme is interpreted.

A sub-theme of perceptions of control which embraces the concept of locus of control (see Lachman, 1986) is that of accountability. Accountability is operationalized as the responsibility to others for actively following through and doing the exercise as agreed upon with another (for example, a GP or exercise practitioner). Nies, Vollman, and Cook (1998) found accountability to be a strong facilitator for exercise especially when personal motivation and commitment to exercise are insufficient to start or adhere to a programme. The accountability theme is apparent in the current study; particularly the accountability to ‘show up’ which in some cases seems to provide the motivation to do it. Stephanie, age 60, finds it difficult to exercise. She runs her own business that she finds stressful and also feels guilty about taking time to do other activities for herself. Also, Stephanie has not done any structured exercise for a long time and finds the exercise physically very hard. The result is an ambiguous feeling about attending the leisure centre. Indeed, Stephanie likens it to going to the dentist that is often associated with negative feelings and pain:

‘When I’ve got an appointment, she says you’ve got to come at 10 o’clock next Monday I’ll come but if I haven’t got to go, if I haven’t got an appointment I don’t know…It’s like going to the dentist. You don’t go till you’ve got an appointment, then you have to go’.

In the above instance, the accountability is towards the exercise practitioner to turn up to a mid-programme check. However, the theme of accountability also surfaces in relation to GP's and health professionals. Joan, age 77, had been diagnosed with the beginnings of osteoporosis and is very keen to do everything she can to prevent further decline "At the clinic they don't want to see me for another 3 years…but I feel it doesn't let me off the hook as it were". Beverly also feels a strong sense of accountability to her GP. Beverly, who is 64 years old, has high cholesterol and is overweight. Beverly feels quite frustrated because she has tried dieting but her weight does not seem to change. Despite her efforts, she feels that her doctor is not satisfied "I go to my doctor every so often to have my cholesterol checked and of course my weight is never very good…he's not happy see. He says you must lose more weight".

Accountability and the feeling of responsibility is not only linked to completing or adhering to the programme but also to looking after one's health and improving health status. There is some evidence that social support is more important to physical activity participation in older age. Wankel, Mummery, Stephens, and Craig (1994) reported that social support from spouses, family members, friends, and doctors contributed more to the intention to become physically active for older people (60 years plus) than for younger people. O'Brien Cousins (1995) also reported that for women aged 70 and over social support is at least as important as self-efficacy (McAuley, 1992) in later life physical activity participation.

Sources of Beliefs Regarding Exercise

It seems that in consideration of the target population (50 years plus) GP's and healthcare professionals are particularly important vehicles for the promotion of physical activity. The Health Education Authority's (HEA, 1997) qualitative study with older people found that one important source of beliefs

regarding the benefit of physical activity came from medical or health professionals. They found that family GP's in particular were seen to hold a certain status and reverence. This puts GP's in a powerful (controlling & empowering) position to promote physical activity and refer patients to a leisure centre for an exercise programme. However, the current data clearly shows the lack of commitment, confidence and encouragement from the GP's in promoting physical activity and referring to a leisure centre. A few examples of how patients reported GP's comments include: "If you think it will do you any good then yes…then you wonder if its right, they don't give you any confidence with it" (Mary, age 66). Stephanie quoted her doctor as saying: "Try it, you can try anything once".

Joan had been diagnosed with osteoporosis and had been back and forth between hospitals. She had been given specific dietary advice but no guidance or encouragement regarding physical activity "The doctor's didn't mention exercise, which I find quite strange really. At no stage by the consultant, hospital or by my own doctor was it ever suggested that this would be a help". Another GP wanted Shirley to change drugs or increase the dosage for high blood pressure "I said no thank you. I said could I do exercise*?* 'You could try', was his response" (GP's comment as reported by the patient). I couldn't believe it, it should have been him mentioning it to me without mentioning going up with the drugs really". Shirley went on to say: "he did in a way as much to say don't think it will make a difference…it was his attitude".

In another study, in terms of events that could be seen as primers of change, new information or advice was the most frequently reported trigger for change in diet and exercise behavior (Currie, Amos, & Hunt, 1991). However, the source of information for dietary change primarily came from the media and health professionals (GP's), whereas information regarding exercise came from friends. This

is supported by the current study, raising the question: why is limited information on exercise coming from GP's? (See Taylor, 1999, for further discussion).

Life-Stages and Support Networks

Life-stage is complex and involves the need to understand life contexts and different motivations and priorities at different stages of life. The individual narrative is important for a holistic understanding of the individual where barriers to physical activity are summed up in cultural, social and gender contexts. The whole notion of life-stage also has implications for practice in terms of opportunities for promotion and intervention. For example, by targeting individuals' at particular life-course events and circumstances (leaving school, marriage, motherhood, starting employment). In this study, Carole (age 61) attributed her decline in exercise to marriage and motherhood "That's when it all started to go wrong as far as weight and exercise went".

Behavior can be viewed as a complex web of biographical, social and cultural dimensions. In the present study older women frequently made reference to what they perceive as culturally appropriate behavior at different life stages and feasible in terms of structural constraints. Stephanie age 60, articulates her feeling of guilt of spending time on herself which seems to stem from her views on appropriate behavior and other responsibilities:

'I've not had time. My life has been work. Being a divorced single mother I've not really had time for myself. Been so busy doing things for other people I've had no time for myself. It doesn't seem right to do it '.

O'Brien Cousins and Keating (1995) explored physical activity patterns across three main life stages (girlhood, adulthood, retirement). Transitional events in the adult and retirement years led to a divergence toward current levels in activity. In the

retirement years some women maintained their commitment to their domestic and caring roles and did not participate in vigorous physical activity. These findings are echoed in the current research where 'time for self' seems to have been a low priority for some women and where the gender role and notion of caring is continued in old age to constrain some women from engaging in physical activity. Anne, 68 years, "When I left school I used to cycle and swim and I loved dancing. So again that's something you give up. Then of course marriage and children and your minds on them for x amount of years". Joan has a husband who is in poor health and feels a strong obligation towards her caring role and domestic responsibilities:

'I'm concerned that I'll say to hell with it, I'm not going to make my week fit around going to the gym because it is very difficult for me. Its not the programme here that's difficult, it's the fitting it in at home'.

Here we begin to see how the combination of context, norms and gender interact with life-stage and behavior.

Within the exercise psychology literature less is known about adoption or resumption of exercise than processes involved in maintenance or adherence (Dishman & Sallis, 1994). However, new approaches are starting to identify specific processes drawn from other behaviours (Reed, 1999). A key question is what causes older people to resume sufficient physical activity to enhance quality of life and avoid a potential downward spiral of increasing inactivity and declining physical capabilities? The current research shows a variety of reasons including retirement, empty nest, getting older and associated health perceptions, operations and rehabilitation, life-events such as moving house and body image (especially putting on weight).

The concept of re-socialization (McPherson, 1990) is valuable with reference to life-stage, whereby an individual enters a new social status (upon retirement, empty nest, widowed). This transition is often experienced as something negative, however it could offer the opportunity for re-socialization through physical activity. From the findings of the current study, it is apparent that the older women desire a sense of belonging and usefulness. A referral to a gym certainly gives some women a sense of social inclusion as articulated by Annette and Yvonne, aged 58 and 65 respectively "It saves you sitting around indoors, you've got somewhere to go…it's good for filling in time…as I say it's something to do and you meet other people as well ". "Coming out and seeing people it's a very good social thing…it means I'm doing something, if I didn't do that (exercise at the gym) I wouldn't do an awful lot".

Scrutton (1992) discusses the importance of social engagement, sense of purpose, and usefulness in the lives of older people. In contrast, social alienation can lead to a multitude of emotional and social problems placing older people on the edge of mainstream society where social exclusion becomes a central feature of life (HEA, 1997; Skelton et al., 1999). In the current study Anne, age 68, clearly articulates the need for something else to 'fill the gap' lost through retirement and the new 'empty nest' stage:

'Perhaps it's something to do with you're not needed anymore therefore you've got to do something to fill that gap…apart from that it's an outlet, it's coming somewhere else, meeting new people, a social thing as well as hopefully getting fitter'.

Social inclusion seems to exercise the mind, encourage physical activity, and help prevent mental decline "Already I feel better in myself, I don't just mean getting out the house, but getting out and doing something" (Pauline, aged 67). "Definitely I feel

happier in myself since I've been here ('how do you think that works'?) Well sort of achieving something each time we come " (Margaret, aged 57).

The maintenance of health in old age is enhanced by preserving links with community life, personal identity, and important social outlets (Scrutton, 1992). The gym environment within a leisure centre could be seen as a social outlet that enhances a sense of purpose and provides a sense of social inclusion.

Social Support in the Gym Environment

The current study indicates that although social support (in one form or another) is important at all ages it appears to be crucial for some of the older age group, especially regarding instruction and the interpersonal skills of the exercise instructor. Joan talks of her need for security and supervision at age 77 and indicates the critical role of the exercise instructor:

'Realised at my age I need supervision…when you get older any change in your life you wish it wasn't going to happen. It didn't have to happen because it's a question of not knowing. You come into something and have no conception what you're coming in to what is expected of you and as I say I'm sure that if it hadn't been for someone of X's calibre I wouldn't be here right now'.

These comments highlight the dimensions of support. These dimensions include technical or professional support, supervision, and attention. There is also some indication of the importance of the interpersonal skills on the part of the exercise practitioner. The current research also suggests that social support is particularly important in the stages of adoption (Sallis, Hovell & Hofstetter, 1992) and for older women (O'Brien Cousins, 1995). The professional support seems to be significant in terms of individualized attention as articulated by Yvonne, age 65, "I don't like particularly just being a number like the fact someone was paying attention to me".

Mary, age 66, highlights the caring side of the instructors "They're so nice…they don't leave you to do it. They show you how to do it". For Pauline, age 67, the exercise instructors served as a source of motivation "You need motivation and guidance, happy to do what they tell me to do like children you need guidelines need to be told what to do". Nies et al., (1998) also found the role of exercise professionals in support of exercise important especially the planning, implementation, and maintenance of an individualized exercise programme.

The notion that social support is more important in the early phase of an exercise programme compared to later is echoed in the current research by Mary, age 66:

'When I've finished here I might go up to Uckfield…[1]I didn't like the staff there much. But when you go in and do your own thing, it's alright once you know what you're doing. I can just go in and do it'.

Mary also commented about the lack of support and individualized attention in the Uckfield gym. However, it would appear that once a routine and confidence had been established "it's alright once you know what you're doing", social support and guidance is not so crucial. Sallis, Hovel, and Hoftstetter (1992) found that the provision of social relationships, guidance, attachment, and integration produce motivational based support. In addition, in some cases support actually determined whether participants attended their sessions. The critical nature of social support for older individuals in the early stages of an exercise programme cannot be stressed enough "It would have taken very little at that stage to put me right off…she got me over the first hurdle"(Joan, age 77). "If I didn't come with my husband I'd probably

[1] The Wealden District Council GP exercise referral scheme is operated in a number of semi-rural locations including Uckfield, Heathfield, Crowborough, and Hailsham with up to 10 miles between gyms.

think oh I won't bother coming down today…I need someone to motivate me"(Paula, age 56).

Ageism and Social Norms

A number of negative social factors have been identified among older adults in the physical activity setting. These include perceived barriers (Connell, Davis, Gallant, & Sharpe, 1994), social disapproval (O'Brien Cousins, 1994; 1996) and stereotypes (Vertinsky, 1995). However, little attention has been paid to the negative social influences on physical activity in older adults. The main focus has tended to be on individual personal barriers such as physical, cognitive, and knowledge-based constructs (O'Neil & Reid, 1991). The meaning attached to frequently cited barriers such as "I'm too old" and "physical activity is too risky" has largely been ignored. The current research suggests the significance of such socio-cultural norms and the notion of age appropriate behavior. Particularly the stigma attached to breaking away from the norms and values of that particular group "A lot of people think you want to be young. It's not that, you want to be the best and feel and look the best for your age you know"(Barbara, age 56). "My husband thinks it's a bit of a joke"(Carole, age 61). "They all think that you're going back to your younger days and trying to be something you're not…I think they've got this attitude why show yourself up in a gym at your age"(Yvonne, age 65).

The impact of social norms for various groups and peer statements such as 'act your age' have not been thoroughly examined. However, the current findings point to the stigma and ridicule faced by women who are becoming active in older age. There also appears to be a socially constructed image of exercise, especially for older people whereby exercise is associated with threat, vulnerability, and harm. Perhaps some of these feelings of vulnerability are based on self-perceptions and an inability to match

all the characteristics of an 'exerciser'. Both Joanne, age 52 and Beverley, age 64, respectively articulate their fear of exercise in that it is associated with both exertion and harm "I thought it was going to be harder…that I'd be much more breathless", "I feel that if you were exercising and suddenly something happens, were they around. I didn't notice anyone. You were worried about harming yourself? *(*Sarah Hardcastle*)* Yes that's what it boiled down to". Pauline, age 67, also reveals her fear of harming herself by participating in exercise "The angina started and it frightened me and I was afraid to do much exercise in case something happened to me".

The existence of socio-cultural norms and associated age appropriate behavior is a reminder of Atchley's (1989) continuity theory which refers to the consistency of a pattern of action across different stages in life. Continuity theory argues that as individuals age they strive to maintain consistency in their lifestyle. Also, later life is a continuation of a person's past and that in later years many people may choose the lifestyle most like the pattern of life they lived in middle age.

Atchley (1989) suggests that continuity theory has two dimensions: internal and external. Internal continuity refers to the persistence over time of psychological patterns (e.g., attitudes, beliefs, values) that have shaped one's global sense of identity. It is proposed that over time these inner mental profiles tend to become resilient despite external pressures being exerted by the outside world. External continuity refers to the persistence of physical and social environments, roles, and activities that form the life course of the individual. It also involves a preference for familiar environments, pursuing familiar interests, and interacting with familiar people (Atchley, 1993). The motivation towards these is determined by the success of previous patterns of behavior. Continuity theory may form an appropriate framework for exploring physical activity behavior, particularly in relation to identity and

physical self-perceptions. Joan, 77 years of age, appears to reinforce the continuity theory expressing certain norms and values, and how in turn, the 'familiar' and 'consistent' lead to security and a feeling of well-being:

'It has been difficult because anything new, the unknown no matter what it is...is a bit scary. You're clinging to what you're familiar with, the procedures, the routines…that sort of thing because this is what makes you feel secure so if you break away from the norm…it becomes a major thing to you'.

One of the benefits of an exercise referral scheme is that it allows inactive individuals the chance to rediscover their physical capabilities in a supportive setting. Comments about the fear of harm confirm the value of support in this type of scheme. Despite the support available at the gym, GP's sometimes undermined this by not discussing the very limited harm that maybe associated with exercise in the scheme.

So What Have We Learned and Whose Knowledge Is It?

The study provides an example of the use of unstructured interviewing as a means of exploring older womens' physical activity adoption processes and adds to our understanding of the following: 1) processes of referral among older women; 2) formal and informal support networks; and 3) interpretations of age-related constraints in the leisure centre/gym environment. The interpretivist approach of the study supports the importance of understanding the complex interplay of physical, psychological, social factors in the physical activity adoption process in a supervised setting. The older people's voices appearing in this article are vivid and reflect lived experiences and perceptions. Additional contextualisation by the authors in the accompanying discussion provides a unique contribution to our understanding of the processes involved in an exercise referral scheme. It was a challenge in places not to

fall back on reductionist theoretical perspectives commonly found in health and exercise psychology texts. On the other hand, the interpretive approach provided a unique opportunity and privilege to fall outside the role of health professional or fitness instructor and be an independent listener to capture the voices of the referred older women.

In terms of implications for practice, the idea that GP's could take a greater role in initiating the referral process has long been recognized. The status and reverence attached to GP's by the older population is such that doctors and health professionals have opportunities to promote physical activity to a large proportion of the population. Health and fitness professionals need to have relevant and useful knowledge regarding the important elements that influence participant experiences. Moreover, exercise leaders responsible for the participants on such schemes need to realize their own important role in ensuring that the participants' experiences are positive, and that both their interpersonal skills and technical supervision are such that barriers are reduced and confidence is enhanced.

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