4 Health Promotion and Quality of Life in Old Age

4.1 Health Promotion

With the world population growing older age-related diseases are on the rise. They are a consequence of the demographic transition. Several scenarios based on varying assumptions attempt to predict the future direction of this development (Nusselder 2003). According to the "expansion of morbidity" theory, increasing life expectation will result directly in an increase of morbidity. In contrast, the "compression of morbidity" theory assumes that the spread of healthy lifestyles among the older population will result in a delayed onset of frailty and hence reduce every person's life span of suffering from age-related diseases. Although there is no evidence for either theory, the latter scenario is obviously more desirable. To achieve this goal health promotion and disease prevention seem to be advisable.

The idea of health promotion began to spread since the publication of the Ottawa Charter for health promotion (WHO 1986). According to the Ottawa Charter "health promotion is the process of enabling people to increase control over, and to improve, their health". Health promotion includes a wide range of social and environmental interventions that are designed to benefit and protect individual people's health and quality of life by addressing and preventing the root causes of ill health. As such, it goes beyond health care and seeks to build a healthy public policy, to create supportive environments, to strengthen public participation, and to encourage the development of personal skills that enable persons to make decisions conducive to health and to deal with illness. In this context, health education that aims to encourage a healthy lifestyle and to change unhealthy behaviour is just one element.

Health promotion is meant to complement disease prevention that seeks to avoid the manifestation of particular diseases. Disease prevention is commonly divided into primary prevention which aims to prevent disease before it occurs (for example by vaccinations or by provision of information on behavioural and medical health risks), secondary prevention which aims to detect and treat diseases as early as possible in order to reduce their impact (for example by regular medical check-ups or diet and exercise programs in the context of treatment), and tertiary prevention which aims to soften the impact of an

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T. Boggatz, *Quality of Life and Person-Centered Care for Older People*,
https://doi.org/10.1007/978-3-030-29990-3_4

illness with lasting effects in order to improve functional capacities, quality of life, and life expectancy (for example by chronic disease management programs or through support groups that allow members to share strategies for living well).

Disease prevention is often said to define health in a negative way as the absence of disease, and to focus on efforts for risk-groups with the intention of bringing people back to "normal life" (Seedhouse 1997). Health promotion, on the other hand, is described as a "holistic" approach as it takes the individual and her context into account and aims to address the social and economic determinants of ill health (MacDonald 1998). In contrast to disease prevention, health promotion strategies have a wider scope. They do not primarily target specific causes of ill health; they rather aim for an increased health, well-being, and resistance to disease. Although conceptually distinct, in practice interventions of health promotion and disease prevention are often similar (Tengland 2010) and for reasons of brevity, we will refer in this chapter to both types of intervention as health promotion. Both try to change environmental factors and individuals' beliefs and attitudes through increasing opportunities or raising awareness. Promoting physical exercises, diet, reduced consumption of alcohol, or community ties is useful to strengthen health, to reduce risks for diseases, and even to avoid complications or recurrences in case of disease. In fact, since many older people are no longer in a state free of disease promoting their health becomes equal to secondary or tertiary prevention. Finally, the ultimate goal of preventing specific diseases and promoting basic health is manifest health, which is—as we have seen in the previous chapter—an integral part of quality of life. At a first glance, it seems therefore reasonable to assume that health promotion and disease prevention will increase older persons' quality of life.

When it comes to concrete interventions, a variety of strategies to promote health and to prevent diseases of older persons can be found in the literature: Health advertisements in the media, health brochures, health advices from general practitioners or community nurses, home visits, courses for health education, exercise groups, where older people can practice together, peer mentorship for individual activities, and of course combinations of two or more of these interventions. These interventions may have a broad focus on health promotion in general or a narrow focus on the prevention of a particular health problem like falls or bone fractures among older persons with osteoporosis. In the first case, there is a heterogeneous target group with a variety of interests and it may be difficult to design a program that fits everybody's needs. In the second case, the target group is more homogeneous, but the program will exclude all those who are not perceived to be at risk.

All interventions mentioned above have in common that they represent just one element of health promotion in its proper sense. They are not so much concerned about creating supportive environments or strengthening community action, they rather focus on the development of personal skills. Since they aim at changing the behaviour of older persons, they intend to interfere more or less in their lives. If older persons do not behave in a recommended way, health experts often interpret this as a lack of knowledge and information that has to be eliminated. For example, a cross-sectional, nationally-representative health surveys in England found that few of the 561 respondents knew the recommended physical activity target, but more than one half believed they had enough physical activity in their daily life (Chaudury and

Nicola Shelton 2010). Such divergence from recommended norms, however, may not be due to a lack of knowledge but due to different conceptualizations of healthy ageing (Hung et al. 2010). Whereas academic experts focus on the maintenance of physical functioning, older persons perceive health in the broader context of quality of life which encompasses social, identity related and developmental dimensions. Hence, at a second glance there is no straightforward relationship between health promotion and quality of life. As a consequence, health promotion as designed by experts may interfere with older persons' habitual balance between opposite orientations of action. This interference may be welcome if it empowers older persons to satisfy their own needs, but it may also be disturbing, if it is implemented in a paternalistic top-down approach and gets into conflict with other dimensions of quality of life that are of greater importance for them. In order to promote health and to prevent diseases in a person-centred way one has to understand the various ways how these kinds of interventions may support or interfere with their orientations of action.

To do so, this chapter will summarize the findings of 49 qualitative studies about older persons' ideas about health promotions and their experiences with health promoting interventions. The studies were identified by a literature research in the databases Pubmed, CINAHL, and Embase as shown in Fig. 4.1. The research was restricted to studies published in either English or German that were not older than 20 years.

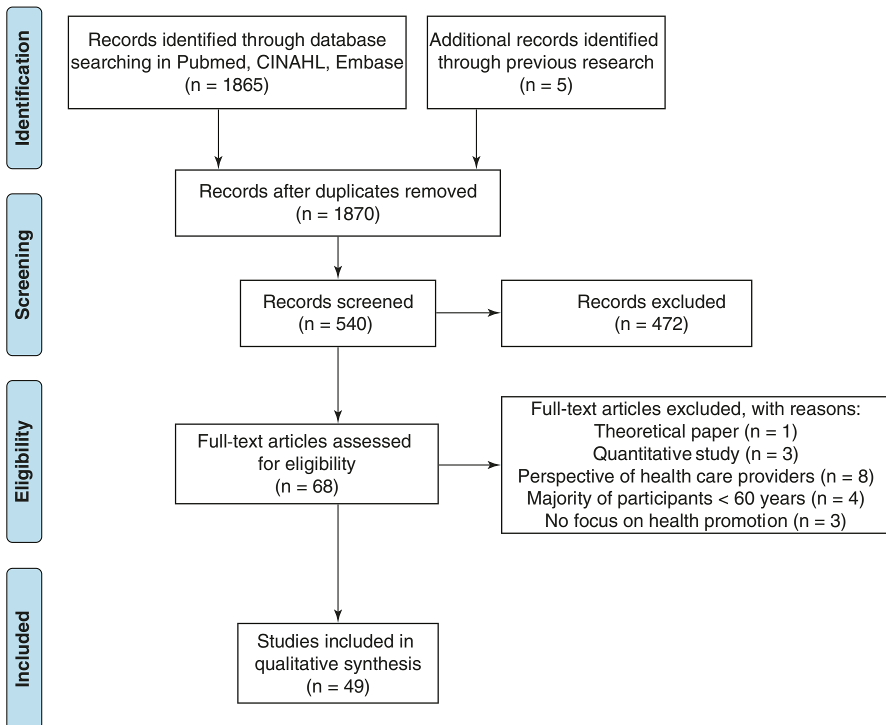

Fig. 4.1 Search strategy according to PRISMA (Moher et al. 2009)

Studies were included if they had a qualitative design and investigated how older persons understood health promotion in general or how they experienced a particular health promoting or disease preventing intervention as participants. The majority of study participants had to be above 60 years so that the results reflected the perspective of the older population. Studies that also described the perspective of health care providers were only included, if the perspective of older persons was depicted separately. Five studies presented in the previous chapter about quality of life among community-dwelling older persons were also included because a part of their results had a direct focus on health promoting activities (Söderhamn 1998; Gustafsson and Sidenvall 2002; Shearer and Fleury 2006; Söderhamn et al. 2011, 2013).

Table 4.1 provides an overview over the countries and the focus of interest of the investigated studies. Altogether 49 studies met the inclusion criteria. The majority of

Table 4.1 Investigated studies by country and focus

	Number of studies
Studies by country	
Europe	*26*
Denmark	1
Norway	1
Sweden	8
Sweden and Ireland	1
Ireland	1
United Kingdom	9
Netherlands	1
Germany	2
Austria	1
Italy	1
America	*19*
USA	17
Canada	2
Asia and the Pacific	*4*
New Zealand	1
Taiwan	1
China	1
Japan	1
Studies by focus	
Perspective of older persons regardless of participation in health-related programs on	*24*
Health promotion in general	15
Fall prevention	4
Mental health	1
Diet	1
Information Seeking	1
Health messages in the media	2
Perspective of participants in/ users of	*25*
Physical exercise program	19
Fall prevention program	2
Health awareness program	2
Complementary health	2

these studies have been carried out in Europe (mainly in the UK and Sweden), followed by America (mainly in the USA). Studies from Australia, New Zealand, and Asia were rather rare. 24 studies investigated ideas about and attitudes towards health promotion and disease prevention regardless of whether older persons participated in health-related programs or not. They provided insight into the perspective of both users and non-users. 15 of these studies had a broad focus and were concerned about health promotion in general; four studies concentrated on the issue of fall prevention; one study focused on ideas regarding mental health, one study on ideas about diet, one study on information seeking strategies regarding health, and two studies on older persons' perceptions of health messages spread in the media. The remaining 25 studies were restricted to users of particular interventions and explored their respective experiences. In 19 of these studies the intervention consisted of a program to promote physical activity and exercise (one of them using peer mentorship to encourage exercising at home), in two studies of exercises with a particular focus on fall prevention, in two further studies of a health awareness program that aimed to increase health-related knowledge and competencies among older immigrants, and finally in two studies of complementary health care that was used by a particular group of older persons. Table 4.2 shows the investigated studies sorted by authors and details their places, focus of interest, participants, and methods. The findings were analysed and synthesized by using the same method as described in Chap. 2.

4.2 Health Promotion and Body-Related Orientations of Action

As expected, health promotion was supported by, but also interfered with body-related orientations of action—except orientations related to sexuality which did not play a role in the context of health promotion. Older persons practiced health-related activities according to their individual balance between physical activity and physical rest, body protection and negligence towards health, as well as food consumption and food abstinence. This balance depended on their physical condition. Internal resources like health-related knowledge and external circumstances also had some influence. Health-related activities were behavioural reactions to perceived threats or unmet needs of body-related orientations of action. They were associated with underlying attitudinal reactions that either reinforced the unsatisfied need or attempted to compensate it by an inner reorientation towards other needs. The aspects of each orientation of action, the different kinds and degrees of their satisfaction, their influencing factors, and the behavioural and attitudinal reactions of the older persons are shown in Table 4.3. As in the previous chapter, they are printed in bold italics in the running text.

4.2.1 Physical Activity Versus Physical Rest

When older persons were asked about their attitudes regarding physical activity, they were concerned about finding a balance between physical activity and physical rest. But there were also some older persons who had a rather one-sided tendency to either activity or rest and could therefore lose a healthy balance between both.

Table 4.2 Investigated studies by authors

Author(s)	Country	Focus on…	Research question	Inclusion criteria	Number of participants	Data collection by	Research tradition
Barenfeld et al. (2015)	Sweden	Health Awareness Program	To explore the experiences of a health promotion program among immigrants ageing in Sweden	Older immigrants >70 years	14	Interviews	Grounded theory
Barenfeld et al. (2017)	Sweden	Health Awareness Program	To explore the use of health promoting messages amongst older immigrants 6 to 12 months after participation in a health promotion program	Older immigrants >70 years	12	Interviews	Grounded theory
Belza et al. (2004)	USA	Exercise/ physical activity	To identify barriers and facilitators to engaging in physical activity and to better understand culturally appropriate physical activity and exercise programs	Older immigrants 52–85 years	71	Focus groups	n.s.
Berlin Hallrup et al. (2009)	Sweden	Fall prevention	To explore the lived experience of fall risk from a lifeworld perspective in elderly women with previous fragility fractures	Older women 76–86 years	13	Interviews	Phenomenology
Berry et al. (2009)	Canada	Health messages	What were the positive and negative aspects of health advertisements, the perceived credibility of the source of the advertisements, and the usefulness of promoting a website?	Older persons 55–80 years	29	Focus groups	n.s.[a]
Bethancourt et al. (2014)	USA	Exercise/ Physical activity	To better understand the barriers and facilitators of PA and participation in PA programs among older adults	Older persons 66–78 years	52	Focus groups	n.s.

Boggatz and Meinhart (2017)	Austria	Health in general	To identify different types of attitudes towards health promotion among older adults	Older persons >60	36	Interviews	Hermeneutics
Boggatz (2011)	Germany	Health in general	To identify different types of attitudes towards health promotion among older adults	Older persons 50–83 years	31	Interviews	Hermeneutics
Brännström et al. (2013)	Sweden	Fall prevention	The lived experience of living in an ageing body and using a walker in daily life.	Older persons 79–95	7	Interviews	Hermeneutic Phenomenology
Bredland et al. (2018)	Norway	Exercise/ physical activity	Challenges and motivators encountered by retired men in maintaining physical activity when ageing	Older men 66–83 years	9	Focus groups and diaries	n.s.
Cartwright (2007)	UK	Complementary health care	The experiences of older people using subsidized complementary health care	Older persons 63–84 years	17	Interviews	Interpretative Phenomenology
Collins et al. (2004)	USA	Health in general	To describe definitions of health in Hispanic and African American elders	Older Hispanics or Africans 65–92 years	45	Interviews	n.s.
Costello et al. (2011)	USA	Exercise/ physical activity	The motivators, barriers, and beliefs regarding physical activity of independent-living older adults with easy access to fitness facilities	Older person >60 years	31	Focus groups	n.s.
Dickinson et al. (2011)	UK	Fall prevention	Older people's perceptions of the facilitators and barriers to participation in fall prevention interventions	Older persons (British, South Asian, Chinese) 60–95 years	65 122	Interviews Focus groups	Grounded theory

(continued)

Table 4.2 (continued)

Author(s)	Country	Focus on…	Research question	Inclusion criteria	Number of participants	Data collection by	Research tradition
Frenn (1996)	USA	Health in general	How older adults promote their health, what influences these effort, what aspects of the environment are relevant for health promotion	Older person 62–88 years	80 31	Participant observation Interviews	Grounded theory
Gilbert et al. (2012)	USA	Health in general	To discover perceptions of facilitators and barriers to healthy ageing	Older persons 80–95 years	10	Interviews	Phenomenology
Graham and Connelly (2013)	Canada	Exercise/ physical activity	To understand rural community-dwelling older adult participants' shared values, beliefs, and behaviours related to exercise as self-care	Older persons >65 years	17	Interviews and participant observation	Ethnography
Grasser and Craft (2000)	USA	Health in general	What self-health care practices do participants identify as important to their well-being?	Older persons 60–85 years	20	Interviews	n.s.
Gustafsson and Sidenvall (2002)	Sweden	Diet	Food-related health perceptions and food habits among older women	Older women >65 years	18	Interviews	Ethnography
Hardy and Grogan (2009)	UK	Exercise/ physical activity	To gain an understanding of personal and social influences on physical activity	Older persons 52–87 years	48	Interviews	Grounded Theory
Horne et al. (2010)	UK	Exercise/ physical activity	To explore the influence of primary health care professionals in increasing exercise and physical activity among older community dwellers	Older persons (White and South Asian) 60–70-years	40 87	Interviews Focus groups	Ethnography

Horne et al. (2013)	UK	Exercise/ physical activity	To explore the barriers for initiating and maintaining regular physical activity among UK Indian, Pakistani, and White British adults in their 60s	Older persons (White and South Asian) 60–70-years	57 116	Interviews Focus groups	Naturalistic Inquiry
Hutton et al. (2000)	New Zealand	Exercise/fall prevention	Perceptions that older adults at risk at falls, and previously involved in organized group exercise, have physical activity	Older persons 68–81 years	20	Focus groups	n.s.
Janssen and Stube (2014)	USA	Exercise/ physical activity	To explore older adults' perceptions of participation in physical activity	Older persons >65 years	15	Interviews and observation	Phenomenology
Komatsu et al. 2017	Japan	Exercise/ physical activity	To understand older persons' perceptions of the physical, mental, and social changes they underwent as a result of the physical activity.	Older persons 66–86 years	26	Focus groups	n.s.
Leavy and Aberg (2010)	Sweden and Ireland	Exercise/ physical activity	To explore perceptions of physical activity held by older adults	Older persons >65 years	30	Interviews	n.s.
Lees et al. (2005)	USA	Exercise/ physical activity	To determine barriers to the exercise behaviour of older adults	Older persons >65 years	66	Focus groups	n.s.
Lette et al. (2017)	Nether-lands	Health in general	To gain insight in older persons' perspectives on health and living environment in relation to living independently at home, to identify their needs and preferences for initiating and receiving care and support	Older persons >55 years[b]	36	Interviews	n.s.

(continued)

Table 4.2 (continued)

Author(s)	Country	Focus on…	Research question	Inclusion criteria	Number of participants	Data collection by	Research tradition
Li et al. (2013)	China	Exercise/ physical activity	To explore the experiences and perceptions of the elderly community regarding physical activity	Older persons 63–73 years	12	Interviews	Phenomenology
Lorenc et al. (2012)	UK	Complementary health care	To explore older peoples' decision making regarding complementary and alternative medicine use and their perceptions and experiences of well-being	Older persons >61 years	37	Focus groups	n.s.
Maddox (1999)	USA	Health in general	The meaning older women give to health and health behaviours the currently are or previously were engaged in	Older women >55 years	25	Interviews	Phenomenology
Mathews et al. (2010)	USA	Mental health	To identify perceived PA enablers and barriers described by focus group participants in the context of cognitive health	Ethnically diverse older person 50–90 years	396	Focus groups	n.s.
McGrath et al. (2016)	Ireland	Information seeking	To explore the strategies used by older people to obtain information about community health and social services	Older persons 62–85 years	17	Focus groups	n.s.
Menichetti and Graffigna (2016)	Italy	Health in general	Older people's experiences and subjective meanings concerning their engagement in health promotion and the emotional and pragmatic difficulties they face during their engagement	Older persons 65–75 years	25	Interviews and Q-sorting task	Ethnoscience

Miller and Iris (2002)	USA	Exercise/ physical activity	To describe older adults' attitudes and beliefs regarding wellness, self-care, and participation in health promotion activities	Older persons 62–91 years	45	Focus groups	n.s.
Miller (2010)	USA	Fall prevention	To gain an understanding of older peoples' experiences and perceptions of education about fall prevention	Older persons 69–98 years	10	Interviews	Hermeneutic phenomenology
Morris Docker (2006)	UK	Exercise/fall prevention	To identify factors that influence the attraction of Tai Chi for older people	Older persons 52–71 years	7	Interviews and observation	Ethnography
Nielsen et al. (2014)	Denmark	Exercise/ physical activity	To explore how and why participants in structured exercise intervention programs continue or stop exercising after the program is finished	Older persons 39–71 years[c]	28	Focus groups	n.s.
Patzelt et al. (2016)	Germany	Health Messages	How older men and women would prefer to be addressed for health and prevention programs	Older persons >65 years	42 12	Focus groups Subsequent interviews	n.s.
Price et al. (2011)	USA	Exercise/ physical activity	Older adults' perceptions of physical activity and cognitive health	Older persons (black and white) 65–74 years	55	Focus groups	n.s.
Resnick et al. (2006)	USA	Exercise/ physical activity	To explore the experience of an exercise self-efficacy and to establish what helped to engage in exercise and what decreased willingness to exercise	Older persons (black minority) >62 years	148	Focus groups	Naturalistic inquiry
Shearer and Fleury (2006)	USA	Health in general	To describe the types and processes of social support for health promotion in older women.	Older women 55–93 years	51	Focus groups	n.s.

(continued)

Table 4.2 (continued)

Author(s)	Country	Focus on…	Research question	Inclusion criteria	Number of participants	Data collection by	Research tradition
Simmonds et al. (2016)	UK	Exercise/ physical activity	To explore the acceptability of high-impact physical activity for increasing bone strength in later life	Older persons 65–88 years	31	Interviews	n.s.
Söderhamn (1998)	Sweden	Health in general	To describe self-care ability in a group of Swedish elderly, to elucidate the meaning of actualizing this self-care ability into self-care activity	Older persons 65–90 years	54	Written statements of participants	Phenomenology
Söderhamn et al. (2011)	Sweden	Health in general	To describe the lived experiences of self-care and features that may influence health and self-care among older persons with a strong sense of coherence	Older persons 67–89 years	11	Interviews	Descriptive phenomenology
Söderhamn et al. (2013)	Sweden	Health in general	To investigate the meaning of the actualization of self-care resources[d]	Older persons 67–89 years	11	Interviews	Hermeneutic phenomenology
Stevens et al. (2015)	UK	Peer mentoring	How peer mentors in a home based exercise program experienced their role.	Older persons volunteering as peer mentors 52–84 years	10	Interviews	n.s.
van Leuven 2010	USA	Health in general	Beliefs, values, and lifestyles of older persons who self-identified as healthy in contrast to those who self-identified as less healthy	Older persons >75 years	18	Interviews	n.s.
Wang et al. (2001)	Taiwan	Health in general	To explore perceptions of health promoting self-care in community-dwelling older adults	Older persons 67–83 years	22	Focus groups	n.s.

n.s. not specified
[a]Qualitative research in a mixed method study
[b]Study included also health professionals but their perspective is not reported here
[c]2 groups with men >60 years, 1 group with men <60 years
[d]Reanalysis of data from Söderhamn et al. (2011)

4.2.1.1 Physical Activity

For some older persons physical activity was *restricted to the performance of daily routines* (Hutton et al. 2000: Boggatz 2011; Graham and Connelly 2013; Horne et al. 2013; Simmonds et al. 2016; Bredland et al. 2018). Self-care, housework, and shopping were considered to be sufficient for a healthy level of activity.

> Do I need to do more exercise? This is what I ask myself… I do all the housework every day. (Horne et al. 2013)

> I think getting up off of the couch is exercise … any movement at all is exercise. (Graham and Connelly 2013)

Some of these older persons explained that daily routines were strenuous enough for their age leaving no energy for exercise (Bredland et al. 2018). Others expected *no benefit from additional exercise* for health (Leavy and Aberg 2010; Mathews et al. 2010; Boggatz 2011; Costello et al. 2011; Horne et al. 2013; Boggatz and Meinhart 2017). Some were convinced that they were too old to improve their health, and others claimed that health was just a result of good luck or of taking medication. In any case, efforts spent in exercising were perceived as rather futile.

Other older persons, however, had an explicit *desire for physical activity* (Hutton et al. 2000; Leavy and Aberg 2010; Söderhamn et al. 2011; Söderhamn et al. 2013). According to their opinion, physical activity should not be restricted to daily routines.

> I think another thing too is … to use your body as a whole kind of thing, rather than just… walking around the house etcetera, you are active but you may not be using all the other parts of your body that need exercise. (Hutton et al. 2000)

Their ideas about exercises corresponded with the aims of physical activity promotion. By performing physical activities they expected to meet their *desire for mobility and physical fitness*. They wanted to maintain the flexibility of their joints and to improve their physical strength in order to endure desired efforts (Miller and Iris 2002; Belza et al. 2004; Hardy and Grogan 2009; Costello et al. 2011; Graham and Connelly 2013; Bethancourt et al. 2014; Patzelt et al. 2016; Boggatz and Meinhart 2017; Lette et al. 2017). Such immediate benefits were also expected to occur in case of existing health problems. Here, physical activity took the character of secondary or even tertiary prevention.

> The main reason I started at the fitness centre was because I had a knee replacement…, but I have to keep my knee, you know healthy and exercise. (Costello et al. 2011)

Beside such immediate mobility-related effects physical activity was motivated by *expectations of further health benefits*. For some older persons these benefits were rather unspecific and consisted of vitality, longevity, and the prevention of diseases (Belza et al. 2004; Hardy and Grogan 2009; Costello et al. 2011; Li et al. 2013). Others, however, had concrete ideas and mentioned weight loss (Belza et al. 2004;

Table 4.3 Body-related orientations of action, influencing factors, behavioural and attitudinal reactions

Orientations of action and their satisfaction	
Physical activity	Restricted to performance of daily routines
	No benefit from additional exercise expected
	Desire for physical activity
	Desire for mobility and physical fitness
	Expectations of further health benefits
	Need for age appropriate exercise
	Desire to get rid of energy
	Going to the limits
Satisfaction of physical activity	Enjoyment of moving the body
	Gain of energy
	Improved mobility
	Getting tired after exercise improved sleep
	Restlessness due to excessive energy
Physical Rest	Balancing activity with rest
	Desire for comfort and inertia
Satisfaction of physical rest	Recovery from efforts
	Physical relief with assistive devices
	Overstrain
Body protection and regeneration	Fear of injuries
	Avoiding unpleasant side effects
	General awareness of health risks
	Avoidance of pain
	Avoidance of toxins
	Observance of medical prescriptions
	Refusal of biomedical treatment
	Desire for wellness
Satisfaction of body protection and regeneration	Sense of physical safety
	Relief of symptoms/pain reduction
	Improved health in general
	No benefit from biomedical treatment
	Unpleasant sensations
	Injuries
Negligence towards health	Disregarding health protection to some extent
	Non-awareness of health risks
	Careless about prevention
	Neglecting treatment
	Resistance to commitments
	Accepting bad habits
Satisfaction of negligence towards health	Waste of energy and time
	Inconvenience
	Physical comfort

Table 4.3 (continued)

Food consumption	Improved appetite
	Preference of rich and tasty food
	Healthy diet
Satisfaction of food consumption	Enjoyment of meals
	Hungry in the evening after diet
Food abstinence	Diet to avoid health problems
	Diet to lose weight
	Diet without exaggeration
Satisfaction of food abstinence	Weight loss
	Failed attempts to lose weight
Influencing factors	
Physical conditions	Age-related diseases/chronic conditions
	Lack of energy
	Functional limitations
	Visual and hearing impairments
	Physical abilities
Psychological factors	Negative mood
	Knowledge deficit
	Language barriers
	Health literacy
External circumstances	Public information
	Access to facilities
	Financial issues
	Environmental features
Behavioural and attitudinal reactions	Domestic work
	Gardening
	Moving around
	Going for a walk
	Physical exercises
	Assistive devices
	Searching health-related information
	Massages
	Health resort/Spa
	Medical check-ups
	Medical treatment
	Therapeutic measures
	Complementary treatment
	Restricted consumption of alcohol
	Balanced diet
	Nutritional supplements
	Fasting
	Acceptance of limitations
	Resilience
	Denial

Janssen and Stube 2014), improved digestion (Belza et al. 2004), regular blood pressure (Belza et al. 2004; Graham and Connelly 2013), reduced cholesterol, improved blood glucose levels (Graham and Connelly 2013), relief of pain and other symptoms (Belza et al. 2004; Bethancourt et al. 2014), and as a consequence a reduced need for medicaments (Costello et al. 2011).

Given these benefits, many older persons expressed their *need for age appropriate exercises*. Physical activities should not be too strenuous as they could exceed physical capacities. They had to be adapted to functional limitations that older persons suffered from (Morris Docker 2006; Resnick et al. 2006; Mathews et al. 2010; Boggatz 2011; Price et al. 2011; Graham and Connelly 2013; Li et al. 2013; Janssen and Stube 2014; Nielsen et al. 2014; Patzelt et al. 2016; Barenfeld et al. 2017). Among the younger older persons, however, there was also a *desire to get rid of excess energy* through physical activities (Leavy and Aberg 2010; Mathews et al. 2010).

> Many old people in their fifties and sixties have a lot of energy, but they don't know where to go and have recreations…the government can organize classes to teach old people how to dance. Through dance classes, old people can be more physically active. (Mathews et al. 2010)

Some male older persons in this age group even saw physical exercises as a challenge and told about their tendency of *going to their limits* (Patzelt et al. 2016; Menichetti and Graffigna 2016; Boggatz and Meinhart 2017; Bredland et al. 2018).

> I say it just once, going to ones limits. For example, I do what I can … Yes, what can I do, and sometimes I experience while biking, for example, when I bike to Hildesheim or to Celle, which is 80 km, then think oh well, then (Patzelt et al. 2016)

The desire to perform a particular kind of physical activity made some of them even gradually consume their health;

> I don't have the illusion that mountaineering substitutes gymnastics. It's a one-sided activity; I feel it when I return from the mountains. My knees and my feet have become stiffer and I have to recover during the week. (Boggatz and Meinhart 2017)

4.2.1.2 Satisfaction of Physical Activity

Physical activities yielded an intrinsic satisfaction. Older persons described how they *enjoyed moving their body* while walking or performing exercises and such positive feelings even chased away negative moods (Berlin Hallrup et al. 2009; Hardy and Grogan 2009; Mathews et al. 2010; Miller 2010; Costello et al. 2011; Graham and Connelly 2013; Li et al. 2013; Söderhamn et al. 2013; Janssen and Stube 2014; Nielsen et al. 2014; Boggatz and Meinhart 2017).

> When I do Tai Chi sword, my body dances with the music, and the attractive physical posture provides me with a feeling of happiness and satisfaction. (Li et al. 2013)

> If I feel kind of depressed or something I go outside and do something and it always helps me. (Mathews et al. 2010)

Beside this immediate pleasure, older persons also reported about extrinsic effects they experienced after performing physical activities for a while. First of all they mentioned a *gain of energy* (Belza et al. 2004; Morris Docker 2006; Resnick et al. 2006; Hardy and Grogan 2009; Mathews et al. 2010; Dickinson et al. 2011; Nielsen et al. 2014; Komatsu et al. 2017). Efforts spent in exercising made them feel stronger:

> Exercising and walking gives you energy. That's how you strengthen your body. Your weakness disappears when you walk a lot. (Belza et al. 2004)

Such effects were sometimes felt immediately after finishing a structured group exercise:

> I always say I'm energized. I feel like a new woman, you do feel different. (Hardy and Grogan 2009)

This gain of strength could also have further positive consequences as in the case of Tai Chi exercises for fall prevention:

> I haven't had a fall and that's why I want to continue doing Tai Chi, because I think doing exercise like this helps me. I think it makes me stronger. My muscles, my leg muscles are stronger, I think. (Dickinson et al. 2011)

Gain of energy contributed to the second extrinsic effect experienced by older persons: *improved mobility*. Study participants reported reduced stiffness and decreased pain that had restricted their degree of mobility after joining an exercise group or using complementary treatments (Cartwright 2007; Resnick et al. 2006; Berlin Hallrup et al. 2009; Lorenc et al. 2012; Söderhamn et al. 2013; Simmonds et al. 2016; Boggatz and Meinhart 2017; Komatsu et al. 2017).

> My back is much better, I am more relaxed, to be able to lie there, and turn, was really nice. And then I had some trouble getting up… so, I needed some help with that in the beginning… but now, the last time I did it myself … and that's proof that it's good for me (Berlin Hallrup et al. 2009)

> I liked the exercise because I had a bad shoulder and when I started to exercise I could hang up the clothes a little bit. It did help me! (Resnick et al. 2006)

Others told about an improved balance after participation in fall prevention programs (Hutton et al. 2000; Morris Docker 2006). A final positive outcome of physical activities was that *getting tired after exercise improved sleep* (Hutton et al. 2000; Belza et al. 2004; Graham and Connelly 2013). In this way, physical activities triggered the need for rest and contributed to its satisfaction. If, however, older persons with a desire to get rid of energy could not satisfy this need, they complained about *restlessness due to excessive energy* (Berlin Hallrup et al. 2009; Leavy and Aberg 2010).

4.2.1.3 Physical Rest

To ensure physical well-being the need for physical activity had to be counterbalanced. Even fitness oriented older persons did not want to exaggerate physical

exercise; they rather strove to *balance activity with rest* in order to recover (Frenn 1996; Boggatz and Meinhart 2017). Others were even less inclined to physical activities and had an explicit *desire for comfort and inertia* (Hutton et al. 2000; Lees et al. 2005; Resnick et al. 2006; Leavy and Aberg 2010; Mathews et al. 2010; Costello et al. 2011; Gilbert et al. 2012; Horne et al. 2013; Bethancourt et al. 2014; Menichetti and Graffigna 2016; Boggatz and Meinhart 2017) As they said, laziness and lack of discipline prevented them from exercising. For some of them this was a rather temporary mood. Others had gradually given up exercising and inertia became a habit so that they remained inactive despite better knowledge.

> I know that I should do sport, in the past I used to go to the gym but in the recent years, I finally chose the oratory and not the gym, whereas I know that this is not the better choice for me. (Menichetti and Graffigna 2016)

Some older persons, however, had never been used to exercises and preferred a sedentary lifestyle.

> I haven't got any will power. That's the biggest thing…. I would just rather sit and chat to my husband and watch television… I just can't be bothered. It just never enters my head. (Horne et al. 2013)

4.2.1.4 Satisfaction of Physical Rest

The need for physical rest was satisfied when older persons *recovered from efforts*. Those inclined to inactivity felt that due to their life-long work they had deserved such rest and they enjoyed to relax (Leavy and Aberg 2010). Older persons who suffered from functional limitations found some *physical relief with assistive devices*. Using a walker allowed them finding rest when needed (Brännström et al. 2013). If, however, older persons were not able to satisfy their need for rest they suffered from *overstrain*. This occurred mainly when they participated in activity groups with over demanding programs in relation to their abilities (Belza et al. 2004; Berlin Hallrup et al. 2009; Boggatz 2011; Costello et al. 2011; Horne et al. 2013; Bethancourt et al. 2014; Janssen and Stube 2014). But also those who went to their limits when doing physical exercises made sometimes similar experiences (Boggatz and Meinhart 2017; Bredland et al. 2018).

4.2.2 Body Protection and Regeneration Versus Negligence Towards Health

Physical activities were performed under the observance of the individual balance between body protection and regeneration on the one hand and negligence towards health on the other hand.

4.2.2.1 Body Protection and Regeneration

Older persons were aware that physical activities despite their apparent benefits for health could also result in physical harm. A major concern in this regard was *fear of*

injuries, mainly falls that could occur while walking or exercising (Söderhamn 1998; Hutton et al. 2000; Belza et al. 2004; Lees et al. 2005; Berlin Hallrup et al. 2009; Hardy and Grogan 2009; Mathews et al. 2010; Miller 2010; Costello et al. 2011; Brännström et al. 2013; Horne et al. 2013; Bethancourt et al. 2014; Patzelt et al. 2016; Simmonds et al. 2016; Boggatz and Meinhart 2017; Bredland et al. 2018)

> Well I find that I am afraid of falling and being alone. I don't want to just lay there because I decided to do such and such as an exercise. (Mathews et al. 2010)

These fears were due to an awareness of either internal or external risk factors.

> When we get older, I know myself, you know, you don't have the balance. Many times you do something or walking and turn around and it feels like you almost could have landed on the floor. The balance isn't the same. (Miller 2010)

> I feel more alert if I go out for a while. I walk, I go up to the road crossing there … then, I turn and walk a couple of times. But, when it gets slippery I don't go there, then I only walk on this here little path to that little gate. (Berlin Hallrup et al. 2009)

Beside fear of injuries older persons were also concerned about *avoiding unpleasant side effects of exercise* (Hutton et al. 2000; Costello et al. 2011).

> I've heard that really after a certain age, probably running isn't particularly good for your joints…walking is probably better and will do less damage to your joints (Costello et al. 2011)

This concern for physical integrity was not restricted to situations when older persons performed physical activities. Rather, it was an expression of a *general awareness of health risks* that may come from factors other than stressful physical activity (Graham and Connelly 2013; Menichetti and Graffigna 2016; Simmonds et al. 2016).

> At a certain age, you have to start thinking about your health and yourself, sooner or later something happens … there is an exponential curve between age and health, and I'm at the point in which something will happen … so I'm aware that I want to live the last years fully and peacefully! (Menichetti and Graffigna 2016)

For some older persons this risk awareness was mainly aimed at the *avoidance of pain*, since pain was frightening and having no pain was equated to good health (Collins et al. 2004; Menichetti and Graffigna 2016). Others considered also potential threats to health that would show a negative impact on the long run. Caring about health and physical integrity meant for them the *avoidance of toxins* like alcohol or nicotine (Wang et al. 2001; Collins et al. 2004; Graham and Connelly 2013; Patzelt et al. 2016). *Observance of medical prescriptions* was a further way to care for physical integrity. These older persons regularly went to medical check-ups, took medications as prescribed, and followed advices for a healthy lifestyle (Collins et al. 2004; Horne et al. 2010; Gilbert et al. 2012; Graham and Connelly 2013; Söderhamn et al. 2013)

> Well, I suppose if the doctor said your health will deteriorate a lot if you don't start doing something, then I would have to seriously consider it (Horne et al. 2010)

By contrast, older persons who favoured complementary treatment believed that protecting their physical integrity required the refusal of biomedical treatment as this would harm their health (Belza et al. 2004; Cartwright 2007; Lorenc et al. 2012)

> The whole, holistic idea that your body is being treated, the whole body is being treated as well, and the mind […] you know, that is what I like about it and also not having chemicals I don't really like chemical medicines, I know I have to take them but I would like to be totally un-chemical! (Cartwright 2007)

For some older persons, protecting and regenerating the body was not restricted to the prevention or treatment of diseases, they rather wanted to promote their health and had an explicit *desire for wellness* (Boggatz 2011). They took treatments at health resorts or spas to increase their vitality.

4.2.2.2 Satisfaction of Body Protection and Regeneration

The need for body protection and regeneration could be satisfied in a variety of ways. Older persons who were afraid of injuries could gain a *sense of physical safety*, for example, through exercises to improve their balance or when frailty prevented such improvements by using a walker (Morris Docker 2006; Brännström et al. 2013). Some of those who suffered from some kind of ailments reported about a *relief of symptoms* or *pain reduction* when they observed medical prescriptions, did exercises, or used a complementary treatment (Belza et al. 2004; Resnick et al. 2006; Cartwright 2007; Mathews et al. 2010; Lorenc et al. 2012; Boggatz and Meinhart 2017).

> Before I started this exercise program if I had pain I would just want to sit down. It has definitely changed my focus. Like in the morning now when I am stiff and sore I exercise! The instructor also taught us how to rub our sore joints (Resnick et al. 2006)

Others reported about an *improved health in general* as a consequence of exercises, lifestyle changes, or complementary treatments (Belza et al. 2004; Resnick et al. 2006; Cartwright 2007; Hardy and Grogan 2009; Leavy and Aberg 2010; Costello et al. 2011; Li et al. 2013; Nielsen et al. 2014). The need for physical integrity, however, was not always satisfied. There were also negative reports about the effects of treatments or preventive measures. Some older persons claimed that there was *no benefit from biomedical treatment* (Berlin Hallrup et al. 2009; van Leuven 2010; Lorenc et al. 2012).

> I do it just because I've been prescribed (take the medicine), I don't believe in it, not much… it's probably too late… I don't think you can rebuild anything new on an old woman like me, I don't … and I don't notice any difference since I've taken these pills. (Berlin Hallrup et al. 2009)

The experience of ineffective treatments made some older persons more inclined to the use of complementary methods—at least for some kind of health problems:

> Doctors – I don't think they offer much help for stress. (Lorenc et al. 2012)

Also exercises that were meant to promote physical health could result in *unpleasant sensations*.

> I felt afraid at first. I was afraid because I am a little bit heavy and I thought I would have a heart attack. I was afraid of shortness of breath. I got a little bit scared when she said drink a lot of water. I felt that something was going to happen to me and my heart beat faster. (Resnick et al. 2006)

In some cases older persons even suffered from *injuries* they wanted to avoid as a consequence of their health promoting activities (Horne et al. 2013).

4.2.2.3 Negligence Towards Health

The orientation to body protection and regeneration was counterbalanced in different degrees by negligence towards health. Some older persons admitted *disregarding health protection to some extent* (Price et al. 2011; Menichetti and Graffigna 2016; Boggatz and Meinhart 2017). They did not want to exaggerate health promoting activities, because they accepted age-related physical limitations. Hence, they allowed themselves some lack of discipline. Living a balanced and moderate lifestyle was their central concern.

> I say, you should live your life as you can. To worry about doing this or that, well… I eat healthy, I sometimes drink a glass of wine, I don't deny myself… but to worry about having this or that; I don't like it […] I let everything happen, it comes as it comes (Boggatz and Meinhart 2017)

Others showed a more or less conscious *non-awareness of health risks* (Berlin Hallrup et al. 2009; Miller 2010; Boggatz 2011; Menichetti and Graffigna 2016; Simmonds et al. 2016; Barenfeld et al. 2017). Some of them thought that they were not prone to particular risks and that recommendations to protect health pertained to other older persons. They simply believed that they did not belong to this age group or that potential risks did not apply to their own situation as it was described by an older woman who had received instruction for fall prevention.

> It's always about that woman going up the stairs and I don't go up the stairs anymore (Miller 2010)

Others simply disregarded advices despite better knowledge.

> I think that, I have to be careful so I don't fall … because my daughter says to me, 'Don't bother climbing your step ladder or this to take something down.' But, I do anyway when I can't reach. (Berlin Hallrup et al. 2009)

Taking care of their health became only relevant when they experienced noticeable symptoms. Otherwise they were *careless about disease prevention* (Menichetti and Graffigna 2016; Patzelt et al. 2016).

> I absolutely do not follow prevention, but if any serious illness came, I would be forced to change to regain my health. (Menichetti and Graffigna 2016)

Other older persons even neglected their treatment when they suffered from diseases (Boggatz 2011; Menichetti and Graffigna 2016). They were careless about symptoms and did not observe prescribed treatments because they did not understand its benefits as it was the case with a woman who suffered from a diabetic ulcer on her leg.

> Why should I keep a diet? I eat what I like… I don't need a diet… my weight is appropriate for my age and body size… otherwise my doctor would have told me… (Boggatz 2011)

This attitude was partly due to a lack of knowledge and partly due to the experience of physical displeasure resulting from restricted satisfaction of acquired habits and needs. Some older persons frankly admitted that they were comfortable with *accepting bad habits* like smoking or drinking alcohol even if these were detrimental to their health.

> I have some bad habits… that are by now in my routine and it is okay for me. (Menichetti and Graffigna 2016)

4.2.2.4 Satisfaction of Negligence Towards Health

The tendency to neglect one's health not met when older persons felt restricted by measures to protect their health. Some older persons believed that such efforts had no benefit and hence resulted in a *waste of energy and time* (Menichetti and Graffigna 2016; Lette et al. 2017).

> I think it's a waste to worry about things you won't be able to do […] not right now at least. […] Yeah, so I'm not really thinking about potential solutions I might someday need, because I would have to prepare for the entire repertoire and that would be a waste of energy. (Lette et al. 2017)

Others reported about *inconvenience* that made them give up measures to protect their health. Using walkers turned out to be complicated because one needed a larger space while walking and had to remember to bring the device and to lock the brakes (Brännström et al. 2013). In a similar way, wearing hip protectors made older persons feel clumsy or uncomfortable:

> I have hip protectors. They (the health service) want me to have that. But I don't want to. It feels very clumsy. (Berlin Hallrup et al. 2009)

> …and you see I always wear these sorts, this sort of a slipper but they hadn't got my size and she insisted that I have the little bootie one… I only took it to shut her up (laughs) and I gave it away to my friend. (Dickinson et al. 2011)

Although not mentioned explicitly it follows from what has been said above that negligence towards health conveyed a sense of *physical comfort*.

4.2.3 Food Consumption Versus Food Abstinence

Physical well-being depended also on a balance between food consumption and food abstinence which in turn was influenced by the individual balance between physical activity and rest.

4.2.3.1 Food Consumption

A consequence of physical activities was according to some older persons an *improved appetite* and hence a desire to eat (Belza et al. 2004; Komatsu et al. 2017). Exercise was, however, not a necessary prerequisite to trigger this desire. Some older persons had a *preference for rich and tasty food*. They used butter for frying and cream in gravy since these gave a better taste and they felt healthy, despite not eating according to present health recommendations (Gustafsson and Sidenvall 2002). Others, however, said that they were careful about their nutrition and paid attention to follow a *healthy diet* (Wang et al. 2001; Miller and Iris 2002; Belza et al. 2004; Collins et al. 2004; Söderhamn et al. 2011; Graham and Connelly 2013; Menichetti and Graffigna 2016; Boggatz and Meinhart 2017). The meaning of healthy diet, however, varied depending on individual and cultural habits. For some it was "not so much meat, also no sweets", but "preferably vegetables", for others it was rather "a lot of milk" (Boggatz and Meinhart 2017). A healthy diet could also include dietary supplements like Omega-3 or cod liver oil, calcium, and magnesium (Söderhamn et al. 2011).

4.2.3.2 Satisfaction of Food Consumption

The desire for food consumption was satisfied when older persons *enjoyed their meals* and this enjoyment was interpreted as a sign of health:

> I believe that how much you enjoy eating is an indicator of your well-being. Don't you think so? I really enjoy my meals (Komatsu et al. 2017)

If they, however, observed a diet, it could happen that they felt *hungry in the evening* and satisfied their need by eating (Gustafsson and Sidenvall 2002).

4.2.3.3 Food Abstinence

Despite their desire to eat, some older persons felt the necessity to observe a *diet to avoid health problems* (Gustafsson and Sidenvall 2002; Söderhamn et al. 2013; Patzelt et al. 2016)

> We like food. We really do. It should taste nice, of course. So I use butter and cream. I usually say to my husband, of course I can cook, but we have to cut down a bit. You can't go on like this all the time. (Gustafsson and Sidenvall 2002)

Diabetics hoped to maintain normal levels of blood glucose by observing a diet. Other older persons just had an interest in a temporary *diet to lose weight* (Boggatz 2011). But also here older persons just wanted a *diet without exaggeration*.

> I pay attention to my food. Some food is bad for me but I however eat it. (Menichetti and Graffigna 2016)

4.2.3.4 Satisfaction of Food Abstinence

If older succeeded in observing a diet they were happy about their *weight loss* which increased their physical and emotional well-being (Söderhamn 1998; Resnick et al. 2006).

> At midsummer I had lost 14 kg and felt satisfied in my body and soul […] I got better in my joints and the blood pressure was perfect. (Söderhamn 1998)

Those, however, who could not resist their desire to eat after being on diet all day complained about *failed attempts to lose weight*.

> And I tell you, I'm eating all this light stuff – I eat low-fat cheese, just 10% fat, and low-fat milk and everything, but I haven't lost a pound! (Gustafsson and Sidenvall 2002)

4.2.4 Influencing Factors

Health promotion and the satisfaction of body-related orientations of action depended on internal factors and external circumstances. Internal factors consisted of the older persons' physical condition and psychological factors like knowledge and mood. Among the external circumstances the availability of information, facilities, and finances were important.

4.2.4.1 Physical Condition

Not surprisingly, older persons' engagement in health promoting activities depended on their physical condition. *Age-related diseases* and *chronic conditions* were the most commonly reported barriers to physical activities (Hutton et al. 2000; Belza et al. 2004; Lees et al. 2005; Cartwright 2007; Leavy and Aberg 2010; Mathews et al. 2010: Boggatz 2011; Dickinson et al. 2011; Gilbert et al. 2012; Lorenc et al. 2012; Horne et al. 2013; Li et al. 2013; Lette et al. 2017). At the same time, however, they could trigger health awareness:

> I had a heart valve replacement and a stroke and while I got over it, I consequently had several bouts of congestive heart failure and dehydration put me in the hospital. I think that becoming very aware of how easy it is to get into trouble is probably one of the things that has made me able to live longer because I feel better than I had felt in a long time. I eat better; I watch my fluid because I have kidney failure… (Gilbert et al. 2012)

In some cases chronic conditions also made older persons use complementary treatments that were believed to be more effective than a biomedical approach (Cartwright 2007). Other older persons referred to a *lack of energy* (Belza et al. 2004; Leavy and Aberg 2010; Brännström et al. 2013; Barenfeld et al. 2017; Bredland et al. 2018) or *functional limitations* (Belza et al. 2004; Hardy and Grogan 2009; Leavy and Aberg 2010; Horne et al. 2013; Li et al. 2013; Bethancourt et al. 2014; Boggatz and Meinhart 2017) that resulted from age-related diseases when they were asked about factors influencing their physical activities. *Visual and hearing impairments* were a further physical condition that prevented older persons from exercising (Belza et al. 2004; Lees et al. 2005). It goes without saying that physical abilities were a resource and supported participation in physical activities (Barenfeld et al. 2017).

4.2.4.2 Psychological Factors

Beside physical conditions there were also psychological factors that influenced the level of physical activities. Some older persons told how *negative moods* caused them to become inactive (Barenfeld et al. 2017). *Knowledge deficits* about health issues supported inattentiveness to health problems and their prevention (Horne et al. 2010: Miller 2010; Boggatz 2011; Price et al. 2011; Patzelt et al. 2016; Barenfeld et al. 2017). Such knowledge deficits were intensified by *language barriers* among migrants who had grown old in a foreign country (Dickinson et al. 2011). *Knowledge about health*, on the other hand, was a promoting factor for physical activities (Maddox 1999; Price et al. 2011; Bethancourt et al. 2014).

4.2.4.3 External Circumstances

A variety of external circumstances influenced older persons' body-related orientations of action. Access to *public information* could support an engagement in health promoting activities. The required information concerned both methods to stay healthy in general, and local programs that supported older persons in doing so. Older persons obtained such information from newspapers, health-related books, brochures, and sometimes also from the internet (Frenn 1996; Wang et al. 2001; Leavy and Aberg 2010; Lette et al. 2017). Others complained about difficulties to obtain required information, especially when information was mainly available from the internet.

> You have to seek it [i.e. information] yourself, and a lot of people in my generation don't buy the newspaper […] they don't have computers either and can't afford to buy them. So we can't keep up, we get left behind, we who were born in the 20s or 30s. (Leavy and Aberg 2010)

> Everybody expects that we all have computers and we are all on the internet. And we're not. Especially in the rural areas, because you don't get high-speed internet (Berry et al. 2009)

Participation in health promotion programs could be facilitated or impeded by the *access to facilities*. Physical effort required to reach a particular program was an issue. Hence, programs offered in the vicinities were perceived as inviting (Hutton et al. 2000; Mathews et al. 2010; Costello et al. 2011; Dickinson et al. 2011; Li et al. 2013; Bethancourt et al. 2014; Patzelt et al. 2016; Barenfeld et al. 2017; Boggatz and Meinhart 2017).

> I think the exercise classes need to be community based. Age Concern had the idea of getting little groups going here and there in church halls and community halls and so forth, that's grass roots stuff, that's where the classes need to be. They need to be small they need to be local. (Hutton et al. 2000)

If health promotion programs were rather far away from the place of living lack of convenient public transportation could prevent older persons from participation (Hutton et al. 2000; Mathews et al. 2010; Horne et al. 2013; Janssen and Stube 2014).

Financial issues also influenced participation in such programs (Hutton et al. 2000; Söderhamn et al. 2011; Barenfeld et al. 2017; Lette et al. 2017). They were attractive if they were free of cost or available at reasonable prices (Horne et al. 2010; Mathews et al. 2010; Boggatz 2011; Costello et al. 2011; Dickinson et al. 2011). Quite often, however, older persons perceived them to be too expensive and they could not to afford them (Frenn 1996; Belza et al. 2004; Cartwright 2007; Hardy and Grogan 2009; Mathews et al. 2010: Boggatz 2011; Li et al. 2013; Bethancourt et al. 2014; Janssen and Stube 2014; Patzelt et al. 2016; Boggatz and Meinhart 2017).

> I would like to see a, a gym that I can afford. They have gyms, but I can't afford to join one. (Mathews et al. 2010)

The performance of individual physical activities depended on *environmental features*. Access to aesthetically pleasing places with flat, even surfaces and available resting spots encouraged older persons to remain physically active (Mathews et al. 2010; Costello et al. 2011; Gilbert et al. 2012; Graham and Connelly 2013; Bethancourt et al. 2014).

> I am blessed to be living in this environment. Everything is so close, food is next door and there are no stairs. (Gilbert et al. 2012)

Other older persons perceived their environment as hazardous to health. They complained about obstacles like uneven surfaces on the sidewalks that caused fear of falling. (Gilbert et al. 2012; Brännström et al. 2013; Bethancourt et al. 2014; Janssen and Stube 2014). No available space, air pollution, and too much traffic were described as hindrances for outdoor activities in bigger cities (Leavy and Aberg 2010; Mathews et al. 2010; Li et al. 2013; Bredland et al. 2018). Bad weather, gravel, ice, and snow were impeding factors regardless of the place of living (Belza et al. 2004; Brännström et al. 2013; Bredland et al. 2018).

4.2.5 Behavioural and Attitudinal Reactions

If older persons could not satisfy their body-related needs or perceived them to be under threat they showed a variety of behavioural and attitudinal responses. When asked how they met their need for physical activity, many of them said that they performed everyday activities like *domestic work* (Frenn 1996; Grasser and Craft 2000; Wang et al. 2001; Miller and Iris 2002; Leavy and Aberg 2010; van Leuven 2010: Boggatz 2011; Söderhamn et al. 2011; Li et al. 2013; Patzelt et al. 2016; Boggatz and Meinhart 2017), *gardening* (Maddox 1999; Söderhamn et al. 2011; Patzelt et al. 2016), and *moving around* to accomplish affairs (Belza et al. 2004; Boggatz 2011; Li et al. 2013). Some believed that these daily routines were sufficient to stay healthy, others, however, performed additional activities to maintain their fitness. *Going for a walk* was common (Frenn 1996; Grasser and Craft 2000; Costello et al. 2011; Price et al. 2011; Söderhamn et al. 2011; Gilbert et al. 2012; Graham and Connelly 2013; Barenfeld et al. 2017; Boggatz and Meinhart 2017).

Physical exercises were also mentioned quite often. According to the abilities of the older persons they consisted of biking, swimming, jogging, Nordic walking, training in a fitness studio, dancing, aerobic, gymnastics, Tai Chi, Yoga, or chair-based exercises (Frenn 1996; Grasser and Craft 2000; Wang et al. 2001; Miller and Iris 2002; Belza et al. 2004; Collins et al. 2004; Leavy and Aberg 2010; van Leuven 2010; Boggatz 2011; Costello et al. 2011; Price et al. 2011; Söderhamn et al. 2011; Gilbert et al. 2012; Li et al. 2013; Nielsen et al. 2014; Janssen and Stube 2014; Patzelt et al. 2016; Boggatz and Meinhart 2017). In case of functional limitations older persons used *assistive devices* like canes or walkers to reduce efforts when moving around and to protect the body against falls (Berlin Hallrup et al. 2009; Miller 2010; Söderhamn et al. 2011; Graham and Connelly 2013; Boggatz and Meinhart 2017). In some cases, older persons who were concerned about protecting their physical integrity actively *searched health-related information* by reading brochures or visiting lectures or courses about health (Grasser and Craft 2000; Wang et al. 2001; Patzelt et al. 2016). If older persons had a desire for wellness they wanted to have *massages* (Resnick et al. 2006) or went to a *health resort or spa* (Boggatz 2011). *Medical check-ups* were used for the early detection and prevention of diseases (Wang et al. 2001; Collins et al. 2004; van Leuven 2010; Boggatz 2011; Söderhamn et al. 2011; Gilbert et al. 2012) and in case of sickness they searched for *medical treatment*, went to their physician, and took medication as prescribed (Frenn 1996; Wang et al. 2001; Boggatz 2011; Söderhamn et al. 2011; Gilbert et al. 2012; Patzelt et al. 2016). If necessary, they also followed other therapeutic measures like physiotherapy (Boggatz 2011; Gilbert et al. 2012). *Complementary treatment* was used when biomedical approaches had failed to succeed or when they were perceived as not compatible with a holistic idea about health (Cartwright 2007; Lorenc et al. 2012; Patzelt et al. 2016; Boggatz and Meinhart 2017). Further measures to protect physical integrity were *to stop smoking* and a *reduced consumption of alcohol* (Wang et al. 2001; Patzelt et al. 2016). Regarding the consumption of and abstinence from food older persons claimed to observe a *balanced diet* (Grasser and Craft 2000; Miller and Iris 2002; van Leuven 2010; Boggatz 2011; Söderhamn et al. 2011; Gilbert et al. 2012; Patzelt et al. 2016). Some of them took also *nutritional supplements* like vitamins or glucosamine (Wang et al. 2001; Lorenc et al. 2012; Simmonds et al. 2016), whereas others made efforts of *fasting* in order to lose weight (Söderhamn 1998; Boggatz 2011).

These health-related activities, however, were not always successful. If older persons could not satisfy their desire to maintain physical activities they began to *accept their physical limitations* (Söderhamn 1998; Wang et al. 2001; Söderhamn et al. 2011; Boggatz and Meinhart 2017; Menichetti and Graffigna 2016). This attitudinal reaction corresponded to a tendency to critical self-perception which is an identity-related orientation of action, as we will see below. On the other hand, there were also older persons who were less inclined to give up. They wanted to maintain their physical activities despite limitations and hence resorted to *resilience* (Collins et al. 2004; Cartwright 2007; Leavy and Aberg 2010; Gilbert et al. 2012; Söderhamn et al. 2013). Although they had to slow down, they were not ready to give up and struggled to remain active as much as possible.

> My body betrays me sometimes, I guess by 81, you kind of slow down. You do just have to stay with it. If you don't stay with it, boy you are lost.
>
> I've got a bad leg, and it doesn't keep me from walking but it keeps me from walking far. (Gilbert et al. 2012)

Others, however, were not willing to face their health problems and tried to deal with them by *denial* which resulted in delayed help seeking:

> When I'm sick, I avoid thinking about this and do nothing (Menichetti and Graffigna 2016)

> We have been taught that we men should put up with things more than women and accept our situation, even though we have heard it is important to get early help, like seeing a doctor or a physiotherapist. (Bredland et al. 2018)

This attitude was not restricted to men as the quotation above suggests. To some extent, also women were reported to ignore health risks despite better knowledge, for example, when they became aware of their risk of falling.

> … it's nothing I think about every day, that I'm very fragile … It's just to think I'm going to try to manage on my own and not fall … I soon will have to give up, that's nothing I go around thinking about … no, I really don't. (Berlin Hallrup et al. 2009)

4.3 Health Promotion and Social Orientations of Action

Although health promotion programs as described above focused on the physical aspect of health, older persons did not only regard their body-related orientations of action when they considered participation. Health promotion was a social activity and therefore it also concerned older persons' social orientations of action. The satisfaction of social orientations of action was not only perceived as a precondition for health promotion, for many older persons it rather contributed directly to their health. Health promotion meant for them to enjoy social contacts and to have privacy, to be self-reliant and to receive care when necessary, to be in control of their health promoting activities without becoming a burden for others, and to adjust to social norms while at the same time enjoying some unconventionality. For this reason, it was not possible to promote physical fitness without paying attention to the satisfaction of social needs. As above, Table 4.4 provides an overview over the aspects of each orientation of action, their influencing factors, and the behavioural and attitudinal responses of the older persons.

4.3.1 Self-Reliance Versus Being Cared for

4.3.1.1 Self-Reliance

As we saw in the previous chapter, the *desire to remain self-reliant* was of central concern for older persons. It also came to the fore in the context of health promotion (Maddox 1999; Wang et al. 2001; Collins et al. 2004; Cartwright 2007; Price et al.

Table 4.4 Social orientations of action, influencing factors, behavioural and attitudinal reactions

Orientations of action and their satisfaction	
Self-reliance	Desire to remain self-reliant
	Taking responsibility for their health
	Proactive search for health-related information
	Remaining passive
Satisfaction of self-reliance	Remaining independent
	Sense of self-efficacy
	Disabled by an overprotective environment
	Losing the sense of self-efficacy
Being cared for	Desire for being cared for
	Desire for guidance and encouragement
	Desire for credible sources
	Rejection of unsettling messages
	Desire for a safe environment
Satisfaction of being cared for	Feeling safe during treatment
	Feeling safe through careful coaching
	Being encouraged by family members
	Encouragement from peers
	Lack of guidance and encouragement
	Uncertainty caused by public information
	Security provided by social network
	Fear to be abandoned
	Fear of crime
Exerting influence on others	Remaining in control over prevention and treatment
	Rejection of advice
	Having choices
	Imposing group norms on others
Satisfaction of exerting influence on others	Being empowered to make own decision
	Being encouraged to express one's opinion
	Informed performance
	Feeling exposed to a pressure to comply
	Exposed to pressure from overprotective environment
Attention to the needs of others	Fear to become a burden
	Getting health-related information without bothering others
Satisfaction of attention to the needs of others	Feeling indebted
Social adjustment	Adherence to social norms
	Adaptation to expectations of significant others
	Sense of obligation towards a group
	Need to be accountable
	Observing own cultural norms when participating
Satisfaction of social adjustment	Gaining an inner structure
	Loss of discipline
	Feeling guilty due to non-observance
	Conflict with own cultural norms

(continued)

Table 4.4 (continued)

Unconventionality	Some neglect of rules and regulations
	Unconventional way of ageing
	Disregarding advices
Satisfaction of unconventionality	Own way of life
	Feeling constrained by schedules and regulations
Closeness	Desire to socialize
	To become an integrated group member
	Desire for contact with younger persons
	Maintaining relationships with unsportsmanlike friends
Satisfaction of closeness	Gaining contacts
	Social bonds
	Positive relationship with instructor
	Lack of social contacts
	No partner
	No sense of belonging
Distance	Preferring social distance
	Desire for private exercise
	Deterred by overcrowded events
	Separating the desire for exercise from the desire for social contact
Satisfaction of distance	Being able to maintain privacy
Influencing factors	
Physical and psychological factors	*Same as in Table 4.3 under physical condition and psychological factors*
External circumstances	Social network
	Organizational matters
	Quality of care
	Features of the social environment
Behavioural and attitudinal reactions	Participation in group activities
	Home based exercises
	Fitness studio
	Accepting limitations
	Resilience

2011; Graham and Connelly 2013; Patzelt et al. 2016; Boggatz and Meinhart 2017; Lette et al. 2017). Older persons even equated independence and health.

> A person is healthy if they are able to take care of themselves
>
> Health is being independent and being myself; not what someone else wants me to be or do (Collins et al. 2004)

In other words, physical fitness was not an end in itself. It allowed remaining mobile and doing what was desired. Remaining independent was the deeper meaning of all efforts to promote physical activity. It was, however, not only the aim of health promotion, it also shaped the way how older persons approached this issue. Those with

a strong desire for independence motivated themselves to exercise and were ready to *take responsibility for their health* (van Leuven 2010; Gilbert et al. 2012; Simmonds et al. 2016; Patzelt et al. 2016; Lette et al. 2017)

> I don't have anybody saying you can't do this or you can't do that, so that's me. (Gilbert et al. 2012)

> No, that's your own responsibility. You'd need to pull yourself up by the bootstraps. (Lette et al. 2017)

Sometimes, the awareness of their own responsibility was triggered by a critical incident that made older persons rethink their way of life—as in the case of an older man who stopped drinking:

> I began to get periods of black-outs and I did not know where I was. I then understood that if I did not do something drastic, it was all finished … (Söderhamn et al. 2013)

Some of these older persons also told about their *proactive search for health-related information*, which was another way of assuming responsibility (Miller 2010; McGrath et al. 2016; Menichetti and Graffigna 2016; Patzelt et al. 2016; Lette et al. 2017). Some went to the health insurance office to request information and take home brochures. Others searched the internet or they learned about services either through talking to other people or by observing developments in their local community. On the other hand, there were also older persons who were less inclined to become active regarding their health. Although they would not deny their desire for independence, they *remained passive* and did not take the initiative, because they attributed their complaints to their age and believed that they could not influence their health through their own activities (Boggatz 2011; Menichetti and Graffigna 2016).

> It is useless to worry about what may happen and what can be done to prevent mishaps… cancer or other diseases can occur also if you have an optimal lifestyle… (Menichetti and Graffigna 2016)

If they relied on anything at all, it was on taking medication to improve their condition.

> Well, what shall you do when you're growing old… There is not so much that can be done… you may take some pills, and go from one doctor to another… that's all. (Boggatz 2011)

4.3.1.2 Satisfaction of Self-Reliance

The desire for independence was satisfied when older person succeeded in *remaining independent* and when they attributed this success to their health promotion efforts (Graham and Connelly 2013). Furthermore they could also achieve a *sense of self-efficacy* regarding the performance of health promoting activities (Belza et al. 2004; Resnick et al. 2006; Menichetti and Graffigna 2016; Barenfeld et al. 2017) They gained self-confidence and inner strength by practicing.

> By doing the exercise it gave me my confidence back in my ability to exercise. (Resnick et al. 2006)

On the other hand, there were older persons who could not satisfy their desire for independence despite their attempt to do so. They felt *disabled by an overprotective environment* that tried to relieve them of all efforts and duties considered to be too difficult. (Bredland et al. 2018). Some older persons, for example, told how their neighbours shovelled away snow in the wintertime in front of their house or how they came up the stairs every morning with the newspaper—and how such well-meant help restricted at the same time their self-reliance.

> She is so helpful, however, I needed and would have enjoyed that activity. Now I have no reason to walk down the stairs every morning. (Bredland et al. 2018)

On the long run, overprotective environments could undermine older persons trust in their self-reliance and ability to decide for themselves.

> When we are seniors we seem to be more sensitive to how our family and friends think we should behave, I am trusting my own judgement less and less (Bredland et al. 2018)

There were also those who had *lost their sense of self-efficacy* and did not believe that they were still able to exercise (Mathews et al. 2010; Horne et al. 2013). In some cases, this attitude became a habit and as a consequence these older persons developed an external locus of control that made them remain passive. Unable to satisfy their desire for independence, they resigned and gave up.

4.3.1.3 Being Cared for

The desire for independence was counterbalanced by a *desire for being cared for* that influenced the health behaviour. Older persons wanted to have access to their family doctor, to hospitals, and to care homes in the neighbourhood in order to be treated by skilled health care professionals in a way that was adapted to their individual needs (Söderhamn et al. 2011). To be called to the physician for check-ups and continuous visits provided a feeling of security (ibid). In short, they felt relieved if others took some part of the responsibility for their health. The same need was apparent regarding their participation in health promotion programs. Here, they expressed a *desire for guidance and encouragement* (Hutton et al. 2000; Horne et al. 2010; Mathews et al. 2010; Dickinson et al. 2011; Söderhamn et al. 2013; Patzelt et al. 2016; Simmonds et al. 2016; Bredland et al. 2018) According to these older persons, guidance was necessary to make them join such programs and to get them to perform exercises correctly. In the first case, physicians were of central importance as advisors, in the second case instructors and trainers.

> I would do it if it was on the doctor's recommendation, yes. If he thought I was capable of doing it… I wouldn't undertake it unless I was advised. Or unless I confirmed it was safe to do it. (Simmonds et al. 2016)

> I would go to the gym if I had one-to-one…a personal trainer. If I'm doing all these things I'm thinking have I done enough or have I not done enough… I need someone to tell me, 'right now, you do six weeks of these and you will be really good and toned up. (Horne et al. 2010)

Such guidance, however, was not perceived to be an external control that restricted the older persons' self-determination. It was rather an emotional support and encouragement that helped them to overcome their inertia and gave them a sense of self-efficacy.

> Not necessarily an instructor but somebody there, you know, to say do this and that and that. You know, like you're a five year old child. Saying "come on, come on"… I need a bit of encouragement, because I put myself back [doesn't push himself]. (Horne et al. 2010)

The desire to be cared for was often related to a need for security that should be provided by others. This was apparent when older persons talked about health-related information that was available in the media. They expressed a *desire for credible sources* such as associations of retired persons, the medical association, universities, or clinics that had a reputation of trustworthiness (Berry et al. 2009; Price et al. 2011). The same desire for security was apparent in their *rejection of unsettling messages*, that created rather fear of diseases than trust in possibilities to prevent them (Berry et al. 2009; Price et al. 2011). Security was also of importance if older persons wanted to perform outdoor activities. Some were afraid of social threats like rape or robbery and expressed in this way their *desire for a safe environment* (Belza et al. 2004; Hardy and Grogan 2009).

4.3.1.4 Satisfaction of Being Cared for

The desire for being cared for and for security was satisfied in a variety of ways. Regarding medical care some older persons reported how they *felt safe during treatment* if they had a stable relationship to their family doctor (Frenn 1996; Cartwright 2007; Berlin Hallrup et al. 2009; Horne et al. 2010; Lorenc et al. 2012).

> When you have a doctor, it's nice to see the same one .... It feels safe, yes it does, because he knows exactly what my life is like. (Berlin Hallrup et al. 2009)

The same feeling of security was reported by some of those who preferred alternative treatments.

> I think it's somewhere to go where I get treatment that I find valuable, and people who listen and time spent, and the confidence I feel in it, I feel safe here, comfortable. (Cartwright 2007)

If older persons participated in health promoting exercise programs they *felt safe through careful coaching* (Resnick et al. 2006; Dickinson et al. 2011).

> Having the instructor made me feel safer. She would tell you how much you could take, how much time. I felt that she knew what she was doing. Some people just let you exercise to take your money. She would not push you. She would help you. (Resnick et al. 2006)

Most of all, however, the need for support was satisfied by the encouragement of significant others. Many older persons told how they were *encouraged by family members* to exercise and join activity groups (Miller and Iris 2002; Belza et al. 2004; Shearer and Fleury 2006; Miller 2010; Price et al. 2011; Li et al. 2013;

Söderhamn et al. 2013; Bethancourt et al. 2014). Even more important was the *encouragement from peers* who participated in the same program (Hutton et al. 2000; Miller and Iris 2002; Belza et al. 2004; Resnick et al. 2006; Hardy and Grogan 2009;; Shearer and Fleury 2006; Mathews et al. 2010; Costello et al. 2011; Price et al. 2011; Söderhamn et al. 2011; Horne et al. 2013; Li et al. 2013; Bethancourt et al. 2014; Patzelt et al. 2016; Komatsu et al. 2017).

> The motivation from one person to the next is important. When you come to the class and you see others doing the exercise it helps. We lift each other up and push each other along. (Resnick et al. 2006)

On the other hand, there was also *lack of guidance and encouragement* (Horne et al. 2010, 2013; Leavy and Aberg 2010; Lorenc et al. 2012; Bethancourt et al. 2014). Older persons complained about physicians who gave only insufficient advice about the appropriate level of exercise and about training facilities where participants did not get their due attention.

> The nurse gave me a prescription for exercise. I took it down to X Street but there is no supervisor for the gym and there are only two machines. So I stopped going. (Horne et al. 2010)

Superficial diagnoses and advices that simply attributed problems to old age could have a discouraging effect, because older persons did not feel to be taken seriously and to be cared for.

> I think sometimes the medical profession are too quick to look at your age and say 'you've got to this age', […] I think sometimes they are too quick to jump in and say, 'oh well it's deterioration' and that de-motivates people [to exercise] and I was de-motivated then. (Horne et al. 2010)

In a similar way, some older persons complained about *uncertainty caused by public information* spread in the media (Gustafsson and Sidenvall 2002; Berry et al. 2009; Price et al. 2011). Advices were perceived as inconsistent or even scaring. Regarding recommendations for healthy nutrition one older woman observed:

> I suppose some of it is good, but it is almost too much. They frighten you so you get scared of everything. (Gustafsson and Sidenvall 2002)

A final aspect concerned the *security provided by the social network*. Staying in a familiar neighbourhood gave older persons a feeling of being protected:

> Well see, the comfort of having lived somewhere for a long time, such as I have now, is knowing people very well. Thus [I am aware that] they know that when I need help with something, it's okay for me to come to their door and ask: Would you mind helping me for a minute or would you mind doing this for me? (Lette et al. 2017)

Less familiar environments, however, caused a *fear of being abandoned* in case of health hazards.

> What would I do if I fell? I am not sure that I can call them (the children), or them over there (the neighbours) … but it's not for certain that they'll ring and care about me. I might end up lying there. (Berlin Hallrup et al. 2009)

Some older persons even perceived their environment as a threat to social security and had a *fear of crime* that prevented them from outdoor activities (Belza et al. 2004; Hardy and Grogan 2009). All these cases show that older persons felt enabled to promote their health if their desire for being cared for and for security was met. In other words, a reasonable degree of care was necessary to promote their self-reliance.

4.3.2 Exerting Influence on Others Versus Attention to the Needs of Others

4.3.2.1 Exerting Influence on Others

When older persons participated in health promotion programs their need for staying in control of the situaton and exerting influence on those who were responsible for these programs become important. This was apparent in their reaction to medical check-ups and treatment. They disliked having help and support imposed upon them and preferred to *remain in control over preventive measures and treatment*.

> So she'd make a plan based on what she thinks is necessary, but she won't overrule me, she always tells me what she's going to do and why, and I like that. That way, you're respected as a person and that's very important to me. (Lette et al. 2017)

In some cases the desire for self-assertion and control resulted in a complete *rejection of advices* (Boggatz 2011; Menichetti and Graffigna 2016).

> No matter who would tell me, you have to eat fruits, you have to do this and I do not know … drink juice … but I don't, no … because I don't want … I've got my own head (Boggatz 2011)

Other older persons were less dismissive, but in order to remain in control they wanted to *have choices* regarding both the person who gave advices and the kind and extent of recommended activities (Cartwright 2007; Miller 2010; Price et al. 2011; Patzelt et al. 2016; Lette et al. 2017).

> I choose where I get my advice and I choose the workshops I attend. (Miller 2010)

Having choices also meant having enough time to think about participation and to consider pros and cons when being invited to join a health promotion program.

> So I would prefer to be informed specifically by written notice. … I ended up lying there. I can read, I've got all day. Then they can leave me two days' time to answer. (Patzelt et al. 2016)

A desire to exert influence was also apparent when older persons were members in an activity group, identified with the group's unwritten rules, and *imposed group norms on others* (Nielsen et al. 2014). Newcomers were expected to comply or they demanded their exclusion.

> It (our football team) is very closed and the environments (in sports associations) are very closed. They are closed for various reasons, exactly like we are. You know what you have, when you meet; it works. You're dependent on a certain number of people. If you get some people who come and go and such, it will ruin everything. So, one is very careful to get something that works. That's also what we did here. (Nielsen et al. 2014)

4.3.2.2 Satisfaction of Exerting Influence on Others

The desire to exert influence on others and to stay in control was satisfied, when older persons felt *empowered to make their own decision*. This was the case when they found persons who did not command them but listened instead and gave them a chance to express thoughts and feelings.

> Family likes to boss me around. Friends pat you on the back, we listen to each other, and we don't laugh without each other. (Shearer and Fleury 2006)

Such non-directive relationships provided an open space where older persons could reflect upon their needs in order to come to a decision. They made this experience in informal relationships but also in health promotion programs when they *were encouraged to express their opinion* by trainers or instructors (Barenfeld et al. 2015). Expressing their needs and getting explanations about the reasons why something should be done in a particular way resulted in an *informed performance* of activities, that gave them a feeling of being in control despite receiving instructions (Resnick et al. 2006; Söderhamn et al. 2013).

> It was also helpful that she told us what to do and why we were doing it. She told us this exercise is for the heart and this is for the legs and she told us to drink a lot of water. When she noticed we were not doing it right she would tell us that. (Resnick et al. 2006)

In this case, the care of the instructor did not result in a feeling of being controlled because she strengthened the sense of self-efficacy and independence of the older person. In other cases, however, older persons *felt exposed to a pressure to comply* with health-related norms and advices. This occurred when a trainer or therapist was too demanding (Miller 2010; Horne et al. 2013) or when the performance level of an activity group was above the capabilities of the older person and a competitive atmosphere created a pressure to perform although they felt unable to keep pace (Hutton et al. 2000).

> I don't like therapists. They're pushy. I don't like pushy (Miller 2010)

> Some people try to push you into it without going into why you don't want to do it. (Horne et al. 2013)

External pressure could also prevent older people from engaging in physical activity. Those who told how they had a feeling of being disabled by the well-meant help of families or friends, sometimes also felt *exposed to pressure from these overprotective environments* (Grasser and Craft 2000; Bredland et al. 2018). Family members sometimes stopped their physical activities out of fear

that an accident might happen. In some cases a previous accident was the cause of worry, in other cases simply excessive anxiety.

> After that, I was never permitted to take a shower without Amy (a niece who shared her home) being around. It was terrible…terrible…very frustrating because I have always been a very independent person…but I thought this was just the most horrifying experience and since then I am deathly afraid… I just hope I never fall again…because I do not ever want to be incapacitated again… (Grasser and Craft 2000)

> My children won't let me walk in the woods alone, as I have always loved to do. (Bredland et al. 2018)

> When I want to do a little work outside the house, she's always watching and telling me to be careful. (ibid.)

A permanent supervision not only restricted the self-determination of older persons, it could also result in a loss of their self-reliance.

4.3.2.3 Attention to the Need of Others

Despite their desire to exert influence on others older persons were generally not inclined to exert pressure on them. Being aware of their needs they disliked to be too demanding in case they should need help and *feared to become a burden* (Söderhamn 1998; Grasser and Craft 2000; Berlin Hallrup et al. 2009; Price et al. 2011; Lette et al. 2017). As a consequence they refrained from asking for help:

> I don't drive so I have to ask others for a ride… oh, I haven't asked anyone because I'm just one block from the bus line and I just take the bus… If the weather is real nasty, I would just have to call and cancel it… I'm not going to ask anyone to help me, not yet. (Grasser and Craft 2000)

Some of them attributed this attitude to the climate of individualism and social distance in Western societies.

> I think the problem is, at least here in the Netherlands, I barely ever see my neighbours. Do you think I would ask them if I ever needed something? No, I wouldn't do that. (Lette et al. 2017)

This attitude came also to the fore when older persons tried to *get health-related information without bothering others* who could provide such information since they were knowledgeable insiders at official places.

> …and very often if you have a very keen interest, the receptionist or somebody like that would be happy to give advice. Then again, you'd have to use a bit of common sense and don't be bothering them when they're busy and maybe wait until the mad rush is over and then go over and have a chat with them. (McGrath et al. 2016)

4.3.2.4 Satisfaction of Attention to the Needs of Others

In some cases older persons were not able to satisfy their desire to pay attention to the need of others. When they received their help they *felt indebted* because they saw it as their duty to reciprocate and were at the same time afraid that they could not (Grasser and Craft 2000).

4.3.3 Social Adjustment Versus Unconventionality

4.3.3.1 Social Adjustment

When older persons made efforts to promote their health it was often an attempt to adjust their behaviour to social norms and expectations. *Adherence to social norms* could induce them to engage in activities in which they took less pleasure. If they kept a diet, for example, they were partly motivated by adapting to a beauty ideal that prevailed in Western societies (Patzelt et al. 2016). In a similar way, some older persons perceived physical activity to be a duty they had to observe regardless of whether they liked it or not. For them, it was an unwritten rule that one had to stay active in order to lead a socially acceptable life (Menichetti and Graffigna 2016; Bredland et al. 2018). Social norms are often conveyed via the social network. Hence, adjustment to social norms often occurred as an *adaptation to the expectation of significant others* like family members or friends. Some older persons told that they would listen to the advices of their children regarding the protection of their health (Miller 2010). Others performed alternative practices like kinesiology half-heartedly because they had been influenced by a friend who was convinced of this method (Boggatz and Meinhart 2017). Adjustment to social norms also occurred when older persons became a member of an activity group. Being a group member sometimes meant to have a common goal that created a *sense of obligation towards the group* and forced its members to "pull together" (Resnick et al. 2006; Shearer and Fleury 2006; Nielsen et al. 2014).

Feeling obliged to meet social expectations was perceived as helpful for maintaining discipline by some older persons. For this reason they expressed their *need to be accountable* to someone—preferably the instructor of an activity group who had sufficient authority to convey rules of the group.

> We need supervision! We need the instructor to help us keep it up or else we do not do it. At least once a week we need that external boost. It is not easy to do the exercise on your own! (Resnick et al. 2006)

A similar motive came to the fore when older persons told about their *obedience to medical experts*. They felt obliged to comply with their physicians prescriptions because he or she had more knowledge and authority to convey rules for a healthy lifestyle.

Adjustment to social norms was, however, not always supportive for health promotion. Social norms could also restrict or prevent participation in such programs. Older immigrants who were not familiar with cultural habits in Western countries wanted to *observe their own cultural norms when participating* in health promotion programs. Muslim Asian women, for example, were concerned about gender segregation and expected that no men were in the group (Dickinson et al. 2011).

4.3.3.2 Satisfaction of Social Adjustment

The desire for social adjustment was satisfied when older persons *gained an inner structure* that shaped their behaviour and kept them on track. Their initial observance of health-related activities was not due to an increased sense of self-efficacy but due

to a sense of being controlled by some kind of authority that deserved respect. After some time as a member of an activity group, however, they internalized a required discipline that made them comply with rules rather automatically and without efforts to overcome an inner resistance. Health promoting activities thus became a habit.

> It is just something you do without reflecting, negotiating and making the choice every time. (Nielsen et al. 2014)

Maintaining such habits depended, however, on an external source of control. If an activity group interrupted its activity or terminated its existence the older persons felt that they were *losing their discipline* and gave up exercising (Nielsen et al. 2014). In a similar way, lack of permanent control by a physician could result in abandoning a prescribed treatment.

> But the doctor that did these investigations on osteoporosis wasn't here for very long. Then he wasn't here anymore, they (the carers) thought that we'd care about the medication. But, anyway … I stopped taking it. Because I didn't hear from him (the doctor) again… (Berlin Hallrup et al. 2009)

In some cases older persons *felt guilty for a non-observance* of health-related recommendations. They wanted to adapt to social norms of healthy behaviour but failed to do so due to lack of discipline (Menichetti and Graffigna 2016). Older women, for example, who tried to keep a diet during the day felt hungry in the evening, gave in to their desire and later accused themselves for their failure (Gustafsson and Sidenvall 2002).

For older immigrants, participation in health promotion programs did not always meet their need for social adjustment. Rather, it resulted in a *conflict with own cultural norms* (Horne et al. 2013). Fasting during the month of Ramadan could become a barrier to physical activities and some Muslim women felt disturbed if they were offered a program that had no gender segregation.

> I was given 'Fitness for Life' by the Doctor … I asked a friend … She said it was a mixed session and told me about X [AgeingWell Co-ordinator] because I didn't want to exercise in mixed sessions. (Horne et al. 2013)

4.3.3.3 Unconventionality

Non-observance of rules for healthy living, however, was not always associated with feelings of disappointment. Older person also had a desire for unconventionality and felt restricted if they should adjust to social norms in an exaggerated way. There were those who did not refuse totally to comply with health-related recommendations but were inclined to *some neglect of rules and regulations* (Graham and Connelly 2013; Menichetti and Graffigna 2016; Boggatz and Meinhart 2017).

> I do exercise, I don't go to a gym … I don't like them. I use the stairs more often … We'll take [our dog] and go to the beaches and do the walk thing … [The gym] is too regimented for me. I just don't like that you've got to be there at eleven and someone tells you what to do; and I'm just not that kind of person… (Graham and Connelly 2013)

Others were even more inclined to an *unconventional way of ageing* (Wang et al. 2001; Leavy and Aberg 2010; Price et al. 2011; Menichetti and Graffigna 2016; Boggatz and Meinhart 2017). They disliked the idea of being physically active just because there was a social norm that forced older persons into active ageing. Instead, they wanted to grow old in a natural way, free of rules and regulations.

> Old people should be allowed to be old and to do their everyday things. They have driven this thing with gyms and strength training so much that I think they have almost gone too far. (Leavy and Aberg 2010)

> Allow people to be old. We get worn out, we all die, that's a fact! But seize the day and take things for what they are. Later life is so restricted, even if you reach the age of 70. But people wouldn't dare to voice that nowadays, they have to be physically active, they have to be healthy, and they have to stay beautiful right up until they die […] If you are old, well then you should be grateful that you can get out of bed and go outside and eat a nice meal and enjoy other people company, enjoy those things instead of constantly chasing after something that is beyond. Live your life here and now. There are a lot of people who don't allow themselves to do that. (Leavy and Aberg 2010)

Such opposition to norms of healthy and successful ageing was a motive behind the above-mentioned negligence towards health. When older persons *disregarded advices* of health care providers they just wanted to follow their own way of life and felt more comfortable if they made no efforts to comply. This was the case, for example, when they were expected to wear anti slip socks to prevent falls.

> I told her I was going to do it [wear my own socks] anyhow and I did. I don't mind people tell me what to do, but I'm not accustomed to it… she wasn't rude about it…I just didn't want to do it. (Miller 2010)

4.3.3.4 Satisfaction of Unconventionality

The desire for unconventionality was obviously satisfied if older persons could live what they felt to be their *own way of life*—unrestrained by regulations (Söderhamn 1998; Söderhamn et al. 2011). This allowed them to enjoy the freedom they had gained after their retirement. One older man described his feelings in the following way:

> The summer was lovely warm and nice. I packed the picnic basket and went to the beach. I visited good friends and had a very good time. (Söderhamn 1998)

Satisfaction of unconventionality did not necessarily preclude participation in health promoting activities. However, what mattered for the older persons was that such participation was not associated with undue restrictions of their liberty. If the latter was the case, older persons *felt constrained by time schedules and regulations* that eventually led to the abandonment of their participation (Nielsen et al. 2014). The same was true for some older peoples' compliance with medical appointments

(Lees et al. 2005). A further factor that affected only older men was that most participants of health promotion programs were women who automatically influenced the programs' social climate with their female habits. As a consequence, male participants could not act to their own habits and *felt restricted by female dominance* (Hutton et al. 2000; Patzelt et al. 2016). Although they did not precisely describe what was alienating them, participants of a focus group discussion made clear that men were rather discouraged to join.

> Since there are usually 99.9% women, men find it very difficult [to participate]. (Patzelt et al. 2016)

4.3.4 Closeness Versus Distance

4.3.4.1 Closeness

Health promoting behaviour of older adults was also influenced by their desire for closeness and social contacts. Since most activity programs were group-based participation depended on the older persons' need for social relationships and on the extent to which this need was satisfied. As described in the previous chapter older persons had an apparent *desire to socialize* (Söderhamn 1998; Wang et al. 2001; Belza et al. 2004; Collins et al. 2004; Berlin Hallrup et al. 2009; Leavy and Aberg 2010; Söderhamn et al. 2011; Brännström et al. 2013; Graham and Connelly 2013; Söderhamn et al. 2013: Patzelt et al. 2016; Lette et al. 2017; Bredland et al. 2018).

> It is very important to have friends … If you do not have a social network, it is not easy to live … I am visiting a man who is alone. He likes me visiting him, and I like to visit him. (Söderhamn et al. 2013)

Health promoting activities were also expected to have a socializing effect and to increase social well-being. Women in particular associated health with social participation (Patzelt et al. 2016). It was this desire that made many older persons join exercise groups. *To become an integrated group member* even seemed to be more important than their intention to promote their health (Hutton et al. 2000; Belza et al. 2004; Price et al. 2011; Boggatz 2011; Nielsen et al. 2014; Patzelt et al. 2016; Boggatz and Meinhart 2017). What program developers may have seen as a positive side effect turned out to be the most important pull factor for participants.

> We should go among people […] and reach out to people. Yes, Go and entertain… to form small groups, to go jogging or to make handicrafts, so, at least not remain alone, but to join a group somewhere(Patzelt et al. 2016)

> It's really important for us in the world to have a safe, healthy community and that's what really helps to come to my exercise classes. I'm excited to see everybody and hear what they have to say and share maybe a little bit of me too. (Price et al. 2011)

As the last statement suggests, social contacts were not only a central motive for participation in group activities, they were also the source of encouragement that gave group members a feeling of being cared for. Some older persons had an explicit *desire for contact with younger persons* since these contacts motivated them to stay active.

> Many people our own age often are unwell, and talk about illness and problems. Such negative talk can easily make you quite depressed. The younger ones do in contrast talk about other things, such as family, home making and leisure activities (Bredland et al. 2018)

As this quotation suggests, social contacts with peers can also have negative impact on the motivation to stay active and to promote one's health. This was also the case if older persons *maintained relationships with unsportsmanlike friends*.

> I have friends I used to work with and we get together. They can keep me from exercising (Lees et al. 2005)

4.3.4.2 Satisfaction of Closeness

The desire for closeness was satisfied when older persons *gained social contacts* through their participation in activity groups. It enabled them to maintain old contacts, make new friends, and enjoy their time together (Frenn 1996; Maddox 1999: Hutton et al. 2000; Miller and Iris 2002; Belza et al. 2004; Morris Docker 2006; Hardy and Grogan 2009; Mathews et al. 2010; Costello et al. 2011; Dickinson et al. 2011; Price et al. 2011; Söderhamn et al. 2011; Graham and Connelly 2013; Li et al. 2013; Nielsen et al. 2014; Barenfeld et al. 2015; Stevens et al. 2015; Patzelt et al. 2016; Komatsu et al. 2017).

> I think these centres are great because we get to talk to other people, even if it is just for an hour. (Frenn 1996)

> We were 16 persons that walked the pilgrim tour. They were very nice people, and we had a pleasant time … and when you know them, you can totally relax. (Söderhamn et al. 2013)

> You don't have as many friends as before, they don't call so often anymore, so you kind of have to pull yourself up and exercise is a good way to do that. Especially because these guys here become your new friends; they replace the ones I've lost (Nielsen et al. 2014)

By joining a group, they could build *social bonds* with other group members they were attracted to, and it were these bonds that encouraged them to continue and ensured their discipline.

> I go to the gym with somebody and that's always nice, you know, to have somebody to encourage you even if you don't feel like going. (Graham and Connelly 2013)

In the same way, older persons established sometimes *positive relationships with their instructor* that gave them a feeling of being cared for and encouraged their participation (Hutton et al. 2000; Horne et al. 2010).

> If you get somebody pleasant [instructor] you know, it does make a difference as well… If you had a bad instructor that was a bit well, not a nice personality… it would put you off. (Horne et al. 2010)

On the other hand, there were also older persons who suffered from a *lack of social contacts* (Leavy and Aberg 2010: Lette et al. 2017). Due to ailments and functional limitations they were not able to go out and participate in group activities. Their inability to promote their health was also an inability to satisfy their need for social contacts. Others were still able to exercise, but they had *no partner* with whom to engage in physical activities (Belza et al. 2004; Boggatz 2011). Since their social needs remained unsatisfied they had no motivation to spent efforts in exercising. But also group membership was not always supportive. Some groups had a social climate that did not suit everybody. If older persons felt that they did not fit into a group they had *no sense of belonging* and gave up both membership and exercising (Belza et al. 2004; Barenfeld et al. 2015). This happened because of differences in age or interests.

> Yes, I suppose it was partly due to the fact that they were all 70 years old, and that I was so much older. And then I thought they were the sort that played golf and [coughs] went fishing and [did] all sorts of things. (Barenfeld et al. 2015)

4.3.4.3 Distance

Not everybody, however, searched for social contacts. Some older persons showed a *preference for social distance* (Leavy and Aberg 2010; Menichetti and Graffigna 2016). They claimed not to be a “group person”, and said that they were not “fond of those places where people go to find a social life” (Leavy and Aberg 2010). Some were afraid that group members would “hassle” them, whereas others abhorred the idea of being “tied down” by social bonds and thought it would be “a nightmare to be part of a club” (ibid.). If these older person were interested in promoting their health they wanted to do it on their own and had a *desire for private exercise* (Hutton et al. 2000). Likewise there were those who were *deterred by overcrowded events* that tried to advertise health promotion (Boggatz 2011).

There were also those who *separated their desire for exercise from their desire for social contact*. They did not refuse social relationships, but when they trained they were not interested in them. The fitness centre was the place that suited them.

> In the fitness centre it’s like getting on the bus. You work out with the ones who randomly sit next to you. We have no social interaction because there’s not time. You come in, sit on the bike and leave again and don’t talk to anyone. (Nielsen et al. 2014)

4.3.4.4 Satisfaction of Distance

Older people with a preference for social distance were *able to maintain their privacy* by either staying away from group exercises and not exercising at all, or by exercising alone (Hutton et al. 2000) or in an environment that prevented social interaction (Nielsen et al. 2014).

4.3.5 Influencing Factors

The satisfaction of social orientations of action depended on the same internal factors as described above. Functional limitations, visual and hearing impairments could be an obstacle for social participation. In the same way psychological factors such as negative moods, knowledge deficit, or language barriers (when older persons were immigrants) could have a negative impact on the participation in group exercises. But also external circumstances played a role. Beside the availability of information, facilities and finances—as mentioned above—social network, organizational matters, quality of care, and features of the social environment were important.

As we saw in the previous section, public information by the media was a prerequisite for participation in health promotion. Advertisements in the newspaper or television made knowledge available in the community. More important for the diffusion of information was the older persons' *social network*. Family (mainly the own children) and friends were a major source of information about available activities and programs (Shearer and Fleury 2006; Dickinson et al. 2011; McGrath et al. 2016; Patzelt et al. 2016; Lette et al. 2017). However, they did not just inform older persons. Their encouragement moved them to action, and made them join and continue a health promoting activity (Hutton et al. 2000; Miller and Iris 2002; Belza et al. 2004; Boggatz 2011; Costello et al. 2011; Price et al. 2011; Horne et al. 2013; Li et al. 2013; Bethancourt et al. 2014; Barenfeld et al. 2017; Boggatz and Meinhart 2017)

> Through a friend who has done it for years and is a right bossy lady and she said 'you should go' so I thought I'd give it a try. (Dickinson et al. 2011)

> It's nice to have a friend, because if you don't feel like going, she might say something to encourage you. Or she might be after you so much that you say, 'Oh, yeah, I'll go.' And you feel so much better afterwards. Believe me. (Belza et al. 2004)

Such encouragement satisfied several orientations of action at the same time. It gave older persons a feeling of closeness and being cared for and allowed them adjusting to social expectations. Some programs used peer mentors to achieve this effect (Horne et al. 2010; Stevens et al. 2015). These were older persons of the same age who had received a short training course that enabled them to encourage and advice others who should be motivated to do home-based exercises. Sometimes general practitioners fulfilled a similar function when they informed and encouraged older persons (Horne et al. 2013; Janssen and Stube 2014). If there was no information available in the social network, it was tiring for older persons to find it.

> You have to ask. You have to be forward. They won't come to you. Yes, nobody's going to come into you personally. (McGrath et al. 2016)

Lack of encouragement from peers could result in abandoning health promoting activities:

> In the beginning I had a female friend here… we were out and… she had a walker too and we could walk as far as the woods… ! But now she's dead like all old folks… and then… I don't have the strength walking so far any longer. (Brännström et al. 2013)

The satisfaction of social needs was also influenced by the *organizational matters.* Discouragement occurred when a fixed program to promote physical activity came to an end and participants lost their contact and were left alone to continue exercising (Dickinson et al. 2011). The timing of exercises was another issue. Older persons preferred to attend programs at daytime because they disliked to go out in the evening (Dickinson et al. 2011). In some cases older persons felt restricted by bureaucracy (Patzelt et al. 2016: Barenfeld et al. 2017), for example, if they wanted to get support from their health insurance to purchase an assistive device.

> I thought it was plus-minus nothing. I thought it was only a huge fight to get a damned, er, bath board! Why can't it be like it was, when I had it before, and I come back with it broken. Why can't I replace it without any fuss. It's the lack of flexibility in the small things that I think is missing, that's what I reckon. (Barenfeld et al. 2017)

Such instances limited older persons' independence and gave them a feeling of not being cared for.

Beside these organizational issues the *quality of care* older persons received from physicians and trainers had a crucial impact on the satisfaction of their social needs. Medical doctors who had no time to listen or to give advice gave them a feeling of not being cared for (Patzelt et al. 2016). Occasional advices provided during a medical check-up or consultation could have the opposite effect.

> I'm diabetic and I started staggering around earlier this year, round about May. And I saw the doctor and the doctor recommended me to go to the Falls Clinic and I have had some benefit from it really. (Dickinson et al. 2011)

Regarding exercise programs it was important that these were designed according to the abilities of the participants (Hardy and Grogan 2009; Mathews et al. 2010; Costello et al. 2011; Dickinson et al. 2011; Li et al. 2013; Janssen and Stube 2014; Boggatz and Meinhart 2017). This gave them a sense of security and promoted in the long run their self-efficacy in exercising. The composition of the training group played a key role as trainers were able to adapt their instructions to an average level of ability and older persons did not feel that they annoyed others with their physical limitations.

> Well I don't know. I think if you're in a mixed age group you might feel a bit more embarrassed about not being able to do some of the exercises and it's probably better to be in a more or less of our own age group and you can all struggle together sort of thing. (Dickinson et al. 2011)

Encouragement by the trainer in a non-authoritarian way (Miller and Iris 2002; Costello et al. 2011) was another important aspect that responded to older persons' need of security and being cared for without restricting independency.

> But it is essential that I have the help of the staff in guiding me; you know if that machine gives you a problem, why don't you try this? (Costello et al. 2011)

Some programs provided the opportunity to monitor the progress achieved in a period of training. Testing their function drew the attention of the participants to their abilities and strengthened their sense of self-efficacy (Barenfeld et al. 2015).

When discussing health issues, an approach was welcome that allowed conversations and reflections because it provided the opportunity to make choices, and gave older persons a feeling of control (Barenfeld et al. 2015).

On the other hand, a uniform training that disregarded individual need, the exertion of pressure, and a top-down approach to instructions without explanations had an intimidating and discouraging character (Miller 2010; Horne et al. 2013). It ignored older persons need for exerting influence on others and gave them a feeling of not being cared for.

Features of the social environment had also some influence on the satisfaction of social needs. If elderly people lived in an unsafe area where they were afraid of crime, they could not meet their desire for security and they abstained from outdoor activities (Belza et al. 2004; Costello et al. 2011; Horne et al. 2013).

4.3.6 Behavioural and Attitudinal Reactions

The behavioural and attitudinal reactions that older persons showed in order to meet their social needs also shaped the way how they promoted their health. By *participation in group activities* older persons could satisfy their need for social contacts. At the same time they reinforced the tendency to social adjustment since they were held at regular times and participation required a sense of obligation. For others, however, such an obligation was an impediment to their desire for unconventionality, as group exercises restricted the liberty to dispose of their time. (Nielsen et al. 2014). Older persons with a need for unconventionality or a need for distance preferred *home-based exercises* (Stevens et al. 2015) or visited a *fitness studio* (Nielsen et al. 2014). In both of these cases, they were able to engage in physical activity without being bound by social ties and restricted by norms that governed groups.

When older people were unable to satisfy their desire for self-reliance, they began to *accept their limitations*. Other older persons who wanted to remain independent as much as possible resorted to *resilience* which was motivated by the desire to maintain self-reliance. Both attitudinal reactions were the same that older persons showed if they were unable to satisfy their desire for physical activity—as mentioned above in the previous section.

4.4 Health Promotion and Identity-Related Orientations of Action

Health promotion did not only have an impact on social orientations of action, it also influenced older persons' identity by either supporting or impeding their identity-related needs. How older people promoted their health depended on how they

shaped their identity and their life. The satisfaction of identity-related orientations of action was not simply a further prerequisite for health, for many older people it was rather a manifestation of health itself. In other words, the appropriate balance between work and relaxation, diversion and reflection, concern for others and self-interest, self-presentation and self-concealment, and a positive as well as critical self-perception were attributes of a healthy life that resulted in a sustained state of health. Table 4.5 provides an overview over the aspects of the identity-related orientations of action, their satisfaction or disruption through health promotion or disease prevention, the influencing factors, and the behavioural and attitudinal reactions of the older persons.

Table 4.5 Identity-related orientations of action, influencing factors, behavioural and attitudinal reactions

Orientations of action and their satisfaction	
Work	Desire for meaningful activity
	Work as a suitable means of overcoming diseases
	Work more important than physical exercise
	Disliking exercises as an end in themselves
Satisfaction of work	Fulfilment through activities
	Bored by meaningless physical exercises
Relaxation	Take a break and relax
	Desire to be lazy
Satisfaction of relaxation	Stress reduction and mental relaxation
	Enjoyment of nature
Diversion	Searching for entertainment
Satisfaction of diversion	Having fun and entertainment
	Lack of entertainment when performing exercises
Reflection	Desire for cognitive integrity
	Physically active out of a desire for reflection
	Intellectual interest in health promotion
Satisfaction of reflection	Improved mental fitness
	Intellectual satisfaction
	Exercises appear to be trivial
Concern for others	Desire to be needed
	Concern for others instead of an interest in health promotion
	Supporting others in promoting their health
	Desire to contribute to a team
Satisfaction of concern for others	Having done something for others
	Feeling useful as peer mentor
Self-centredness	Doing something for themselves
Satisfaction of self-centredness	Feeling rewarded for efforts
	Duties prevented the desired participation in health promoting activities
Self-presentation	Leaving a positive impression on others
	Desire to be respected

(continued)

Table 4.5 (continued)

Satisfaction of self-presentation	Feeling of being valued
	Sense of equality
	Stigmatized when needing a walker
	Feeling degraded
	Social exclusion
Self-concealment	Preferring to go unnoticed
	Fear of attracting the attention of others because of physical limitations
Satisfaction of self-concealment	Feeling of annoying others
Positive self-perception	Need to maintain a positive self-image
	Gaining a sense of achievement
	Downward comparisons
	Reminiscence
Satisfaction of positive-self-perception	Positive memories
	Self-acceptance despite limitations
	Experiencing own competence
	Achieving self-imposed goals
	Feeling superior to others
	Feeling ridiculous
	Feeling inferior to others
Critical self-perception	Adjusting self-image to real abilities
Satisfaction of critical self-perception	Self-acceptance despite limitations
Influencing factors	
Internal factors	*Same as in Table 4.3 under physical condition and psychological factors*
External circumstances	*Same as in Table 4.4 under external circumstances*
Behavioural and attitudinal reactions	*Same as in Table 4.4 under coping with help of activities*

4.4.1 Work Versus Relaxation

4.4.1.1 Work

When older persons were asked what contributed to their health, quite often they expressed a *desire for meaningful activities* (Frenn 1996; Söderhamn 1998; Maddox 1999; Wang et al. 2001; Belza et al. 2004; Söderhamn et al. 2011: Gilbert et al. 2012; Söderhamn et al. 2013; Bredland et al. 2018).

> I think you just have to get up and go or sit down and die. Nobody pushes you to do anything at my age and I think people would say not to do this or that, but that is the wrong attitude. You have to get up and go. (Gilbert et al. 2012)

Activities were meaningful if they were of interest to the older persons, kept them busy and filled their daily routine. This could be housework, gardening, any hobby, or regular work. Most of these activities involved physical efforts and satisfied the body-related need for physical activity. In this way, they promoted physical fitness

and health, but older persons did not perform them for the sake of this purpose. They rather worked out of a desire to be busy and to feel that they were achieving some results.

> Even though I am 65 years old, I still work as a newspaper deliverer. Every morning, I wake up very early to get some physical activity. In addition to physical activities, mental activities are required. I need to remember where to deliver the newspaper, where to stop. (Belza et al. 2004)

Older persons were convinced that work and meaningful activity automatically promoted their health and they equated active life with health.

> If you stay active, you don't need a doctor (Frenn 1996)

This idea was a reason why some older person believed that performing everyday activities was sufficient to promote their health. Other older persons were even convinced that demanding activities such as *work was a suitable means of overcoming diseases*.

> I think that if you have satisfaction in your job, you will become healthier. I have a chronic disease, and I think it is very important not to sit down … Then I informed the physician that I was working full time and asked if it was a right choice. OK, you are working … I suspected it, he said, and so he took me off the sick list. (Söderhamn et al. 2013)

Others explained that for them their *work is more important than physical exercise* (Mathews et al. 2010; Costello et al. 2011; Dickinson et al. 2011; Patzelt et al. 2016).

> I don't have time to go exercise because I like to do house chores. (Mathews et al. 2010)

For some older persons, exercises for the purpose of exercising without providing any meaningful result were deprived of meaning. They *disliked exercises as an end in themselves* and preferred other activities they perceived to be more meaningful (Hardy and Grogan 2009; Dickinson et al. 2011; Bethancourt et al. 2014; Bredland et al. 2018).

> I am of the view that I only come in order to be able to do other things that are enjoyable … [I] keep fit to enable me to go walking or gardening or whatever but exercise in itself has no pleasure whatsoever for me. (Hardy and Grogan 2009)

4.4.1.2 Satisfaction of Work

The desire to work was met when older persons found *fulfilment through meaningful activities* (Söderhamn et al. 2011; Bredland et al. 2018). Since these activities involved physical efforts they also contributed to their health. In comparison to physical exercises for the sake of exercising they were perceived to be more meaningful. For example, an older man who liked doing repairs said:

> These types of activities feel more meaningful than exercising in the gym. (Bredland et al. 2018)

Older persons like him felt rather *bored by meaningless physical exercises* (Hardy and Grogan 2009; Leavy and Aberg 2010: Costello et al. 2011; Dickinson et al. 2011; Bredland et al. 2018)

> I don't go to a lot of them [exercise classes] but I have been to some and I've come away and I've thought, what did I learn there except to throw this silly ball. (Dickinson et al. 2011)

4.4.1.3 Relaxation

Just like physical activity, work had to be counterbalanced by relaxation. Some older persons said that it was important to *take a break and relax* since recovering from stress would promote their mental well-being (Belza et al. 2004; Söderhamn et al. 2013). Others told about their *desire to be lazy* sometimes:

> …sometimes a lazy streak comes in there every once in a while. I like to do things but, sometimes I just want to vegetate and do nothing. It's all about attitude. (Gilbert et al. 2012)

4.4.1.4 Satisfaction of Relaxation

As a consequence of mental relaxation, older persons *experienced stress reduction and mental relaxation* (Belza et al. 2004; Morris Docker 2006; Cartwright 2007; Li et al. 2013; Boggatz and Meinhart 2017). This occurred, for example, after having received treatment or after finishing exercises:

> You go home [after Qigong, the author] and feel free… free and it is as if… well, as if I am more relaxed. (Boggatz and Meinhart 2017)

Several times this experience was associated with an *enjoyment of nature* (Frenn 1996; Belza et al. 2004; Leavy and Aberg 2010). Walking helped older persons to promote their mental relaxation when they did so in a quiet way and in a peaceful environment. Tai Chi and Qigong could produce a similar effect.

4.4.2 Diversion Versus Reflection

4.4.2.1 Diversion

When older persons participated in health promoting activities they were not only concerned about fitness and social contacts, they also *searched for entertainment* that gave an additional meaning to their group exercises (Belza et al. 2004; Collins et al. 2004; Gilbert et al. 2012; Li et al. 2013; Nielsen et al. 2014).

> That we are together and have fun together is the essence. It also removes any pressure. You just go because you feel like it (Nielsen et al. 2014)

Entertainment was found in the social interaction during and after exercising. But there was also *stimulation through exercise* itself when music or rhythmical movements were involved allowing older persons to physically express their feelings (Belza et al. 2004; Price et al. 2011; Li et al. 2013). For this reason some older

persons preferred to dance as their way of physical exercise. But also other kinds of exercises could show a similar effect. Participants in a fall prevention program, for example, felt attracted by Tai Chi because doing the movements together was like creating a graceful slow dance (Morris Docker 2006).

4.4.2.2 Satisfaction of Diversion

The desire for diversion was satisfied when older persons *had fun and entertainment* during exercising and also beyond (Belza et al. 2004; Resnick et al. 2006; Costello et al. 2011; Graham and Connelly 2013; Nielsen et al. 2014). As group members, for example, they could meet up at external venues, such as birthdays, summer, and Christmas parties, and have drinks together after exercising.

> All of us are happy because there's laughter, storytelling, someone wins, someone loses. When we go home, we sleep soundly because there was laughter, and we played bingo. (Belza et al. 2004)

But also the performance of particular exercises itself was associated with feelings of pleasure and fun (Belza et al. 2004; Morris Docker 2006; Price et al. 2011; Li et al. 2013). Participants in a Tai Chi course, for example, described the esthetical pleasure they derived from the movements they performed together (Morris Docker 2006), while other older persons asserted that "dancing is fun" (Price et al. 2011).

However, having fun together did not always contribute to health promotion. Some older persons who were diabetics described dining out with families and friends as their preferred way of diversion.

> We eat out an awful lot, so that's kind of entertainment for us. When you are retired you can do that. (Graham and Connelly 2013)

Although this kind of pleasure contributed to their entertainment, it is rather unlikely that it also promoted their health. On the other hand, health promotion could also have no entertaining value. Exercising without any further purpose was not only perceived to be meaningless and futile, due to their monotonous character some older persons complained about a *lack of entertainment when they performed exercises* (Lees et al. 2005; Bethancourt et al. 2014; Boggatz and Meinhart 2017) These feelings, however, did not apply equally to all types of physical exercise. One older woman contrasted gymnastics with dancing:

> I have to force myself to go to the gym, I don't have to force myself to dance. (Bethancourt et al. 2014)

4.4.2.3 Reflection

Diversion and entertainment had to be counterbalanced by some degree of reflection. Older person had a fundamental interest in cognitive efforts due to their *desire for cognitive integrity* which was the prerequisite for maintaining their identity. (Miller and Iris 2002; Belza et al. 2004; Mathews et al. 2010; Price et al. 2011; Lorenc et al. 2012; Söderhamn et al. 2013; Patzelt et al. 2016; Komatsu et al. 2017; Lette et al. 2017).

> We need to use all approaches to keep the brain healthy…. This is an issue of all aspects… diet, exercise (Mathews et al. 2010)

> I'm a firm believer in that in order to stay… healthy… I need to be mentally and physically alert… participate in all physical things you are capable of and keep the mind open by studying and keeping abreast of what's happening. (Miller and Iris 2002)

As the last statement suggests, these older people were convinced that their mental integrity was also enhanced by physical activity as the Latin proverb mens sana in corpore sano (a healthy mind in a healthy body) says. Mental engagement involved in physical activities was believed to improve mental fitness. Consequently, they were *physically active out of a desire for reflection* (Morris Docker 2006; Komatsu et al. 2017). Walking, for example, was not just a movement of the body, it also satisfied personal interests as it allowed seeing other things, or just thinking about one's life. Performing exercises required them to pay attention to their movements and strengthened their ability to concentrate.

> I am not just exercising but am constantly focusing on how each exercise affects each part of the body. Once I know which exercise is for which body part, I try to stretch correctly. (Komatsu et al. 2017).

For some older people, cognitive efforts were not just a means to maintain cognitive integrity, but a source of inner satisfaction, and they developed an *intellectual interest in particular health promoting practices*. For example, some of them studied herbal medicine and obtained a profound knowledge about healing plants and their application (Boggatz and Meinhart 2017). Others wanted to understand the philosophy behind Tai Chi and were keen to get such information from their instructors (Morris Docker 2006).

4.4.2.4 Satisfaction of Reflection

Older persons who were eager to meet their desire for reflection through physical activities reported about an *improved mental fitness* (Morris Docker 2006; Lorenc et al. 2012; Komatsu et al. 2017). Participants of a Tai Chi course, for example, said that their concentration and body awareness had improved since they started exercising (Morris Docker 2006). But also other activities that required concentration like piano playing could have this effect (Lorenc et al. 2012). Those who had an intellectual interest in health promotion could derive some *intellectual satisfaction* from the deeper examination of this topic (Boggatz and Meinhart 2017). At the same time, however, intellectual interest could make simple *exercises appear to be trivial*. For this reason, some older persons complained about the constant repetitive practicing of Tai Chi (Morris Docker 2006).

4.4.3 Concern for Others Versus Self-Centredness

Concern for others was a central motive for staying active. Depending on the kind of activity that older persons performed in the interest of others, it was in line with

health-related activities or it consumed time that prevented older persons from doing something for their health. The same was true for self-centredness that counterbalanced older persons' concern for others. Both orientations of action could have a direct or an indirect influence on the way how older persons promoted their health.

4.4.3.1 Concern for Others

Older persons wanted to be useful for others and had a *desire to be needed*. Helping their children, grandparenting, or volunteering were common ways to meet this desire (Maddox 1999; Grasser and Craft 2000; Wang et al. 2001; Collins et al. 2004; Shearer and Fleury 2006; van Leuven 2010; Costello et al. 2011; Söderhamn et al. 2011, 2013; Lette et al. 2017; Bredland et al. 2018). At the same time, however, caring for others was believed to increase one's own well-being and in this sense it was a way of health promotion for older adults (Collins et al. 2004).

There was, however, no straightforward relationship between this broad understanding of health promotion and its rather narrow meaning in programs that aimed to promote physical activity and exercise. Some older persons had a *concern for others instead of an interest in health promotion*. They gave a higher priority to their social duties and perceived them to be more meaningful than physical exercise (Hutton et al. 2000; Lees et al. 2005; Boggatz 2011; Costello et al. 2011; Söderhamn et al. 2013; Bredland et al. 2018).

> My day is busy I don't have time to be bored, and it's hard sometimes to coordinate and that's why I had to stop um classes because it was pick-up time to drive out there and (pick-up the grandchildren), so I have trouble trying to fit classes around duties (Hutton et al. 2000)

Sometimes, however, health promotion programs met the desire to be useful by giving older persons opportunities to *support others in promoting their health* (Shearer and Fleury 2006; Stevens et al. 2015; Barenfeld et al. 2017; Komatsu et al. 2017). As we saw in the previous section, peer support encouraged participants and gave them a feeling of being cared for. This provided the chance for other group members to show concern for these participants and their needs.

> If someone is absent, I wonder what happened to him or her because he or she is always present. So, to check on the absent person, I call him/her on the way home (Komatsu et al. 2017)

Some older persons also advised non-participating friends to care for their health according to what they had learned in the health promotion program.

> There must be something [to do], I thought when I saw him walking. You have to remember that the foot is bad, but your thighs, you're losing your thigh muscles. What would happen if you couldn't get to that physiotherapist? I think he was at the physiotherapist a few times […] he's been going there all winter, he still goes and he thinks it's good. (Barenfeld et al. 2017)

Some health promotion programs provided a specific framework for such concern for others by engaging and training older persons as peer mentors who visited mentees at home and encouraged them to exercise (Stevens et al. 2015).

Participation in a health promotion program was also consistent with a concern for others if older people had a *desire to contribute to a team*. For these older persons, participation was not just a matter of social adjustment; it had a deeper meaning because they shared a goal with others who depended on their effort. This was, for example, the case when they were members in a football team and wanted to win a match (Nielsen et al. 2014) or when they had to perform dances or exercises in front of a public audience (Resnick et al. 2006).

> We had to do the Cha Cha Slide at the Senior Center Ceremony. We had a goal. (Resnick et al. 2006)

4.4.3.2 Satisfaction of Concern for Others

Concern for others yielded an intrinsic satisfaction. It gave older persons the feeling of *having done something for others* (Costello et al. 2011; Söderhamn et al. 2011: Graham and Connelly 2013; Menichetti and Graffigna 2016; Bredland et al. 2018). One study participant described this benefit as "the fact that you are able to do more things, it allows you to help other people which is really key to being happy" (Costello et al. 2011). Since showing concern for others was a way to promote one's health, the ability to care for them was a sign of being healthy.

> It makes me feel good to know I have helped somebody. (Collins et al. 2004)

> (Being healthy means) I can do extra for other people. (ibid.)

Encouraging and advising others in their health promotion could yield such a satisfaction. In particular, older persons *felt useful as peer mentors* (Stevens et al. 2015).

Not every older person could show his or her concern for others. Some complained about *feeling useless* and this had a negative impact on their health and well-being.

> Well, it's just that people, you're not interesting anymore […] I mean, it's probably just the feeling one gets, it's probably not the reality, but the feeling that you're no longer of interest to anyone anymore. (Lette et al. 2017)

4.4.3.3 Self-Centredness

Concern for others had to be counterbalanced by self-interest if it was not to result in self-neglect. Older persons wanted *to do something for themselves* (Collins et al. 2004; Leavy and Aberg 2010; Söderhamn et al. 2011). This could be time spent to relax or an activity that provided personal pleasure such as dressing up in new clothes, going to the hairdresser, or having a pedicure. Taking up physical activities to enjoy the time could have the same effect. An older woman described how this helped her to discover her own needs and to promote her well-being and health:

> I had nine children, so when my youngest was 10 I realized that I was ready to do something for myself […] Up until then, I didn't think about myself, so it's a whole new life opened up for me. (Leavy and Aberg 2010)

4.4.3.4 Satisfaction of Self-Centredness

As the quotation above suggests, exercising could provide an intrinsic satisfaction of self-interest. Self-interest was also met when older persons *felt rewarded for their efforts* spent on exercising.

> We are not in the labour market any longer and the exercise is perhaps a bit like doing a job. We come in an hour a week and do our job and get the reward for it. Not being paid as such, but a different kind of reward. (Nielsen et al. 2014)

Although such reward could simply consist of a feeling of having achieved something, trainers sometimes reinforced it by giving incentive gifts to participants after successful training (Resnick et al. 2006). Sometimes, however, other *duties prevented the desired participation in health promoting activities* (Belza et al. 2004; Horne et al. 2013).

> This is the only day that I get to do something for myself. I always really try, but I have missed [exercise class]. I did miss because mum was sick … I had to go live with her so like I couldn't come here. (Horne et al. 2013)

But also the other way around, health promotion could become a duty that interfered with older persons' self-interest. Those who were more inclined to relax and enjoy their time with entertainment were unlikely to join a training program. Due to their absence they had no reason to complain about restrictions of self-interest through health promotion.

4.4.4 Self-Presentation Versus Self-Concealment

To some extent, health promotion was also a matter of self-presentation and getting the attention of others. Such attention, however, could also reveal aspects of their personality older persons preferred to remain unnoticed. For this reason, they also had tendency to conceal aspects of their self. Since health promotion occurred in groups and in public spaces, it had implications for both orientations of action.

4.4.4.1 Self-Presentation

For some older persons health promotion was associated with a desire to *leave a positive impression on others* in order to attract their attention (Li et al. 2013; Bredland et al. 2018). Weight control, for example, was in some cases not only motivated by an adjustment to social norms but by a desire for having an attractive appearance (Li et al. 2013). Others used the outfit required for physical exercise as a sign of their fitness to impress others. Some older men told how Nordic walking poles served this purpose:

> Poles are associated with sport and with younger people, not with old age. (Bredland et al. 2018)

But also those who were less inclined to self-presentation had nevertheless a *desire to be respected* and to get their due attention (Patzelt et al. 2016; Lette et al. 2017).

> Feeling like you're part of it [society], but also being treated with respect. Because we older people shouldn't get the idea that we don't matter anymore and that we're nothing but a nuisance. And that's the way many elderly feel right now. (Lette et al. 2017)

Being treated in a respectful manner was a precondition for any participation in a health promotion program. Respectful treatment was of course determined by cultural standards. Participants in German focus groups, for example, explained that older persons had to be targeted by mailings in which they were personally addressed. Such a personalized mailing had to be sent in a sealed envelope and also to be addressed to their spouse, if appropriate (Patzelt et al. 2016).

4.4.4.2 Satisfaction of Self-Presentation

Older persons felt respected from others when they had a *feeling of being valued* and treated in a person-centred way that allowed them to voice their opinions.

> They have lots of old people in and they check them and various things but they also make them feel that they're worth something and it's pretty awful being old really. (Dickinson et al. 2011)

Quite often, friends were able to convey this feeling even when older persons were losing their health, their abilities, and their self-esteem (Shearer and Fleury 2006).

Attention and acceptance by others was also experienced when a group they had joined for activities conveyed a *sense of equality*. This meant that there was no distinction between rich and poor (Belza et al. 2004), or between locals and immigrants (Barenfeld et al. 2015)

> But at the same time I feel a bit [laughs], and not just because I moved to Sweden, a bit left out. I have my background from Finland and my situation, from the war and everything. So that [short pause], yes, I thought, that now, isn't it good that they want us to feel well. Just as good as the Swedes (Barenfeld et al. 2015)

Homogeneous group regarding social status or ethnicity were of course more likely to create this feeling. Several times, however, health promotion did not result in the acceptance of others. Some older persons complained about *being stigmatized when needing a walker* (Berlin Hallrup et al. 2009; Brännström et al. 2013). They felt ignored and some reported with indignation about the disrespectful treatment by others because they had an unsteady gait.

> Well it's just that some have said 'no, one shouldn't have a walker…no' and they said that to me!! (Brännström et al. 2013).

Others *felt degraded* by the disrespectful behaviour of an instructor. As one participant of a fall prevention program told: "They treated me like I had Alzheimer's" (Miller 2010).

Others older persons reported about *social exclusion* (Janssen and Stube 2014; Nielsen et al. 2014). They were prevented from joining sports associations due to their being too old and felt alienated from the “youthful” fitness culture prevailing in fitness studios.

> The older you get, the harder it is to get in. Imagine being 60 and wanting to play some football; who wants to play football with someone who’s 60? (Nielsen et al. 2014)

4.4.4.3 Self-Concealment

The tendency to self-presentation had to be counterbalanced by a tendency to self-concealment since older persons did not want to attract undesired attention. They *preferred to go unnoticed* especially since they feared that their weaknesses would become apparent. For this reason, some were reluctant to use assistive devices like a walker that made such weakness visible (Miller 2010; Brännström et al. 2013; Bredland et al. 2018).

> You don’t want to be old and it is by preference not to be seen. (Brännström et al. 2013)

In a similar way, others disliked to join exercise groups out of *fear of attracting the attention of others because of their limitations* (Costello et al. 2011; Bethancourt et al. 2014). They believed that their disability would slow the class down and cause the group to wait for them. They were afraid to attract negative attention and become a nuisance to others.

> They have a walking group, and I haven’t joined because I figure I won’t go as fast as they go, and so I wouldn’t be able to keep up. (Costello et al. 2011)

Needless to say that such negative attention from others could easily result in feelings of shame since older persons could not meet the expected standards of such activity groups.

4.4.4.4 Satisfaction of Self-Concealment

Older persons who avoided attracting the attention of others were satisfied when their weaknesses or disabilities remained unnoticed. However, if they participated in exercise groups despite limited abilities they had a *feeling of annoying others* with their disabilities (Costello et al. 2011). Using a walker in public places in order to prevent falls could result in similar feelings, because these older persons needed a larger space and a place for parking the vehicle. Because walkers could become an obstacle for other persons they were worried about creating an undue public disturbance (Brännström et al. 2013).

4.4.5 Positive Versus Critical Self-Perception

Health-related behaviour was also influenced by the positive and critical self-perceptions of older persons. Whereas positive self-perception was a source of

encouragement, critical self-perceptions could have the opposite effect. The performance of health-related activities could have in turn an influence on the way how older persons perceived themselves.

4.4.5.1 Positive Self-Perception

Older persons were not only concerned about doing something for themselves; they also had a *need to maintain a positive self-image* (Maddox 1999; Wang et al. 2001; Miller 2010; Li et al. 2013). For this reason, they rejected anything that did not correspond to this image. Walking aids, for example, could be a sign of unwanted frailty, and hence they were avoided:

> Everybody wants me to go on a walker…and pride gets in your way, you know…I didn't want to use those walkers. I don't need something like a crutch…I can still do it on my own (Miller 2010)

Maintaining a positive self-image could be in line with concern for others when older persons derived confidence from a feeling of being needed, but it could also be consistent with self-interest. Some older persons, for example, were eager to *gain a sense of achievement* through exercising in order to improve their self-image (Resnick et al. 2006; Nielsen et al. 2014; Patzelt et al. 2016; Boggatz and Meinhart 2017).

> We were each looking forward to different things [goals]–some wanted to get stronger and some wanted to lose weight (Resnick et al. 2006)

Some of these older persons became a member of a football team (Nielsen et al. 2014), others were committed to regular individual activities like mountaineering or skiing to obtain a sense of achievement (Boggatz and Meinhart 2017). Older men in particular perceived exercising as a challenge that allowed testing one's limits and having success (Patzelt et al. 2016). Overdoing physical efforts could contribute to establishing a positive self-image in comparison with others:

> In my mind I am still 30 years old, and when I see others walking fast or working hard I want to be as good, or even better than them. (Bredland et al. 2018)

This attitude was sometimes beneficial for health, but it could also be detrimental as one older man admitted when he claimed that by practising sports he had done "everything that had ruined his body" (Boggatz and Meinhart 2017).

These attempts obtain a positive self-image were associated with a desire to impress others and to gain their attention. Others were the frame of reference for self-perception, and their acknowledgement satisfied the need for a positive self-image. Other older persons maintained a positive self-image although they were unable to impress on others. When they experienced a decline of abilities they resorted to *downward comparisons*. Paying attention to others who were worse off allowed them to feel relatively better (Brännström et al. 2013; Cartwright 2007). Others did not even pay attention to people around them at all in order to obtain a

positive self-perception. By *reminiscence* they were able to maintain a positive self-image, so that they did not need any further experiences of success (Brännström et al. 2013; Söderhamn et al. 2013).

4.4.5.2 Satisfaction of Positive Self-Perception

The desire for a positive self-perception was met when older persons felt that they had *mastered a challenge* (Morris Docker 2006; Nielsen et al. 2014; Boggatz and Meinhart 2017). Some of them described the satisfaction they derived from learning the movements of Tai Chi which required concentration and memory. Others told that they were motivated to play football when they succeeded in applying a strategy as a team that yielded a positive result.

> It's important to score goals, it's not important to win. (Nielsen et al. 2014)

Experiencing their own competence by mastering everyday activities or helping others promoted of course a positive self-image (Söderhamn 1998; Söderhamn et al. 2011; Bredland et al. 2018). *Achieving self-imposed goals* when doing sports or exercising had the same effect (Hutton et al. 2000; Resnick et al. 2006; Li et al. 2013; Nielsen et al. 2014; Barenfeld et al. 2015; Patzelt et al. 2016: Boggatz and Meinhart 2017)

> I had to prove to myself that I could do it. It was a bit challenging and scary but I did it! I overcame the fear of exercising just by doing it. (Resnick et al. 2006)

In all these cases, a gain of self-efficacy was associated with a feeling of pride and self-esteem that gave a deeper meaning to the desire for self-reliance that has been discussed in the previous section. Some older persons gained pride because they perceived exercising as a kind of competition that they could win. For others successful participation in exercises was enough to *feel superior to others*—even to younger persons (Hutton et al. 2000; Cartwright 2007; Hardy and Grogan 2009; Brännström et al. 2013; Nielsen et al. 2014; Bredland et al. 2018).

> I thought it was exciting, challenging … the challenge was to be better than the others, but deep down you were competing against yourself (Nielsen et al. 2014)

> We went through perhaps harder times and are perhaps more determined and stoic whereas younger people tend to give up a little bit too easily. (Hardy and Grogan 2009)

Older person who experienced physical decline could obtain feelings of superiority by downward comparisons with those who were worse off:

> I can still get about. When you see people in wheelchairs and sticks, I don't have any of those problems, touch wood, so I would say on the whole I can't complain (Cartwright 2007)

There were, however, also exercises that had a negative influence on self-perception. Jumping as a high impact physical activity to promote bone health in the case of osteoporosis made some older persons *feel ridiculous* in their own eyes and was not

compatible with their self-image. Furthermore, if older persons were unable to keep up with other group members during exercises they did not only perceive themselves to be a nuisance to others, they also *felt inferior* and suffered as a consequence from lack of self-esteem (Hutton et al. 2000; Belza et al. 2004; Cartwright 2007; Costello et al. 2011; Dickinson et al. 2011; Bethancourt et al. 2014; Patzelt et al. 2016).

4.4.5.3 Critical Self-Perception

The desire to maintain a positive self-perception was counterbalanced by a critical self-awareness. Older persons who felt unable to participate in group activities had realized that they were no longer 30 years old and that they had to *adjust their self-image to their real abilities* unless they wanted to entertain an illusionary idea of themselves (Maddox 1999; Brännström et al. 2013).

4.4.5.4 Satisfaction of Critical Self-Perception

Excessive self-criticism could result in a loss of self-esteem, as we saw in the previous section. However, older people with age-related disabilities, who lowered their expectations to a reasonable extent, were able to experience *self-acceptance despite limitations* (Maddox 1999; Brännström et al. 2013). As one older woman put it:

> I like myself better as I begin to grow up and understand myself. (Maddox 1999)

With such an attitude, dependence on a walker had no negative impact on self-image, as the acceptance of their disabilities made them aware of the benefits of such a device.

> No I didn't find it hard to get used to the walker and I've never felt… there are many people that have feelings of shame… I've never felt that…on the contrary it is… it is one's salvation… (Brännström et al. 2013)

4.4.6 Influencing Factors

In the context of health promotion and disease prevention, the satisfaction of identity-related orientations of action depended on the same external circumstances as social orientations of action. The social network and the quality of care had an either positive or negative impact on older person's self-presentation and self-perception. Encouragement by family, peers, or instructors promoted both, whereas lack of attention to their needs or an authoritarian style in group exercises was likely to show the opposite effect. Furthermore, the way how such exercises were performed could meet the desire for entertainment and diversion or it made older persons feel bored until they gave up participation.

4.4.7 Behavioural and Attitudinal Reactions

In the context of health promotion, behavioural reactions for the satisfaction of identity-related orientations of action were the same as for the satisfaction of

body-related needs. Older persons tried to meet their desire to work through a variety of activities like domestic work, gardening, or moving around to accomplish affairs—as mentioned in two sections above. Since these activities involved physical efforts they also had a health promoting effect that was recognized by the older persons. However, this effect was not of central concern for them. It was rather the result that could be achieved through such work that mattered and that made the physical effort involved in it meaningful. It was therefore not surprising that there were those who considered everyday activities to be sufficient to stay healthy and had no interest in physical exercise for the sake of exercise. Those, however, who performed such exercises were motivated by further identity-related needs. Exercising in a group met a desire for diversion, corresponded to a tendency of social adjustment and gave an opportunity to get attention from others and gain their respect. Participation in competitive exercises or just mastering a physical challenge could promote a positive self-image even if it had detrimental effects on health—as it was reported by some men. Walking in the nature, on the other hand, allowed for mental relaxation. Sometimes, alternative methods like Tai Chi or Yoga were chosen out of a similar motivation and could also meet a desire for reflection.

These behavioural responses were of course associated with attitudinal reactions. Resilience that was motivated by the desire for self-reliance also triggered physical efforts older persons made to meet their desire to work and to obtain a positive self-image. Acceptance of age-related limitations corresponded to the tendency of a critical self-perception that allowed older persons to adjust their self-image to their actual abilities. Such an adaptation of self-perception could be compensated by a tendency to think positively which is—as we will see in the following section—a manifestation of the tendency to hope that belongs to the development-related orientations of action.

4.5 Health Promotion and Development-Related Orientations of Action

Health promotion requires to some extent a change of one's life. In some cases, change may be voluntarily initiated out of a desire to learn new things. Health promotion may therefore be motivated by a desire to search for new perspectives. Since, on the other hand, people are also inclined to maintain habits and routines any attempt to induce a behaviour change will also be influenced by this opposite tendency. Growing old is furthermore associated with involuntary change. Frailty implies an increased exposure to health risks. Older persons may respond to such threats by denying or confronting such adversities. Both tendencies will shape their way of health promotion. Finally, if older persons experience a loss of health or become suddenly aware of their health risks, they may remain sceptical about chances of improvement or they may respond with a tendency to hope in order to discover something positive in their negative situation. Both tendencies have of course also an impact on health promotion. As we already mentioned in the previous sections, denial and hope were attitudinal responses of older persons who could

not meet their body-related, social or identity-related needs. The examination of development-related needs thus completes the overall picture and shows how the satisfaction of all aforementioned orientations of action is embedded in the satisfaction of the development-related needs. Again, it should be stressed that for many older persons the satisfaction of these needs was not simply a prerequisite for health, but a manifestation of it. Table 4.6 provides an overview over the aspects of development-related orientations of action, their influencing factors, and the behavioural and attitudinal reactions.

Table 4.6 Development-related orientations of action, influencing factors, behavioural and attitudinal reactions

Orientations of action and their satisfaction	
Attachment to the past	Continuing the habitual way of life
	Cultural preferences
Satisfaction of attachment to the past	Preserving an active lifestyle
	Irritated and disturbed by the idea of health promotion
Searching new perspectives	Desire to discover new things
	Being eager to search health information
	Integrating new behaviours into established routines
Satisfaction of searching new perspectives	Gain of knowledge
	Development of new habits
	Temporary change
Denial of adversities	Avoidance to think about health risks and ill-health
Satisfaction of denial of adversities	Being saved from worries about the future
Facing adversities	Proactive awareness of own vulnerability
	Contemplating a change in behaviour
Satisfaction of facing adversities	Potential for action
	Ability to handle limitations
Scepticism	Sceptical about alternative treatments
Satisfaction of scepticism	Protected from disappointment and disillusionment
	Composure
Hope	Thinking positive
	Practicing a religious belief
	Searching a spiritual dimension
Satisfaction of hope	Enjoying life despite limitations
	Inner strength after overcoming a crisis
	Strength in the face of approaching death
	Religious comfort
	Spiritual experiences Feeling of inner balance and harmony
Influencing factors	*(same as under body-related, social, and identity-related orientations of action)*
Behavioural and attitudinal reactions	Alternative ways of health promotion Religious practices *(attitudinal reactions are the same as development-related orientations of action)*

4.5.1 Attachment to the Past Versus Searching New Perspectives

4.5.1.1 Attachment to the Past

In general, older persons wanted to *continue their habitual way of life*. They had a desire to age at home in their own dwelling (Söderhamn et al. 2013; Lette et al. 2017) and wanted to maintain routines they had acquired—as some of them said—since childhood (Frenn 1996; Wang et al. 2001; Janssen and Stube 2014).

> Childhood don't leave you, because it's there, the whole pattern… when you're raised up like that, you don't change it. (Frenn 1996)

Some of them also admitted that they were less eager to develop new habits:

> After all, my life is ok for me, so I do absolutely nothing to change it … I'm fine by myself as well, so I don't really look for particular situations to increase what I should do to feel better. (Menichetti and Graffigna 2016)

Consequently, those who had never been inclined to sports and exercise were less likely to engage in physical activity in old age (Boggatz 2011), whereas those who were used to exercise had developed the habit of a physically active life (Hutton et al. 2000; Leavy and Aberg 2010; Gilbert et al. 2012).

> If you are active when you are young, you'll keep it up for the rest of your life… it's ingrained in you, I don't think that you can change that. (Leavy and Aberg 2010)

If they participated in health promotion programs, the choice of activities was shaped to some extent by *cultural preferences*. Members of the Chinese minority in the UK, for example, explained:

> But I think most Chinese like to learn [Tai Chi] because it's originally Chinese, isn't it? Lots of history to it and many different forms… Like we said, it's more or less our type of exercise. (Dickinson et al. 2011)

Beside those who maintained a habit of physical activity there were also those who had been active and sporty in their youth but were now less inclined to join health promotion programs. They had *abandoned an active lifestyle* because of physical wear and tear.

> I've been working since I was 14 […] I was always fond of work, work never came hard to me, so when I retired I did too much around the house and burnt myself out. (Leavy and Aberg 2010)

4.5.1.2 Satisfaction of Attachment to the Past

Older persons who had a habit of active life were enabled to *preserve their active lifestyle* through participation in health promotion programs (Miller and Iris 2002; Belza et al. 2004; Leavy and Aberg 2010; Mathews et al. 2010; Boggatz 2011;

Graham and Connelly 2013; Bethancourt et al. 2014; Janssen and Stube 2014; Boggatz and Meinhart 2017)

> Going back to my teenage years when everybody was jumping with joy and pleasure about getting involved in jitterbug and ballroom dancing, that was the thing. Everybody did it. My comment now – well, I never left, I'm still jumping. (Miller and Iris 2002)

Those, however, who had never been used to do sports and physical *exercise felt irritated and disturbed by the idea of health promotion* (Boggatz 2011; Graham and Connelly 2013; Horne et al. 2013; Li et al. 2013; Bethancourt et al. 2014). According to them, exercising was unnatural or not decent.

> We did not do any gymnastics at school, we grew up during the war … we did not have gymnastics and now I'm supposed to twist my bones? (Boggatz 2011)

> Some of us ladies were born at a time where girls didn't sweat. (Bethancourt et al. 2014)

Others, however, who would have liked to exercise, complained about the *loss of their active lifestyle* due to age-related limitations.

> It was just getting to me because I was always an active person, and I was just sitting there staring at the walls or the TV, hopping into the kitchen and getting things to eat, I was putting on weight and I was just painful, painful and depressed I think because I couldn't go out. (Cartwright 2007)

4.5.1.3 Searching New Perspectives

To some extent, older persons were not only concerned about preserving their usual way of life; they also had a *desire to discover new things* and learn about ways of health promotion they were not used to—as for example Tai Chi (Morris Docker 2006; Söderhamn et al. 2011). Some even equated the search for new experiences with health promotion and claimed that travelling to see other cultures and meet other people made them feel good (Söderhamn et al. 2011). Other older persons were *eager to search health information* because they had a keen interest in learning about health.

> This spurs me into action. I sit down at the computer, go out on the internet, find literature that I think will be useful to me and I search, expanding what I find [in the content of the printed material] even more. (Barenfeld et al. 2017)

When it was not just about getting to know something new, but about developing new habits, older persons preferred to *integrate new behaviours into established routines*. As one older woman who was expected to perform high impact physical activity to increase bone strength explained:

> I mean it's not that hard, is it, ten jumps every so often. That's something you could do as you're walking around, sort of thing. Every now and again I'll have a go. Once you got into it, I suppose you could do it really just without thinking. (Simmonds et al. 2016)

4.5.1.4 Satisfaction of Searching New Perspectives

Participation in health promotion programs could result in the *gain of knowledge* that created new health awareness (Frenn 1996; Hutton et al. 2000; Resnick et al. 2006; Dickinson et al. 2011; Barenfeld et al. 2015)

> We learned new things about exercise. She [the instructor] helped us know how to do the exercises. She kept doing new things to keep it interesting and kept it fun! She taught us all to take pulses and that was great. (Resnick et al. 2006)

As a consequence, several older persons reported about the *development of new habits* and lifestyle changes (Hutton et al. 2000; Leavy and Aberg 2010; Komatsu et al. 2017). Exercising became a substitute for activities they had performed before retirement and satisfied a desire for change that had been induced by the loss of their life-long occupation.

> After I retired, I was so free that I often tended to get up late. But when I know it's an exercise day, I get up on time and get myself ready. I think it's good for me. (Komatsu et al. 2017)

> The biggest thing of exercise I believe is doing it, the regularity, I do mine every day. It's become a habit If you don't do it you feel something's gone wrong or something's missing. (Hutton et al. 2000)

Others, however, achieved only a *temporary change* (Horne et al. 2010). For them, participation in health promotion was not related to a desire to try out something new. Due to the lack of internal motivation they depended on external encouragement and failed to sustain their activities if such encouragement was missing.

> I mean quite a few years ago I got a referral from the doctors to go to fitness for life, and they stop it. They give you so long and then they stop it. Now perhaps if that had carried on, I might have carried on, but they only gave you so long and then stopped it. (Horne et al. 2010)

4.5.2 Denial of Adversities Versus Facing Adversities

Health promotion was not only influenced by readiness for voluntary change. Older persons had also to deal with risks and adversities that could change their lives against their will. In response, some were rather inclined to a denial of such adversities whereas others tended to face them.

4.5.2.1 Denial of Adversities

Some older persons showed an *avoidance to think about their health risks and ill-health* (Berlin Hallrup et al. 2009; Menichetti and Graffigna 2016; Lette et al. 2017; Bredland et al. 2018). Despite their awareness of their frailty and vulnerability, they disliked to take precautions and tried to continue their life as if there was nothing to

worry about. They were afraid of diseases and their consequences, but saw no way to avoid them. The only solution was apparently to ignore them. These older persons remind us of those who avoided consulting a doctor for fear of a diagnosis, as we saw in the previous chapter (Leung et al. 2004). One may assume that such denial was in some cases an underlying motive for the above-mentioned negligence towards health and served as an ineffective coping strategy. When feeling sick they disliked seeing a doctor and even if they had to struggle to maintain an independent life they pretended that everything was fine. As one of them said:

> When I'm sick I avoid to think about this and I do nothing. (Menichetti and Graffigna 2016)

4.5.2.2 Satisfaction of Denial of Adversities

Such non-observance of adversities *saved* older persons *from worries about the future* and allowed them to continue their usual way of life at least for some time (Berlin Hallrup et al. 2009; Menichetti and Graffigna 2016; Lette et al. 2017; Bredland et al. 2018). The investigated studies, however, do not report what happened when they had to give up their denial. We will turn to this issue in the following chapter where we investigate the experience of quality of life in long-term care facilities.

4.5.2.3 Facing Adversities

Other older persons showed a rather *proactive awareness of their vulnerability* (Wang et al. 2001; Brännström et al. 2013). They discussed health risks, the possibility of becoming care dependent, and even their approaching death with families and friends. Such awareness could be triggered by the experience of critical incidences. This could be a disease they had experienced (Graham and Connelly 2013) or the observance of how others got struck by illness which was described as turning point in their lives (Hardy and Grogan 2009; Price et al. 2011).

> My mother died much younger than I did, both my sisters have died, it's given me a spur to stay fit, to keep my weight down because of joint problems […] it's given me a spur to do as much as I can because to get as much out of life as I can so it was quite a turning point when it happened to me (Hardy and Grogan 2009)

While in some cases risk awareness led older persons to take action, others just *contemplated a change in behaviour* in case it should become necessary (Hutton et al. 2000; Barenfeld et al. 2017).

> I know that I can hold off things, so I think, when I need to. And later on, maybe I start to root around [for more information] if I want to. But not right at the moment. (Barenfeld et al. 2017)

4.5.2.4 Satisfaction of Facing Adversities

A proactive awareness for risks did not necessarily have a discouraging and paralyzing effect. In a healthy extent it could rather trigger a *potential for action* as the quotation above suggests, where a critical incidence became a turning point in the

older persons' life (Hardy and Grogan 2009; Price et al. 2011; Graham and Connelly 2013). If older persons already had to cope with disabilities an awareness of risks reinforced their tendency to protect their physical integrity and by taking precautions they gained *an ability to handle their limitations*. For example, those who were willing to use a walker learned the necessary skills to handle the device and developed new routines that enabled them to minimize their risk for falls (Brännström et al. 2013).

4.5.3 Scepticism Versus Hope

When older persons were confronted with adversities like the loss of their health or functional decline they could resort to scepticism or hope. A sceptical attitude prevented them from illusions about their future perspective and allowed them to accept their given situation, but it could also result in despair. Hope, on the other hand, could promote self-deceptions about future opportunities, but it allowed also discovering something positive in a negative situation.

4.5.3.1 Scepticism

The experience of illness triggered of course a desire to be cured. Some older persons, however, did not believe in the effect of every available treatment option. They rather remained *sceptical about alternative treatments*. For them, alleged effects of such treatments were rather miraculous and just a result of wishful thinking. One of them told about his mistrust in homeopathy.

> Something I've always, not despised, but thought ludicrous, where you dilute and dilute and dilute. (Lorenc et al. 2012)

Another one criticized reflexology for similar reasons:

> The science of reflexology, which I just cannot tolerate, that rubbing your big toe for instance will cure a headache. As a logical person, which I hope I am, I just cannot accept. (ibid.)

According to them, health promotion should not be based on belief but on empirical evidence.

4.5.3.2 Satisfaction of Scepticism

Scepticism about alternative treatments *protected* older persons *from disappointment and disillusionment* (Lorenc et al. 2012). A sceptical attitude also allowed for a realistic assessment of possibilities and prepared older persons to accept a decline of health. They learned to perceive ageing as a normal process and to endure diseases with *composure* which enabled them to accept their limitations (Söderhamn 1998; Wang et al. 2001; Menichetti and Graffigna 2016). As an older woman put it:

> The problem is not to avoid diseases but to live with them in a decent way and in line with your life. (Menichetti and Graffigna 2016)

4.5.3.3 Hope

Scepticism had to be counterbalanced by some degree of hope in order to find life still worth living in the face of adversities. The most common way to find something positive in a negative situation was to *think positively* (Maddox 1999; Grasser and Craft 2000; Miller and Iris 2002; Collins et al. 2004; Cartwright 2007; Söderhamn et al. 2011, 2013; Gilbert et al. 2012; Patzelt et al. 2016). This prevented older persons from being depressed and enabled them to continue their life and to promote their health despite their limitations.

> Being healthy is having a positive outlook on life regardless of whether the person has a disability or something else. (Miller and Iris 2002)

> I think the important thing is to be optimistic … to keep believing that you will stay healthy and age in peace and harmony, and that your interests will include other things besides just coping with your illnesses (Patzelt et al. 2016)

Some older persons dealt with health risks and adversities by *practicing a religious belief*. They perceived praying to be a way of health promotion. Health had for them a religious dimension and implied obtaining salvation. As some members of the Hispanic and Afro-American minorities in the USA put it:

> I go to church every day. That's the best medicine.
>
> Prayer and belief in the Lord (make you a healthy person). (Collins et al. 2004)

For some older persons physical exercise to promote their health was directly related to their desire for spiritual devotion.

> When I wake up, the first thing that I do is to pray to God. The second, I exercise. (Belza et al. 2004)

Other older persons did not have an affiliation with an established religion but they *searched for a spiritual dimension* (Morris Docker 2006; Boggatz 2011; Boggatz and Meinhart 2017). According to them health promotion included practices like meditation, Yoga, or Qi Gong. One older woman explained her interest in such practices in the following way:

> These are spiritual things that play a role in it (…) you just get ideas that go beyond the physical. (Boggatz 2011)

Users of alternative treatments were sometimes inclined to search for such a dimension.

4.5.3.4 Satisfaction of Hope

Older persons who were inclined to think positively were able to *enjoy their life despite limitations* since they were able to discover the positive aspects of their condition (Maddox 1999; Grasser and Craft 2000; Miller and Iris 2002; Collins et al. 2004; Cartwright 2007; Leavy and Aberg 2010; Söderhamn et al. 2011, 2013; Gilbert et al. 2012; Patzelt et al. 2016).

> I turn 70 in 2 years, and for example, my shoulder is ruined, I am not as flexible and my knees are very bad… It's actually very nice to relax now. (Leavy and Aberg 2010)

Such an enjoyment despite limitations went beyond a narrow understanding of health as physical fitness. For these older persons, health did not preclude physical limitations. It rather consisted of mental and emotional well-being that enabled them to live with such limitations.

A tendency to hope in the face of a serious disease could furthermore result in an *inner strength after overcoming a crisis* (Söderhamn 1998; Maddox 1999; Söderhamn et al. 2013; Menichetti and Graffigna 2016)

> When I got cancer I thought it through some days. So I was finished with it. I saw on it with a good mood. The more you have gone through, the more it will help for the future. (Söderhamn et al. 2013)

Hope gave these older persons *strength in the face of the approaching death* and health meant for them to expect death with inner peace and calmness.

> Sooner or later life ends. It is important to have the satisfaction of having done something, to have done things, to have left something … more than the fear of death, I'd rather end in a particular way. (Menichetti and Graffigna 2016)

Among older persons who practiced a religious belief such experiences were often associated with a gain of *religious comfort* (Söderhamn 1998; Maddox 1999; Price et al. 2011; Söderhamn et al. 2011, 2013). They were grateful to a superior force for the health they got and trusted in God because—as an older nun put it—they were convinced that he took care for those who are doing his work on earth (Maddox 1999). Another woman explained:

> I mean that we, who are Christians, are very lucky … we do not need to think negative thoughts because we can slough them and get a new start and look forward … Yes, you have to put the future in the hands of God (Söderhamn et al. 2013)

For some of them, a simple activity like walking provided a religious experience:

> It might sound silly, but I walk and pray. When you are in nature, you find yourself grateful to be alive. (Belza et al. 2004)

Those who were in search of a spiritual dimension described sometimes their *spiritual experiences*. An older man, for example, who practised Christian mysticism to overcome his chronic disease told about vision he once had:

> The meditation I just did has an impact on every aspect of my health. It's not simply that my asthma is gone… the energy rises from my toes and it comes with colours and with light. (Boggatz and Meinhart 2017)

From a sceptical point of view, such an experience may be the result of an exaggerated believe in miraculous powers. Unfortunately, the available studies do not provide any

information on the extent to which such beliefs have or have not been satisfied on the long run and therefore do not allow any conclusions to be drawn about the credibility of such statements. Older persons who were less inclined to such mysticism just described the result of alternative ways of health promotion like Tai Chi as a *feeling of inner balance and harmony* between body and mind (Morris Docker 2006; Boggatz 2011).

4.5.4 Influencing Factors

As mentioned above, a decline of health could stimulate a readjustment of body-related orientations of actions (Boggatz 2011; Gilbert et al. 2012). The experience of physical limitations led to a change of consciousness, which gave the impetus to face adversities. We also saw that in response to the experience of symptoms, some older people were inclined to avoid diagnosis and treatment (Leung et al. 2004; Berlin Hallrup et al. 2009; Menichetti and Graffigna 2016; Lette et al. 2017; Bredland et al. 2018). Whether older persons were ready to deal with perceived risks for their health and began to search for new perspectives in their life depended of course on external circumstances. These were, as mentioned above, the availability of health promotion programs, a convenient transportation system, a supporting social network, and financial resources. If available and familiar to the older persons, programs that offered alternative ways of health promotion like Tai Chi or Yoga could meet a desire for inner peace and harmony which was a way to find hope and think positive.

4.5.5 Behavioural and Attitudinal Reactions

Practicing such *alternative ways of health promotion* was a way to react to a threat or loss of inner balance. *Religious practices* had the same function. All these behavioural reactions aimed to promote health in a broader and holistic sense that was not restricted to the ideal of physical fitness and functionality. As far physical well-being itself was concerned, development-related orientations of action were at the same time attitudinal reactions to a perceived threat of health. Facing adversities by becoming aware of one's vulnerability could trigger a potential for action, and searching for new perspectives could help to overcome a lack of health-related knowledge and sometimes even the routines of a sedentary lifestyle. A denial of health risks had of course the opposite effect. Thinking positive as an expression of hope could give older persons the inner strength to deal with adversities and help—as some of them said—to overcome crises caused by illness.

4.6 Discussion

This chapter investigated how health promotion and disease prevention interfere with quality of life as it is perceived by older persons. The orientations of action as described in the previous chapter turned out to be a useful framework for

understanding their attitudes towards health-related interventions. The only exceptions were sexual desire and sexual abstinence that were not mentioned in any of the investigated studies. Although sexual activity may have a positive effect on health (DeLamater 2012), it is apparently not considered to be of relevance in the context of health promotion. The non-observance of this topic by health promotion programs and older persons may be due to the taboo of sexuality in old age.

Studies investigated in this chapter are likely to have a similar bias of social desirability as studies described in the previous chapter. As explained earlier, this bias is not avoidable because performance of social roles according to the expectations of others is an essential aspect of personhood. Furthermore, if aspects are rarely mentioned, it is because older persons are only partially aware of the habits that shape their way of living and produce their experiences.

It is furthermore noticeable that most health-related programs investigated by the studies in this chapter understand health promotion and disease prevention as a part of individual behaviour. They rarely address health in old age as a responsibility of the society. When asked about their ideas regarding health promotion, older persons nevertheless told about external circumstances that influenced their health behaviour. Unsafe environments, lack of facilities in the vicinity, lack of convenient transportation systems, ageism, and unequal distribution of income that allowed or prevented participation were issues raised by participants. Exercise programs that were implemented under such circumstances had no possibility to change them. Community work with the aim of empowering older persons to control such health-related issues in their community was apparently absent. One investigated program tried at least to involve participants in its design and implementation so that they could influence it within its framework (Patzelt et al. 2016). The prevailing impression, however, was that health promotion was meant to instruct and train older persons in a unidirectional top-down approach. The mismatch between older persons' orientations of action and the aims of such programs that was found in the investigated studies is partly due to this approach.

4.7 Conclusion

As expected, there is no straightforward relationship between the health-related ideas of health professionals and those of older persons. The various ways how health promotion as designed by experts can be in accordance or non-accordance with older persons' orientations of action are shown in Table 4.7.

In some cases, health-related interventions are in accordance with older persons' orientation of action. Exercise programs, for example, may meet their desires for physical activity, closeness, and diversion. Such a fit between orientations of action and health-related interventions depends to some extent on the attitudes of the older persons, but also on the character of the intervention.

There are other cases where the opinion of health experts is in contradiction to the orientations of actions of the older persons. Sometimes such a contradiction may provoke a readjustment of the attitudes and behaviour of the older persons.

Table 4.7 Health promotion and orientations of action

Body-related orientations of action	
Physical activity *In accordance with health promotion* if older persons enjoy physical activity and gain fitness through exercises *Not in accordance with health promotion* if older persons tend to go to their limits and overload their physical capacities	*Physical rest* *In accordance with health promotion* if older persons can recover from physical activities and improve their sleep *Not in accordance with health promotion* if older persons are inclined to comfort and inertia
Body protection and regeneration *In accordance with health promotion* if older persons are careful about their physical integrity, take preventive measures, observe medical treatments, and get advice how to manage unpleasant symptoms when exercising *Not in accordance with health promotion* if older persons are afraid of getting injuries through exercises	*Negligence towards health* *In accordance with health promotion* if older persons may perform health-promoting activities according to their convenience *Not in accordance with health promotion* if older persons perceive preventive measures and treatment as inconvenient
Food consumption *In accordance with health promotion* if older persons prefer a healthy and balanced diet *Not in accordance with health promotion* if older persons have a preference for rich and tasty food	*Food abstinence* *In accordance with health promotion* if older persons want to make a diet to reduce body weight *No case of non-accordance reported*[a]
Sexual desire *Not relevant with regard to health promotion*	*Sexual abstinence* *Not relevant with regard to health promotion*
Social orientations of action	
Self-reliance *In accordance with health promotion* if older persons take responsibility for their health, search proactively for health-related information, and strive to maintain self-efficacy through exercising *Not in accordance with health promotion* if older persons are not inclined to become active regarding their health and do not take the initiative	*Being cared for* *In accordance with health promotion* if older persons feel safe due to careful coaching *Not in accordance with health promotion* if older persons like to get more attention and support than they receive in health-related programmes
Exerting influence on others *In accordance with health promotion* if older persons have choices, can express their opinion, make own decisions, are informed about the purpose of exercises *Not in accordance with health promotion* if older persons cannot exert influence on health-related programmes and feel exposed to pressure by instructors	*Attention to the needs of others* *In accordance with health promotion* if older persons do not have to bother others in order to promote their health *Not in accordance with health promotion* if older persons fear to become a burden with their attempts to promote their health

Table 4.7 (continued)

Social adjustment *In accordance with health promotion* if older persons feel comfortable when complying with advices from experts or significant others, develop a sense of obligations to a group, and gain an inner structure *Not in accordance with health promotion* if older persons lacked discipline or if they were left to do the exercises on their own	*Unconventionality* *In accordance with health promotion* if health-related activities do not disturb older persons' own way of life *Not in accordance with health promotion* if older persons dislike advices and feel constrained by rules and regulations
Closeness *In accordance with health promotion* if older persons gain social contacts in exercise groups *Not in accordance with health promotion* if group activities had a social climate that did not meet their social inclinations	*Distance* *In accordance with health promotion* if older persons who prefer social distance can exercise at home or in a fitness studio *Not in accordance with health promotion* if health promotion is a mass event and older persons dislike overcrowding
Identity-related orientations of action	
Work *In accordance with health promotion* if older persons have the feeling to perform meaningful activities that also contribute to physical fitness *Not in accordance with health promotion* if older persons perceive activities other than exercise as meaningful and therefore feel bored with exercises	*Relaxation* *In accordance with health promotion* if older persons can reduce mental stress and find relaxation through physical activities like walking *Not in accordance with health promotion* if health-related activities result in stress and prevent relaxation
Reflection *In accordance with health promotion* if older persons can meet their desire for cognitive integrity or satisfy intellectual interests through health-related activities *Not in accordance with health promotion* if older persons have other intellectual interests and therefore perceive exercises trivial	*Diversion* *In accordance with health promotion* if older persons have fun and entertainment during exercises *Not in accordance with health promotion* if older persons prefer other kinds of entertainment than exercising or derive pleasure from entertaining activities that may be harmful to health
Self-presentation *In accordance with health promotion* if older persons can leave a positive impression on others and feel valued and respected when participating in exercise groups *Not in accordance with health promotion* if health-related measures (e.g. using walker for fall prevention) or participation in activity groups prevented older persons from building their desired image	*Self-concealment* *In accordance with health promotion* if older persons remain unnoticed from others if they performed health-related activities *Not in accordance with health promotion* if older persons fear to attract the attention of others because of their physical limitations

(continued)

Table 4.7 (continued)

Self-centredness *In accordance with health promotion* if older persons feel that they can do something for themselves or if they are rewarded for efforts spent on exercising *Not in accordance with health promotion* if physical exercise becomes a duty that does not serve self-interest	*Concern for others* *In accordance with health promotion* if older persons can support others by advice and encouragement to promote their health *Not in accordance with health promotion* if health-related activities prevent older persons from showing concern for others who are of central importance for them (like children or grandchildren)
Positive self-perception *In accordance with health promotion* if older persons get a sense of achievement through exercising *Not in accordance with health promotion* if older persons cannot achieve a positive self-perception through participating in activity groups that feel inferior to other group members	*Critical self-perception* *In accordance with health promotion* if older persons get aware of their limitations and can adjust their physical activities accordingly *Not in accordance with health promotion* if older persons believe that they have no longer the abilities to participate in exercises because they have a negative self-image as a result of excessive self-criticism
Development-related orientations of action	
Attachment to the past *In accordance with health promotion* if older persons can continue their habitual physical activity *Not in accordance with health promotion* if older persons have no habit of exercising or if exercising gets into conflict with cultural norms	*Searching new perspectives* *In accordance with health promotion* if older persons are inclined to change, gain new knowledge, and are enabled to develop new habits and routines *No case of non-accordance reported*
Denial of adversities *In accordance with health promotion* if older persons can avoid unnecessary worries about health that may prevent them from participating in health-related activities *Not in accordance with health promotion* if older persons avoid to think about health risks	*Facing adversities* *In accordance with health promotion* if older persons have a proactive awareness of their vulnerability and contemplate a behaviour change *No case of non-accordance reported*
Hope *In accordance with health promotion* if older persons can combine hope or religious beliefs with health-related practices *Not in accordance with health promotion* if older persons get attached to unrealistic beliefs regarding maintaining their health	*Scepticism* *In accordance with health promotion* if older persons have realistic ideas and beliefs about health that prevent them from disillusionment and strengthen their composure *Not in accordance with health promotion* if older persons are too sceptical about health-related interventions and give up hope at all

[a]A case of non-accordance may occur in younger persons who suffer from anorexia. This condition is unlikely to be met among older persons

Encouragement to exercise may stimulate those who are inclined to physical rest, whereas those who tend to excessive exercising may need an advice to slow down.

In other cases, however, health-related interventions may have a negative impact on the satisfaction of older persons' orientation of action. For example, physical exercises that exceed the abilities of older persons provoke fear of injuries and contradict in this way their need for physical integrity. They may also interfere with the desires for self-presentation and a positive self-image if they prevent older persons from building a desired image and make them feel inferior to members of an activity group who still have more physical capacities.

The mismatch between quality of life according to older persons and health-related interventions as designed by experts is partly due to a different understanding of health. Whereas health experts focus narrowly on the maintenance of physical fitness and the prevention of diseases, older persons have a broader understanding of health. For them, health promotion is not a one-sided activity to promote physical fitness and strength in order to increase resistance to disease. Rather, it means finding an inner balance between physical effort and physical rest, between pleasure and restraint, and between attention to and negligence of health.

Furthermore, the aim of health promotion is not restricted to physical well-being. It is rather concerned about finding an inner balance at all four levels of the orientations of action. Health promotion programs with a narrow focus on fitness and functional improvement are likely to counteract social, identity-, and development-related needs. As an end in itself, the satisfaction of body-related orientations of action is rather meaningless. These orientations gain their final meaning by serving the satisfaction of the other orientations of action that are of greater importance in life. Due to this subordinated character of body-related orientations of action in the complete context of life older persons may perceive activities with no explicit focus on physical fitness as health promoting, whereas health experts may either ignore such activities or perceive them as a distracting from what they consider to be beneficial for health. For example, older persons may satisfy their need for entertainment and social contacts in a social environment that is not inclined to healthy behaviours. Although involvement in such a social environment may be rather detrimental to health from a medical point of view, older people will find it beneficial to their well-being as it allows them to avoid loneliness, which actually has a negative impact on health. In a similar way, concern for others may prevent participation in health promotion programs. However, helping others enables older people to find a purpose in life. For them, it has a higher priority and the health promoting value of their social engagement should be recognized.

Finally, one has to recall that health in old age does not simply mean to be physically fit and active as it is suggested by the idea of active and successful ageing. Sooner or later, older persons will suffer from functional limitations and they have to cope with their losses. In this context, health rather means to develop serenity in the face of physical limitations. Seen in this way, the limited interest in physical

fitness as it was shown by some older persons is an attempt to restore an inner balance by finding a compensation for lost abilities at a higher level of the orientations of action. If older persons develop a positive acceptance of ageing, physical activities to prevent diseases and to increase fitness are no longer their priority. They may rather gain a sense of well-being that is based on inner peace and serenity and goes beyond the narrow perspective of active ageing that is inherent in most health promotion programs. This is not to say, that active ageing is a misleading attempt to promote health in old age. One should, however, be aware that a one-sided focus on fitness and activity is not suitable for everybody and needs to be counterbalanced with increasing age by an understanding of health that encompasses the satisfaction of identity- and development-related orientations of action.

If we keep this partial discrepancy between the promotion of physical fitness on the one hand and quality of life on the other hand in mind, we can close this chapter with the following recommendations for health promotion in a person-centred way:

- Public information on health-related issues should be clear and easy to understand in order to avoid confusion and uncertainty among recipients.
- Health promotion and disease prevention programs should be offered in the vicinity to avoid discouragement due to inconvenient transportation.
- Health promotion and disease prevention programs should be offered during the day as older persons feel insecure in the dark.
- Exercise groups should be composed of members with similar abilities to avoid feelings of inferiority and feelings of disturbing others with one's limitations.
- Health advice and attempts to exert some influence may stimulate a behaviour change in older persons if they are made with caution.
- Instructors of exercise groups should avoid exerting pressure on participants, because older persons will feel overstrained and have the impression of being humiliated and losing control.
- Instructors should instead provide guidance to give participants a feeling of being cared for and at the same time they should offer choices and allow discussions to give participants a sense of control and a feeling of being respected.
- Instructors should give advices how to manage unpleasant symptoms when exercising in order to satisfy participant's need for physical integrity.
- Group-based programs should offer the opportunity to socialize and get entertainment as the desires for closeness and amusement are main motives for participation.
- Health promotion programs should recruit participants by using the social network of older persons because encouragement by peers and significant others is an important trigger and satisfies the desire for being cared for.
- Older persons with a preference for social distance should be encouraged to exercise at home or in a fitness studio.
- Peer mentors may provide encouragement for those who prefer to exercise alone.
- Finally, health promoters should recognize that older persons may be less prone to physical activities due to an age-related decline of abilities or due to a lack of habit. Rather than insisting on a specific level of activity they should acknowl-

edge that performing everyday activities and participating in social events have a health promoting effect that meets the needs and abilities of older adults. Hence, supporting self-care activities and offering opportunities to socialize (not for the sake of exercising but for the sake of socializing) are essential components of health promotion.

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