

## Motivating older adults to exercise: what works?

The health benefits of regular physical activity are clear and are relevant at any age. However, declining activity rates in older age coupled with physiological aging and disease make exercise that much more important for older adults. Regular physical activity can help older persons reduce their risk of chronic disease, manage illnesses they already have, function better physically and mentally, avoid injuries such as falls, and live longer independently.<sup>1</sup> Evidence for the benefits of exercise for older adults has been accumulating for quite some time and the question of whether or not exercise is beneficial has largely been answered. A more relevant question now is how do we effectively motivate adults to change their exercise behaviours and stay active as they age? Current research presents us with some ideas for clinical practice and raises questions for future research about reasons older adults do not exercise and whether or not behaviour change can be sustained.

The recommended amount of exercise for older adults is the same as that for adults aged 18–64 years—at least 150 min weekly (about 30 min 5 days a week) of moderate-intensity physical activity. However, most older adults do not come close to meeting these recommendations.<sup>2</sup> When older adults exercise, they mostly walk because it is both practical and beneficial. Strengthening exercise is also very important for older adults, yet it remains difficult to engage seniors in this activity with only 10–12% of persons 65 and older saying they do strengthening exercise more than twice a week.<sup>3</sup>

Effective approaches to motivating older adults are clearly needed. The article in this issue by Schneider and colleagues tested an 8-week cognitive-behavioural (CBT) group therapy approach to encourage exercise, but found few differences in exercise behaviours or functional outcomes at 3, 6 and 12 months among the CBT group, an education group, and a control group. The authors suggested that an individual CBT therapy intervention may have been more effective, but this has yet to be tested.

However, individual approaches have worked in prior studies, some of which could be practical in a clinical setting and are simpler than full CBT therapy. For example, a single motivational session and 15-booster telephone calls, delivered by phone or computer, led to significant increases in physical activity over 1 year and to a higher percentage of intervention participants meeting recommended levels of physical activity compared with controls.<sup>4</sup> Similarly, a single session with a person trained in motivational interviewing,<sup>5</sup> followed by telephone calls increased exercise in older adult cancer survivors.<sup>6</sup> In a study of rural adults, brief advice by nurse practitioners followed by telephone

calls from a trained motivational counsellor who never met the participants in person, was effective in increasing self-efficacy for exercise, a step towards increasing physical activity.<sup>7</sup> All these interventions encouraged walking and the findings suggest that brief advice by a healthcare professional is an effective motivator. Are the additional telephone calls essential? Only further research will answer that question, but implementing advice during a clinic visit, with or without telephone calls, is a simple intervention that is probably worth the time.

An exercise programme, even if shown to be efficacious, loses its impact if it cannot be sustained long term. Longer-term trials and follow-up after trial completion are necessary so that the sustainability of a particular approach can be evaluated. Schneider and colleagues are to be commended for following their participants for 12 months and for having low attrition during that time. Longer trials are more expensive, difficult to recruit for and vulnerable to attrition and waning attendance but they reflect the real challenges to face when motivating older adults to be more active. Identifying patterns in attendance and compliance to exercise over time may point to windows of time when drop out increases and/or subgroups of participants more vulnerable to dropping out. In the Lifestyles Intervention and Independence for Elders Pilot Trial (LIFE-P), illness was identified as a major reason that older participants experienced temporary or sustained lapses in physical activity that compromised the benefits of the exercise programme on functional outcomes, and these participants could be identified at baseline by number of medications and low physical functioning scores.<sup>8</sup> This same study included a 2-year follow-up assessment of the original year-long intervention and reported sustained differences in physical activity and function favouring the exercise group compared with a control group.<sup>9</sup> Continued follow-up of this cohort will provide important information on whether or not a limited duration intervention can effectively change lifelong behaviour and the characteristics of participants who continue to exercise compared with those who do not.

Though there is much left to learn, there is evidence that brief advice by a healthcare professional can motivate older adults to start walking, at least short term. After an initial conversation during a clinic visit about physical activity, continued mention at subsequent appointments, or telephone booster calls, could help keep patients active over the long term. This simple and practical clinical advice is best used for walking exercise and a ‘moderate’ effort should be described so that an older adult does not think a

leisurely stroll or window shopping is sufficient. Moderate-intensity walking can be described as 'brisk' or 'being able to talk while walking but not sing'. Pedometers can be helpful motivators and taking about 3,000 steps in a half-hour could also help patients gauge that they are moving at a sufficient pace.

We know that there is work to be done before we can effectively change the daily exercise habits of older adults. Researchers are currently investigating novel approaches and practical implementation of effective interventions to change exercise behaviour and are also trying to better understand the needs of older adults who do not exercise. Whether or not motivational tools that promote walking could also be used to engage older adults in strength training is an important question that must be addressed. There is little doubt that effective long-term behavioural approaches will be found, and we look forward to seeing them implemented in future clinical practice.

### Conflicts of interest

None declared.

JILL A. BENNETT\*, KERRI WINTERS-STONE

School of Nursing, Oregon Health & Science University, Portland,  
OR, USA

Tel: (+1) 503 418 3523; Fax: (+1) 503 418 0903

Email: [bennett@ohsu.edu](mailto:bennett@ohsu.edu)

\*To whom correspondence should be addressed

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