Older adults face multiple barriers to becoming and staying physically active and are less likely to meet public health goals for physical activity. Indeed, 57% of Canadian adults aged 65 or older are insufficiently active. A recently published review of the health literature discusses barriers, describes physical activity program interventions that have incorporated self-efficacy theory to address these barriers, and provides practical suggestions for theory-based programming.

**MULTIPLE BARRIERS**
Seniors are likely to hold misconceptions about the aging process or concerns about injury and falling, believe that their health status or disability is a barrier, see activity as irrelevant to their lifestyle or to them personally, be unaware of the benefits, have low confidence in their ability to exercise, believe they have no will power, or lack the time management skills or knowledge of how to fit activity into their daily routines. In addition they may have difficulty accessing information on how to commence activities or to perform them safely and effectively.

**SELF-EFFICACY IMPROVES ACTIVITY LEVEL**
Self-efficacy theory takes into account these psychological components. It refers to self-confidence in one’s own ability to perform a particular behaviour in a variety of circumstances. Persistence, and level of effort, as well as activity choice, are closely related to self-efficacy levels. A mismatch between perceived self-efficacy and expected outcome of the health behaviour affects its adoption, the modification of unhealthy habits, and the maintenance of change. For example, a person may agree that there are health benefits to doing exercise in general, but judge themselves incapable of including regular exercise in their own daily life. Thus, while an individual may believe that the behaviour is beneficial, they may not take action themselves. In addition, belief in a positive outcome of a particular behaviour may be more important than whether the behaviour has really caused a positive consequence in the past. Therefore, whether or not the relevant knowledge and skills are present, having confidence in the personal ability to adopt a behaviour may be sufficient to initiate it.
MULTIPLE SOURCES OF INFORMATION
Self-efficacy levels are fed by information and feedback from four sources:
> performance accomplishments,
> vicarious learning,
> verbal encouragement, and
> physiological and affective states.

Performance accomplishments are believed to be the most influential of these sources. They are based on personal experience and, therefore have greater authenticity to the individual. Disappointments on the other hand can reduce feelings of self-efficacy. Breaking the task down into small achievable stages will build up and accumulate confidence while documenting goal achievement will help make the effort and progress visible.

WHAT HAVE WE LEARNED?
> Establish small individualized goals in program tailored to the needs and capacities of each participant.
> Provide greater support at the initial stage of a new behaviour to enhance confidence and minimize frustration.
> Ensure positive experiences and document goals achievement in a log or diary.
> Reinforce the positive outcomes aspects of an activity, such as pleasure, comfort, physical, psychological and social benefits.
> Provide opportunities for observation of peers engaging in the planned physical activity. Choose role models who are comparable to participants, with similar health problems and barriers.
> Consider linking individuals for social support or forming exercise buddy groups. Consider pairing successful participants with beginners.
> Significant others, health care and other professionals should provide realistic positive feedback that interprets experiences as successes.
> Reassure participants that psychological and physiological responses that they are experiencing are normal and not a symptom of their age or physical condition.

Vicarious learning is achieved through the observation of peers who are successfully undertaking behaviours. This can be accomplished through personal visits, direct observation of a class or activity or through the use of videos. Role models should be ones that the participants can relate to in terms of their limitations and who accomplish goals through slow progression or trial and error rather than demonstrate quick, problem-free success.

Verbal encouragement from a trusted, credible source that interprets experiences as successes, and that conveys confidence that the participant can achieve goals, has been shown to increase self-efficacy. However, it must not promote unrealistic beliefs about personal capabilities, which may lead to a loss of credibility of the provider and weaken the participant’s confidence. Both face-to-face and telephone encouragement and support have been found to facilitate regular walking behaviour.

Finally, providing information regarding psychological and physiological responses to exercise is important to counteract potential negative interpretations. Explaining that muscle ache or fatigue in the early stages of taking up exercise is necessary to longer term health gains rather than indicators of physical inefficacy or declining physical abilities helps to alleviate stress that participants may be feeling about these symptoms.

A program designed to provide information from all four of these sources is likely to produce optimal results, as the way individuals weigh and integrate information from each source in forming a personal judgement about self-efficacy varies. An individual’s performance may be improved through seeing, hearing and feeling what they are doing.

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