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Gender Differences in Attitudes to Ageing among Norwegian Older Adults

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Abstract

Increased life expectancy has led to policy interest in adding quality to years of life and in related concepts such as attitudes to ageing. Improving attitudes to ageing is regarded as one means of improving the participation and contribution of older people within society. In considering age-related attitudes in the dynamic nature of social identity, age is not just one social category that may or may not constitute a part of one's identity. Other identities such as gender may be more salient in attitudes to ageing. The purpose of this study was to explore Norwegian gender differences in attitudes to ageing among 282 females and 200 males living in the community. Attitudes to ageing were measured using the Attitudes to Ageing Questionnaire (AAQ; Laidlaw, Power, Schmidt, & the WHOQOL-OLD Group, 2007). Both genders in this study had positive attitudes toward their ageing, in spite of acknowledging loss with problems of exclusion, making friends and talking about difficult feelings. Compared to men, women perceived ageing as a time of greater loss, however, they felt more strongly that ageing brought wisdom and that their life had made a difference. On the other hand, men felt more strongly that physical problems did not hold them back from doing what they wanted to do and believed more strongly that they passed on their experiences to others. Both genders felt that their identity was not defined by age, they didn't feel old, aging was a privilege, and appraised the importance of exercising. Attitudes to ageing are becoming increasingly important in ageing societies. Such positive attitudes should be regarded with importance to health professionals, leaders and policy makers in planning interventions to buffer the detrimental aspects of ageing.

Keywords

Attitudes to Ageing, Gender, Elderly, Community, Attitudes to Ageing Questionnaire

1. Introduction

Populations worldwide are ageing with women living longer than men. Women make up two-thirds of the global

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population over 80 and as life expectancy rises, this proportion will increase. On average, women also live 2 - 8 years longer than men, and make up a larger proportion of the "old-old" group. They have a greater chance of being widowed, experience reduced nutrition, lower education, and limited access to services in earlier life resulting in poor health in old age. Men, on the other hand, tend to suffer from the loss of a declining capacity to meet their traditional role as breadwinners in old age, which can leave them vulnerable. Men also have higher mortality rates, shorter life spans, and exhibit more risk taking behaviour from a global perspective. Many policy makers proclaim that this situation will result in higher expenditures on health and social services for this age group [1].

Norway is also ageing. Those aged 65 and over account for 13% of the population with an expected increase to 21% in 2050 [2]. This translates to an increasing number of women particularly over the age of 85. Also, in Norway the portion of women living alone rises from 40 percent at age 70, to 70 percent at age 80, and from 20 - 30 percent among men [3].

Increased life expectancy has led to policy interest in adding quality to years of life and in related concepts such as attitudes to ageing and successful ageing. Ageing attitudes have powerful influences not only upon older adults' perception of health, quality of life and utilization of health and social care services, but should also influence the provision of health services for this age group. Improving attitudes to ageing is regarded as one means of improving the participation and contribution of older people within society [4]. When speaking of attitudes to ageing such attitudes can be understood as cognitive presentations of a person's evaluation of his or her situation in terms of actual versus intended course of personal development [5]. These appraisals pertain to physical and social losses and gains in the past and present and continual psychological growth.

Researchers have been criticized for perpetuating a narrow view of aging by concentrating on the central tendencies within a group and ignoring the substantial differences [6]. In considering age-related attitudes in the dynamic nature of social identity, age is not just one social category that may or may not constitute a part of one's identity. Other identities such as gender may be more salient in attitudes to ageing; however, this is a notion that is largely overlooked in the relevant literature. Such a focus is important given the different role trajectories of women and men. In Norway, as globally, women also live longer than men, often marrying someone older then themselves, and are more likely to be widowed or a spousal caregiver [7]. Notably, Fry & Debats [8] in a longitudinal study found gender differences in socioeconomic and psychosocial predictors of mortality. For men, the greatest predictors were lower levels of education, perceived control, personal commitment and physical functioning. Whereas, for women, the greatest predictors were lower levels of social support and engagement. Importantly, the factors that were influential for women were inconsequential for men and vice versa. Such gender related differences in attitudes to ageing should constitute a key issue in planning for an aging Norwegian society, motivated not only in concern for public expenditure, but also in support for optimizing quality of life in old age. The aim of this study, therefore, is to explore gender differences in attitudes to ageing in relation to physical and social losses and gains among community based-older adults.

Theoretical Perspective

Erik Erikson proposed a psychosocial theory of development which is perhaps one of the best known stage theories of adult personality [9]. The sequences of Erikson's eight stages of development is based on the assumption that personality moves through stages in an ordered fashion. He suggested that a person's ego identity is constantly changing, due to new experiences and information people acquire in their daily interactions, and proposed eight stages of development that people pass through in their life. As people face each new stage, they confront a new challenge that can motivate further development or hinder it as part their identity. Erikson proposed that this challenge or conflict serves as a turning point in development if the stage is handled well, with ensuing sense of mastery and ego strength. If people successfully deal with the conflict, they emerge with psychological strengths that will serve them well for the rest of their life. For Erikson, these challenges are of a psychosocial nature because they involve psychological needs of the individual (*i.e.* psycho) conflicting with the needs of society (*i.e.* social). Consequently, ego identity is the conscious sense of self that we develop through social interaction. Erikson also postulated that a sense of competence motivates behaviors and actions. Consequently, each stage in his theory is concerned with becoming competent in an area of life.

Erikson described the last stage of life development as "wisdom: ego integrity versus despair" covering the

ages from 65 to death. Successful resolution of this stage results in being able to look back on one's life, finding meaning and developing a sense of wisdom before death. Alternatively, meaningless and despair can ensue if life review results in primarily negative outcomes. If the stage is managed poorly, the person will emerge with a sense of inadequacy and not develop the essential skills needed for a strong sense of identity and self. In other words, feelings of ego integrity versus despair, are focused on retrospection where people look back on their lives and accomplishments and confront the existential question of "is it okay to have been me in this life?" People develop feelings of wisdom, contentment and integrity if they believe that they have led a happy, productive and successful life. However, if they regard their lives as unproductive, experience guilt, or feel that they did not accomplish their goals, they become dissatisfied with life and develop despair, often leading to depression and hopelessness.

2. Material and Method

2.1. Procedure and Subjects

The data used in this paper is part of a larger study of quality of life among older adults funded by the European Commission, in collaboration with the World Health Organization [10]; where 23 countries participated, including Norway, 2003-2006. The Norwegian Field Trial study consisted of two cohorts. The largest consisted of a randomly selected stratified sample of older adults from 20 geographically dispersed communities drawn by allocated proportional design by Statistics Norway. Community sizes were up to 5000 inhabitants, 5000 - 20,000 inhabitants, and more than 20,000 inhabitants.

Of the 802 older adults who were sent invitations to participate, 401 consented and were sent questionnaires by mail. Another randomized sample of 89 older adults receiving formalized health care services (home care) was drawn from Statistics Norway to increase participation of frailer older people more likely to have morbidities, primarily with a view to capturing varied levels of quality of life. These frailer older people were also personally interviewed to minimize respondent burden. A total of 282 females and 200 males participated in the study. For the sample participating in the postal survey the response rate was 53%. Unfortunately, no record was kept regarding those participants were asked yet refused to take part by personal interviews. Inclusion criteria were: 60 or more years of age, Norwegian speaking, resident of Norway, no illness likely to cause death within the next six months, and no significant cognitive impairment. Questionnaire packets included study information, informed consent forms, sociodemographic questions, an attitude toward aging scale, and questions assessing quality of life, psychological distress and health. This paper is focused on the attitudes to ageing questionnaire data.

2.2. Instrument

Attitude to Ageing Questionnaire (ATA)

The ATA consists of 24 items comprising a three-facet model based on psychosocial loss, physical change and psychological growth [11]. Psychological loss includes whether older adults equate old age with them being lonely, depressed, feeling currently disengaged from society and excluded from things, and, as they get older, are losing their physical independence, and having difficulty making friends and talking about things. Older adults are also asked about physical changes. Physical changes include feeling old, identity not being defined by age, energy and health at present given their age, physical health problems and not holding them back and exercise regularity and importance. The psychological growth that comes with ageing is about better coping and self-acceptance. Psychological growth includes believing that one's life has made a difference, seeing age as a privilege and as pleasant, giving and being a good example to others and felt wisdom.Both classical and modern psychometric methods (Structural Equation Modelling and Item Response Theory) were used to establish the reliability and validity of the instrument [10] [11]. All items are based on self-report with ratings ranging from 1 to 5, where 1 reflects strongly disagree or not at all true, and 5 reflects strongly agree or extremely true. Response scales of negative statements are reversed and recoded so that a higher value means more positive attitude (*i.e.* agreement with a positive statement or disagreement with a negative statement). Time period of assessment is how the older adult feels presently. Internal consistencies with Cronbach's alpha for subscales of the ATA were: psychosocial loss $a = 0.73$, physical change $a = 0.75$ and $a = 0.73$ for psychological growth.

2.3. Data Analysis

Total subscale scores were calculated as the sum of item values in the separate domains. Descriptive statistics were used to examine the frequency distributions and means of the variables. To analyze internal consistency of the ATA, Cronbach alpha was applied. A Cronbach alpha coefficient above 0.70 indicates good reliability [12] [13]. The Statistical Package for Social Sciences (SPSS) version 17.0 was used for analysis.

2.4. Ethical Considerations

The study was approved by the Norwegian Data Inspectorate and the Regional Ethical Committee. For those participating in the postal survey, informed consent was sent and returned with the battery of instruments sent to the participants. For those participating in the personal interviews, written consent was obtained prior to the interviewing.

3. Results

3.1. Sociodemographic Characteristics

The total sample was composed of 58% women and 41% men. Both women and men had a mean age of 76 years. Most adults were married or partnered, 88% women and 87% men. Eleven percent of the women and 13% of the men were non-married, widowed or divorced. Educational status among women showed that 41% had completed primary education, 36% high school, and 23% post-secondary education. Among the men, 28% had completed primary education, 26%, high school, and 55% post-secondary. Both 83% of the women and men appraised themselves to be healthy. In spite of this fact, 28% of both women and men had at least one disease, with 16% of the women and 8% of the men stating they had two diseases. Further, eleven percent of the women and 6% of the men reported three diseases or more.

3.2. Mean Scores of the Attitudes to Ageing Questionnaire

The results in **Table 1** show the overall mean score for the three ATA subscales and the mean values for each item on the scale. Among males and females, attitudes to ageing were found to be quite similar between the genders, although, a few statistical differences were found. Total subscale mean scores on psychosocial loss, physical change and psychosocial growth showed no significant differences between men and women.

3.2.1. Psychosocial Loss

The psychosocial loss subscale showed that for women that attitudes were significantly more negative in appraising old age as a time of loss as compared to men (women 4.13 (SD 0.97), men 3.90 (SD 1.02), $p = 0.05$). For both men and women, the highest mean score for psychosocial loss was feeling excluded from activities due to age (women 4.42 (SD 0.95), men 4.26 (SD 0.80). For men, the next highest mean score regarding psychosocial loss was feeling that old age is a time of loss (3.90 (SD 1.02), followed by perceiving it difficult to make friends (3.68 (SD 1.13) and difficult to talk about feelings (3.66 (SD 104). For women, the next highest mean score was perceiving it difficult to make friends (377 (SD 1.22) and difficulties with talking about feelings (3.77 (SD 1.22). Regarding psychosocial losses, the lowest means scores for both men and women was affirming that old age is a time of loneliness (women 3.11 (SD 1.16), men 3.11 (SD 1.01).

3.2.2. Physical Change

Regarding "physical change" men's attitudes were significantly more positive to feeling that physical problems did not hold them back from doing what they wanted to do (men 3.08 (SD 1.22), women 2.9 (SD 1.28), $p = 0.05$). For both men and women the highest mean scores regarding physical change was the importance of exercising at any age (men 4.64 (SD 5.28), women 4.58 (SD 0.73). The next highest mean scores for men was feeling their identity was not defined by age (3.42 (SD 1.26), followed by the importance of keeping fit by exercising (3.25 (SD 1.25). For women, the next highest mean score was not feeling old (3.41 (SD 1.33), followed by one's identity not defined by age (3.35 (SD 1.36) growing older is easier than thought (3.41 (SD 1.33). Further, for both men and women the lowest mean scores were related to feeling that they did not have more energy than they had expected (men 2.83 (SD 1.18), women 2.75 (SD 1.3).

Table 1. Attitudes to ageing mean scores among Norwegian adults (females n = 282; males n = 200).

Domains and Items	Females Mean (SD)	Males Mean (SD)	Mean Difference (95%CI)
Psychosocial Loss	29.02(4.94)	28.34 (4.72)	0.679 (−0.203 - 1.56)[a]
Old age is a time of loneliness	3.11 (1.16)	3.11 (1.01)	0.003 (−0.192 - 0.199)[a]
Old age is depressing	3.62 (1.04)	3.52 (1.05)	0.120 (−0.069 - 0.310)[a]
Difficult to talk about feelings	3.76 (1.13)	3.66 (1.04)	0.103 (−0.095 - 0.301)[a]
Old age is a time of loss	4.13 (.96)	3.90 (1.02)	0.221 (0.041 - 0.399)[*]
Lose physical independence	3.51 (1.13)	3.46 (1.06)	0.052 (−0.148 - 0.253)[a]
Difficult to make new friends	3.77 (1.22)	3.68 (1.13)	0.086 (−0.128 - 0.301)[a]
Don't feel involved in society	3.44 (1.21)	3.54 (1.15)	−0.093 (−0.309 - 0.122)[a]
Feel excluded due to my age	4.42 (0.95)	4.26 (0.80)	0.156 (−0.005 - 0.317)[a]
Physical Change	26.11 (6.23)	26.76 (5.28)	−0.654 (-1.69 - 0.379)[a]
Important to exercise at any age	4.58 (0.73)	4.64 (0.59)	−0.060 (−0.179 - 0.059)[a]
Growing older is easier than I thought	3.21 (1.19)	3.13 (0.99)	0.071 (−0.125 - 0.268)[a]
I don't feel old	3.41 (1.33)	3.36 (1.21)	0.050 (−0.180 - 0.280)[a]
My identity is not defined by my age	3.35 (1.36)	3.42 (1.26)	−0.066 (−0.306 - 0.173)[a]
I have more energy than expected	2.75 (1.3)	2.83 (1.18)	−0.078 (−0.304 - 0.149)[a]
Physical problems don't hold me back	2.84(1.34)	3.05 (1.28)	−0.245 (−0.484 - 0.006)[*]
Health is better than expected	2.93 (1.3)	3.08 (1.2)	−0.183 (−0.415 - 0.049)[a]
Keep fit by exercising	3.11 (1.4)	3.25 (1.25)	−0.145 (−0.388 - 0.098)[a]
Psychosocial Growth	28.88 (4.86)	28.06 (4.70)	0.821 (−0.050 - 1.69)[a]
Better able to cope	3.28F (0.99)	3.12 (0.88)	0.104 (−0.065 - 0.273)[a]
Growing old is a privilege	3.62 (1.04)	3.61 (1.05)	0.004 (−0.186 - 0.193)[a]
Wisdom comes with age	3.69 (.94)	3.43 (0.95)	0.251 (0.080 - 0.422)[**]
Pleasant things about growing older	3.83 (.91)	3.79 (0.80)	0.046 (−0.112 - 0.203)[a]
More accepting of self	3.31 (1.21)	3.23 (0.98)	0.084 (−0.106 - 0.273)[a]
Pass on benefits of experience	3.63 (1.15)	3.84 (0.98)	-0.216 (−0.409 - 0.023)[*]
My life has made a difference	3.94 (1.01)	3.57 (1.09)	0.364 (0.168 - 0.560)[***]
Want to give a good example	3.68 (1.01)	3.49 (1.03)	0.185 (−0.009 - 0.380)[a]

Note: CI = confidence interval: ns[a], $p < 0.05$[*], $p < 0.01$[**], $p < 0.001$[***]; Note: 8 participants with missing answers.

3.2.3. Psychosocial Growth

Regarding psychosocial growth, more significant differences were found between the genders. Women's attitudes towards gaining wisdom was significantly more positive than men (women 3.69 (SD 0.94), men 3.43 (SD 0.95), $p = 0.01$). Men, on other hand, had more positive attitudes towards feeling that they passed on benefits of experience to younger generations than women (men 3.84 (SD 0.98), women 3.63 (SD 1.15), $p = 0.05$). Significant differences were also found between men and women's attitudes toward believing their life had made a difference, where women were significantly more positive (women 3.94, (SD 1.01, men 3.47 (SD 1.09), $p = 0.001$). For men, the next highest mean score regarding psychosocial growth, was feeling that there were many pleasant things about being older (3.79 (SD 0.80), followed by feeling that growing old was a privilege (2.61 (SD 1.05). For women, the next highest mean score regarding growth, was feeling there are many pleasant things about growing older (3.83 (SD 0.91), followed by feeling wisdom comes with age (3.79 (SD 0.80) and growing old was a privilege (3.62 (SD 1.04). For all three subscales, most items had scores slightly above average mean scores suggesting positive trends towards attitudes to ageing.

4. Discussion

4.1. Psychosocial Loss

Although aging occurs at varying rates, women have been found to find ageing more negative than men [14]. Sontag (1972) described this negativism as the "double paradox of ageing" which portrays women entering old age at a younger point than for men. She contended that getting older is less profoundly wounding for a man, as men are allowed to age without penalty, in several ways women are not. Results of our study showed that both men and women felt that old age represented a time of loss, however, women were more negative than men. Why women had greater negative attitudes towards ageing may have several explanations. One reason could be that older women suffer more from multiple and long-term illnesses and disabilities and may be institutionalized

and require help from others for longer periods of time. In contrast, men are more likely to have a spouse available to act as a primary caregiver in times of need. Although, the majority of both men and women in our sample appraised themselves as being healthy, more women suffered from two or more chronic conditions. Such illnesses, in turn, may have a deleterious effect on women's lives and social support networks.

Women's feeling of loss may be related to appraising more issues as important to their quality of life. This may also be connected to the fact that they have more multiple past-present identities than men. In an earlier study with the same Norwegian sample, comparison across genders revealed that a fourth of the items on a quality of life scale were more important to women [15]. Various psychological issues were important for women such as feeling hopeful, personal beliefs, and positive attitudes towards death and dying. Also, mental activities such as remembering important information, being able to think through everyday activities and making decisions were valued together with the importance of social relationships. Regarding the importance of information, Benjamini, Leventhal, & Leventhal [16] found that women applied a greater number of sources of information when making self-assessed judgments. Perhaps being more attentive to contextual surroundings makes women more conscious of their loss of important sources.

Women have a different relationship to their bodies than men which may have impacted their attitudes. Body image and appearance have been found to be more important to older women than men [17]. According to standards of ageing, men have been described as ageing gracefully, gaining in status and becoming more dignified with age, whereas, women are described as becoming unattractive and of less value. As such, age-related changes in body image and attitudes toward body ageing may represent greater threats to self-identity for women and contribute to higher levels of anxiety among older women, especially changes in their faces. Similarly, Clarke and Griffin [18] argued that women's ageing appearances were pivotal to their experiences of ageism where they engaged in beauty work such as dying their hair and cosmetic surgery to fight against social invisibility. However, Leichty and Yarnal [19] found among women (60 - 69 years), that they gave less priority to their appearance in favour of health and internal characteristics. In another study exploring body image and self-esteem in adulthood (65 - 85 years), Baker and Gringart [20] found body-image concerns differed between men and women. Whilst women appeared to develop various strategies to counter the effects of ageing, men seemed to be more negatively affected, in particular, to body functioning. Similar findings also show that men are more negatively stereotyped than women [21]. In another study (22 - 62 years) men were found to conceptualize their bodies as a holistic entity where women had compartmentalized conceptualizations. Here again, men focused on functionality, whereas women tended to focus on display [22]. As such, women may experience a greater sense of loss in connection with their ageing bodies.

Feeling of loss among older women could also be due to the fact that they compare themselves to younger and middle aged women. Since the Second World War, women's increased educational opportunities, widening occupational and public roles, greater capacity for self–realization and their increased capacity to control their fertility are opportunities few older women have experienced. Older women were largely engaged in childcare and domestic support for their husbands. Feeling of loss in women may therefore reflect a culmination of lifetime experiences within social structures influenced by gender disparity.

Women's feeling of loss may also be related to a sense of diminished sense of control over their lives. Importantly, a sense of control has been shown to be an important resource for avoiding loneliness in later life among Norwegians, especially for people with impairment [23]. In our study, men had more positive attitudes to their physical functioning as compared to women, and felt that physical problems did not hold them back from doing what they wanted to do. Consequently, they may have stronger beliefs regarding their physical stamina needed to control important outcomes in their lives. Men have also been described as retaining power within the caring relationship, whether or not they are carer, or the cared for, with maintaining a sense of control and previous routine over finances and major decisions [24]. Interestingly, Slagsvold and Sørensen [25] found among Norwegians (40 - 79 years), that women felt less personal control than men. In this study, traditional sex roles and limited opportunities prevented women from occupying positions in society that encouraged the development of a sense of control. Women's poorer physical health and lower education were also related to their lower sense of control. In our sample, women were less educated than men; consequently, level of education may have impacted gender attitudes.

4.2. Difficult to Make Friends and Difficult to Talk About Feelings

Both men and women experienced difficulty in talking about feelings. This finding has also been reported by a

large Norwegian survey (2012) showing that 12% of those 67 years or older have little contact with friends, 9% are without a close friend and 9% have little contact with good friends by phone, email, internet, etc. [26]. The finding is noteworthy considering the majority of adults in our study were married and both genders were lonely. Interpersonal communication is a critical tool for life adjustment at any age. Communication serves as an important role in maintaining affiliation with others. With aging, communication skills may decrease due to physiological changes in hearing, voice and speech processes, and changes in physical health, depression and cognitive decline. These issues may have attributed to difficulties in discussing feelings and making friends. Lack of sharing possibilities may also be influenced by the fact that family responsibility norms are described as being weaker in Norway as compared to countries further south and east of Europe [27]. On the other hand, data from national surveys show that expectations towards grandparent's role are comparatively high in Norway, with 60% of grandparents report taking care of grandchildren at least monthly [28].

From a life developmental perspective, the concept of "life review" has been described as being related to developmental task of later age [29]. Much research has shown that reviewing back has contributed significantly to resolution of past conflicts and injustices and to reconciliation and serenity [30] [31]. Thus, reminiscing and written review could enhance talking about difficult feelings. According to Erikson [9]. Successful resolution of development rests in forming a sense of trust and care for the next generation. In this stage, older people seek ways to give their talents to the next generation, moving beyond self-concerns of identity. Since women felt they had gained wisdom from aging and meant their lives had made a difference, in reviewing back, such positive attitudes could be also be explored also in relation to why they felt unsuccessful in passing on their experiences to others. For older men, who felt strongly that they did pass on such experiences, reviewing could be beneficial not only to themselves but also to identifying ways to strengthen intergenerational connections. This is specifically important because the behavior and life course experiences of older adults' children have been found to be related to their own attitudes to ageing [32]. Life review has also been shown to help create positive attitudes towards ageing, resolve conflicts and generate new perspectives [33] [34].

4.3. Feel Excluded From Activities

Both men and women felt excluded from activities due to their age. In another study, which applied the Attitudes to Ageing Questionnaire among older adults, feeling excluded from activities was also a major finding [35]. Older people who are not satisfied with life or who experience poor health may become more easily excluded [36]. Feelings of exclusion, should be considered in light of other negative attitudes such as lack of friends, talking about feelings and feeling lonely.Such attitudes may result in older adults' feeling less valued, dispensable and as useless members of society [37]. Consequently, encouraging social participation and fostering meaningful relationship is especially important for older adults and could enhance opportunities for new friendships, provide opportunities to share feelings, and help reduce loneliness. Research has suggested that active participation in society by club attendance, volunteering, visiting senior centers, group activities, taking new classes and physical activity contribute to a more positive attitude towards ageing [38]. For older adults who master modern technology, computer and communication technologies have been shown to improve quality of life among older people and provide a valuable means for mental stimulation and social interaction [39].

4.4. Physical Changes

Regarding physical changes, positive attitudes toward activity and exercising played an important role for both genders. Activity limitation is one of the most frequent geriatric clinical syndromes with both individual and societal effects. Importantly, the concept of activity is central to the International Classification of Functioning, Disability and Health (ICF) and is considered vital to successful ageing [40]. Research has shown that age–related changes in physical functioning pose the greatest threat to how people see themselves ageing physically. Activities of daily living, mobility and energy were found to be most important to both women and men's quality of life from 22 centers worldwide [41]. Also, findings from a Norwegian national survey among those 60 years of age and older, found that 13% reported decreases in physical activity [42]. Environmental conditions have also been shown to impact physical activity among Norwegian older adults. Halvorsrud and colleagues found that maintaining physical functioning depended on the accessibility of indoor and outdoor environments in order to perform physical activities among older Norwegian adults [43] [44]. Performing day to day activities is vital in order to enhance energy maintenance and exercise capacity. Consequently, interventions which help

adults maintain physically active lifestyles, in spite of reduced energy, are important in contributing to positive ageing attitudes. Women, in particular, may need extra support in finding physical activities they can master as they experienced to a greater degree more physical problems holding them back from activities. A Norwegian study by Bergland *et al.* [45] found that walking was one of the best forms of physical activity for older Norwegian adults.

4.5. Identity Not Defined by Age

Both genders had positive attitudes toward feeling their identity was not defined by age. Queniart and Charpentier [46]. examined views of three generations of older women and found they refused to define themselves as " older" or "elderly women" largely due to the persistent stereotypes liking old age to dependency, social isolation and fragility. Importantly, in this study, representations of ageing expressed positive values of autonomy, independence, consistency and integrity, maintenance of physical and intellectual health and being socially active. Also, Westerhof and Barrett [47] found in two large surveys, focused on middle age development, that feeling younger than one' actual age was related to higher levels of satisfaction and positive effect and to lower levels of negative effect, even when controlling for sociodemographic variables. Similarly, what age people feel,has been found to be a more sensitive indicator, than chronological age, to many indicators of health, psychological and social characteristics [48]. In a Norwegian study exploring the predictors of subjective age (40 - 79 years), chronological age, good physical health, good mental health, a high level of personal mastery and having lower education significantly was found to predict a youthful subjective age perception [23]. Importantly, feeling younger than one's age has been shown buffering effects on health. For example, Rippon & Steptoe [49] found lower mortality among people who felt three years or younger their actual age. These authors suggested that greater resilience, sense of empowerment and will to live, as well as specific behaviors such as adhering to medical advice might explain the lower mortality rates.

4.6. Positive Attitudes to Ageing

Notably, both genders felt there were many positive things about growing in spite of the fact they acknowledged existing losses and physical changes. Positive attitudes to ageing have been found in other national and international research, but unfortunately, become less visible against existing negative stereotypes of ageing. For example, Bryant *et al.* [50] found among older people 60 and over, that positive attitudes were associated with higher levels of satisfaction, better self-report physical and mental health and lower levels of anxiety and depression, after controlling for confounding variables. Further, better financial status and being employed were also associated with more positive attitudes toward ageing. Previous Norwegian cross-sectional data shows positive attitudes with life satisfaction increases from ages 40 to 80 [51]. These trends can also be corroborated by findings from large Western surveys showing stable or increasing life satisfaction from middle age up until at least age 70 [52]. In another Norwegian study of adults receiving nursing care services, many were found to be very resourceful in spite of the fact they had need for home health services [53]. Such positive attitudes of older Norwegians may be reflective of culture and environmental factors connected to the social welfare system. Health care is publicly available and almost free of charge [54]. However, another interpretation could be that older adults have lower expectations and / or aspirations. Older adults are part of a generation influenced by wars, poverty, food rationing, hard physical work and limited resources. Consequently, they represent a generation who are used to having little and could be presently satisfied with what they have. However, positive emotions could also be related to age-related decline in the processing of negative emotional information, which in turn, may contribute to the reported decline in emotional problems in older people [55]. On the other hand, positive attitudes may reflect older adults' a shift or change in their internal standards, values and conceptualizations of self, representing a way to accommodate psychosocial losses and physical changes and enhance psychosocial well-being [56].

5. Recommendations for Future Research

It is recommended that future studies explore subjective meanings and importance issues given to sources of psychological growth, physical changes and psychological growth in both qualitative and quantitative studies. It would also be interesting to investigate such changes from a developmental theoretical perspective in clarifying

gender differences in what constitutes gains and losses in later life and the relationships between them. Because men and women have different relationship to bodily changes, it would be interesting to investigate similarities and differences in body concerns, and what coping strategies are used to manage these changes, together with considering how societal stereotypes and traditional sex-role stereotypes may contribute to gendered perceptions. Because both genders felt excluded from activities due to their age, qualitative data on exploring what potential meaningful activities men and women regard important to their sense of self should be explored, and how such participation might enhance the sharing of difficult feelings. This theme could also be explored in relation to how sensory abilities and civil status impact these aspects. Lastly, because both men and women felt that their identity was not defined by age and there were many positive things about ageing, it would be interesting to explore how old or young older men and women actually feel in regards to their chronological age and how this perceived age is related to other factors such as health, psychological and social characteristics. Here, both qualitative and quantitative studies with longitudinal perspectives would also enhance understanding of the similarities and differences between genders.

6. Limitations

According to recruitment procedures, the strength of this study rests in the representative sampling techniques which were employed. The older people in the sample consisted of a randomized heterogeneous group of older people living in the community with a wide variety of diseases, representing many geographical areas in Norway. In spite of this strength, several limitations to this study should be noted. There is a lack of representation of older ethnic groups in our sample. Non respondents were not recorded and only a few nursing home residents participated who may represent those most frail. Cognitive problems were not measured with the use of validated scales. Although personal interviews are described as the least burdensome method for collecting data among older adults, they have been shown to be more conducive to more positive and socially desirable responses as compared to survey methods [48]. However, Diener and colleagues [57] demonstrated that social desirability may not be a response artefact, but rather a personality characteristic. Lastly, the use of self-report with the majority of older adults appraising themselves as healthy, may suggest possible response bias. In the future, a mixed-methods approach would offer an opportunity to understand individuals' perceptions of attitudes to ageing with qualitative data. Longitudinal studies on attitudes to ageing are also needed in exploring how gender attitudes remain stable or change over time.

7. Conclusion

Older adults are faced with numerous physical, psychological and social changes that challenge their sense of self. Consequently, old age is often characterized as a period of declining quality of life impacted by negative attitudes. Notably, both genders in this study had positive attitudes toward their ageing, in spite of acknowledging loss with problems of exclusion, making friends and talking about difficult feelings. Identity issues such as identity not being defined by age, not feeling old, aging as a privilege and making a difference, growing in wisdom and passing on benefits to the next generation, as well as the importance of physical activity should be explored in relation to how these issues help counter balance negativity and lead to resiliency and ego strength. Attitudes to ageing are becoming increasingly important in ageing societies. Such positive attitudes should be regarded with importance to health professionals, leaders and policy makers in planning interventions to buffer the detrimental aspects of ageing.

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