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From inactivity to becoming physically active: The experiences of behaviour change in people with serious mental illness

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ABSTRACT

Background: Physical activity (PA) has been found to improve physical and mental health and aid recovery in those with serious mental illness (SMI). However, individuals with SMI conduct less PA than the general population but little is known about how people with SMI adopt PA and what is involved in their behaviour change processes. The aim of this study was to explore individual experiences of PA to elucidate the behaviour change processes of PA in people with SMI who are in recovery. Method: A hermeneutic phenomenological approach was undertaken. Eight active participants (4 male, 4 female) who were in recovery with either bipolar disorder or schizophrenia, were interviewed and their data thematically analysed. Findings: Four main themes emerged which identified behaviour change facilitators when initiating and maintaining engagement in PA. Three themes revealed how participants became more active: 'Not ready to engage'; 'Initial steps to engaging in PA' and 'Becoming more active'. Within these themes, a variety of findings emerged, including: an awareness of the body in existence, a PA enabling environment and feeling real and normal. The fourth main theme, was labelled 'Doing PA', this outlined the experienced acts of PA. The type of PA conducted had different beneficial outcomes on the perceived symptoms of SMI. Individuals developed related PA preferences, which motivated them to continue with those activities. Conclusions: Individuals with SMI could be encouraged to conduct more PA by supporting individually meaningful PA. Strategies are suggested which may help individuals to initially engage in PA, but also to continue engaging in PA by enhancing their PA experience.

1. Introduction

People with serious mental illness (SMI) have poorer quality of life and physical health than the general population and mortality has been found to be reduced by up to 32 years (Walker, McGee, & Druss, 2015, Vancampfort, Knapen, Probst & De Hert, 2010; Narvaez, Twamley, McKibbin, Heaton, & Patterson, 2008). This is mainly due to natural causes and poor cardiometabolic health in this population (Correll et al., 2017; Vancampfort, Stubbs, Mitchell et al., 2015, 2016a; Walker et al., 2015). The increased risk for cardio metabolic syndrome is associated with an unhealthy lifestyle and factors related to treatment, such as the weight gain associated with some medication. Physical activity (PA) has been found to provide many benefits, including an improvement to physical and mental health as well as cognition and quality of life in people with SMI (Bartels et al., 2013; Daumit et al., 2013; Dodd, Duffy, Stewart, Impey, & Taylor, 2011; Faulkner, Cohn, Remington, & Irving, 2007; Firth, Cotter, Elliott, French, & Yung, 2015; Firth et al., 2016a; Richardson et al., 2005; Vancampfort, Knapen, & De Hert, 2009). Furthermore, PA has been found to enhance recovery by rebuilding identity (Carless & Douglas, 2008), mastering tasks, increasing their hope for the future (Soundy et al., 2014) and feeling more autonomous in their daily living (Leutwyler Hubbard, Jeste, & Vinogradov, 2012).

Although there are many benefits to being active in people with SMI, uptake can be low and attrition on PA programmes can be high (Archie, Wilson, Osborne, Hobbs, & McNiven, 2003; Beebe et al., 2010). Furthermore, people with SMI engage in less moderate and vigorous PA lower than the general population and sedentary

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behaviour is higher (Soundy et al., 2013; Stubbs, Williams, Gaughran, & Craig, 2016.; Stubbs, Firth et al., 2016).

A multitude of barriers to PA in this population have been reported, these include the symptoms of the illness, side effects of the medications, social physique anxiety, immediate negative outcomes, negative expectations, misconceptions about PA, lack of resources and the built environment (Rastad, Martin, & Åsenlöf, 2014; Soundy et al., 2014; Vancampfort et al., 2013a). Firth et al. (2016b) carried out a meta-analysis of the motivating factors and barriers to PA in SMI and found that motivating factors include losing weight, improving mood and reducing stress. However, the most prevalent barriers were also low mood, stress and lack of support. Clearly, further research is required to explore how people could be supported to overcome these barriers and engage in PA. This has led to the call for more research on how PA is adopted and maintained (Vancampfort & Faulkner, 2013) and to understand what behavioural processes may improve engagement in PA.

Behaviour change theories which have been considered in relation to PA in people with SMI include the Transtheoretical Model (Gorczynski, Faulkner, Greening, & Cohn, 2010), Health Belief Model (Pheonix, Chong, Mak, Wong, & Lau, 2016), Social Cognitive Theory (Beebe et al., 2010) the Self-Determination theory (Vancampfort et al., 2013b, 2016b., Vancampfort, Stubbs, Venigalla, & Probst, 2015.) and a combination of the transtheoretical model and self-determination theory (Vancampfort et al., 2014). Although related studies have found some significant associations between some of these theoretical constructs and PA, for example self-efficacy (Pheonix et al., 2016; Gorczynski et al., 2010), not all have been found to be significant and some have weak associations. Furthermore, these studies do not explore what happens during PA for the behaviour to be repeated. Research in the general population suggests that affect during PA could be central for maintaining PA (Ekkekakis, 2017). Factors such as intensity of PA (Ekkekakis, Parfitt, & Petruzzello, 2011), attentional focus (Lind, Welch, & Ekkekakis, 2009) and the environment (Thompson Coon et al., 2011) have all been found to be associated with affect. Outlining that the more pleasant the PA is perceived, the better the affect. For example, low intensity PA such as walking is associated with higher affect and therefore PA is more likely to be repeated (Ekkekakis et al., 2011). Individuals with SMI have outlined that they do prefer low − to moderate intensity PA, preferably walking (Subramaniapillai et al., 2016). In addition, moderate PA has been found to be associated with an aesthetically pleasing environment (Vancampfort et al., 2013a). These findings suggest that types of PA and environmental considerations could also be important to engaging individuals with SMI in PA. However, what is not known is what is experienced during PA and how these experiences alter throughout recovery. Exploring these experiences and their interaction with the environment allows a deeper exploration of behaviour change processes and sheds light on what empowers and leads to participation and continued engagement in PA. This in turn would help to develop interventions and to understand how they work, consistent with UK Medical Research Council (MRC) guidance (MRC, 2008).

By taking a phenomenological approach to studying PA experiences, we can begin to explore the interaction of the lived body in the environment and consider the experiences of behaviour change processes.

Only two studies to date have used a phenomenological methodology to explore PA and SMI. Johnstone, Nicol, Donaghy, and Laurie (2009) explored the barriers of PA, and Pickard, Rodriguez, and Lewis (2017) explored the lived experience of PA and mental health through pictures, but there was no focus on behaviour change in these studies.

Exploring the lived experiences of individuals who are participating in PA and who are in recovery (but have been through periods of ill health and inactivity) can provide an insight into how individual's with SMI adopt an active lifestyle and what maintains their involvement. Most of the previous research has focussed on the views of people who are on a structured exercise intervention (Pickard et al., 2017) or a cross-section of people, most of whom were not active (Johnstone et al., 2009; Rastad et al., 2014). As there is high attrition on many structured PA interventions for this population, focussing on a variety of everyday PA, which individuals with SMI have chosen to conduct, may provide more in depth information on the behaviour change processes involved in adopting and sustaining PA. Individuals in recovery are more likely to be able to reflect on and share descriptions of their experiences throughout their illness and recovery. Therefore, highlighting how PA can be encouraged for those who may not be so well. Furthermore, exploring the embodied experiences of PA could provide insight into what is perceived to happen during PA and how this may support recovery and maintain effective behaviour change.

The aim is to explore individual experiences of PA to elucidate the behaviour change processes of PA in people with SMI who are in recovery.

2. Method

2.1. Methodological approach and epistemological perspective

An interpretivist epistemological position, underpinned by van Manen's (1990) hermeneutic phenomenology was employed in this study.

Phenomenology is concerned with the lived experiences of individuals, illuminating the understanding of experiences in the real world (Walton, 2001). Hermeneutic phenomenological research explores how things appear in consciousness and argues that the researcher cannot be separated from the participant, nor their own experiences and beliefs. Therefore, in the current study it is accepted that there are multiple realities of the phenomenon and the findings are our interpretation of PA in those with SMI.

This approach is in harmony with the recovery approach in mental health. The recovery approach outlines that meaningful experiences are central to recovery and these experiences are culturally interpreted by each individual. Therefore, a hermeneutic phenomenological approach is well suited to exploring the meaning of PA in recovery from SMI. van Manen (1990) claims that to help us to explore the lived experiences of individuals, four existentials can be drawn upon which pervade the lifeworlds of all human beings. These existentials are considered in the current study: 'Temporality' (lived time), lived time is the subjective time that we experience rather than the objective measured time; 'Spatiality' (lived space), lived space has little to do with geography and mathematical distances but more to do with 'felt space'; 'Embodiment' (lived body), we experience the world through our body; 'Relationality' (lived relation with others), lived relation is the social self that we are in the space that we share with others (van Manen, 1990).

2.2. Data collection & procedure

Purposive sampling was used. Health Care Professionals (HCPs) such as Community Psychiatric Nurses were asked to identify appropriate participants. HCPs were originally approached by a member of the research team with whom they had a professional relationship. This led to the identification of other HCPs who knew of appropriate participants. The criteria the HCPs were asked to use were as follows: diagnosis of an illness falling under the psychosis umbrella, according to ICD-10; Between the ages of 18–65; not in

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