



Examining the physical health and lifestyle of young people at ultra-high risk for psychosis: A qualitative study involving service users, parents and clinicians



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ABSTRACT

Emerging evidence suggests young people at ultra-high risk for psychosis (UHR) are also at-risk for poor physical health, and display high rates of modifiable cardiometabolic risk factors. However, before we can develop effective interventions there is a need to understand factors affecting lifestyle choices in the UHR group. We conducted semi-structured qualitative interviews with 20 UHR individuals (50% male; mean age 21.7), 5 parents (4 mothers, 1 father), and 6 clinicians from early intervention services in the Northwest of England to identify barriers and facilitators to living a healthy lifestyle, including achieving regular exercise, eating well and refraining from excessive substance use. Thematic analysis revealed the main barriers to living a healthy lifestyle related to psychiatric symptoms, beliefs about self, social withdrawal and practical considerations such as accessibility and cost. Provision of social support and promoting autonomy emerged as the two main themes which would facilitate a healthy lifestyle. Promoting physical health in people with emerging symptoms of psychosis is an important, yet neglected area of mental health practice and warrants further investigation. UHR individuals experience numerous barriers to living a healthy lifestyle, and interventions should focus primarily on targeting autonomous motivation and providing social support to facilitate this change.

1. Introduction

People with psychosis are more likely to live unhealthy lifestyles and experience poor physical health at a young age compared with the general population (Mitchell et al., 2013; Shiers et al., 2015). This results in a 10–25 year reduction in life expectancy, mostly due to cardiovascular disease, (Laursen et al., 2012). Physical inactivity, diets low in nutritional value or high in convenience food, smoking and excessive alcohol or substance use are all examples of unhealthy lifestyle behaviours common in people with psychosis. Emerging evidence suggests this unhealthy profile may begin even prior to the onset of full psychotic symptoms; that is in those at ultra-high risk (UHR) for psychosis (Carney et al., 2016, 2017).

The UHR criteria, also known as prodromal, clinical high risk (CHR), or at-risk mental state (ARMS criteria), enable the identification of individuals at high risk for psychosis (Yung et al., 2003; Yung et al., 1996; Fusar-Poli et al., 2013). In order to meet UHR status, an individual must fulfil one or a combination of the following criteria; attenuated psychotic symptoms, brief limited intermittent psychotic

symptoms (BLIPS), or a genetic risk combined with a recent decline in functioning (Yung et al., 2004). An individual meeting the UHR criteria is at greatly increased risk of developing a first episode of psychosis within 1–2 years compared to individuals in the general population (Fusar-Poli et al., 2012).

In a recent study, unmedicated UHR individuals displayed a higher prevalence of cardiometabolic risk factors compared with age matched controls, including higher blood pressure, increased waist circumference and increased fasting blood glucose (Cordes et al., 2017). A recent cross-sectional analysis of cardiometabolic risk factors in the UHR group also found evidence for low levels of physical activity and poor quality sleep (Lederman et al., under review). High rates of cardiometabolic risk factors can largely be attributed to lifestyle factors observed in this group, such as reduced physical activity, and increased rates of smoking and alcohol abuse (Carney et al., 2016). These behaviours are potentially modifiable. Therefore, the UHR phase represents an important opportunity for early intervention, to prevent future ill-health.

Despite the need for physical health interventions in this group, there remains a paucity of research examining physical health promo-

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tion for young people in the UHR phase. Physical health measures are not routinely monitored in early detection settings (Carney et al., 2015) and there have been no documented physical health interventions for this group. However, before we can develop a feasible, acceptable and potentially efficacious intervention there is a need to understand more clearly why the UHR group have poorer lifestyle profiles compared to individuals who are not UHR (Carney et al., 2016; Carney et al., 2017; Lederman et al., under review). Qualitative research enables us to gain insight into a person's subjective experience of physical health and lifestyle. The limited amount of qualitative studies in this group have focused on functional impairment and experience of symptoms (Byrne and Morrison, 2010; Ben-David et al., 2014) however, this approach has not yet been used to explore the physical health of this group. Therefore, we conducted a qualitative study in order to assess the perceptions of UHR individuals, their families and the professionals who worked with them, regarding factors that prevent or promote them living more healthy lifestyles and how they could be supported to improve their physical health.

1.1. Aims

Using qualitative interviews, we aimed to identify:

- Barriers that UHR individuals face to living a healthy lifestyle.
- Facilitators to living a healthy lifestyle for UHR individuals.
- Support that would be useful to help this group improve their physical health.

2. Methods

2.1. Sample

Sampling was purposive. Eligible participants were aged 16 years or over, were English speakers, and fulfilled at-risk mental state criteria according to the Comprehensive Assessment for At-Risk Mental States (CAARMS; Yung et al., 2005). In line with the National Service Framework for Access and Waiting Time Standards (NHS England, 2016), all individuals were offered cognitive behaviour therapy and mental health monitoring in a specialised early intervention or early detection service in the Northwest of England. Twenty UHR individuals were recruited. Five of their parents, and 6 clinicians from the services also agreed to be interviewed, leaving a total sample size of 31.

2.2. Procedure

East Midlands Derby Research Ethics Committee approved the study (ref:15/EM/0559) which took place between January - December 2016. Clinicians were given study information to pass on to their clients and consent to contact was obtained. UHR individuals were contacted by the lead author (RC) and provided with further information before arranging to meet. Written informed consent was sought from all participants prior to all interviews taking place. After taking part, UHR individuals were asked for their consent to contact a parent to complete a similar interview about their physical health. Clinicians were also contacted again and invited to take part. Participants were reimbursed for their time. Data collection was finalised once data saturation had been reached in the UHR sample and no further parents or clinicians were willing or available to be interviewed.

2.3. Demographic information

Age, gender, ethnicity, marital, vocational and living status and highest educational qualification were recorded for UHR individuals (Table 1).

Table 1
UHR demographics.

Demographic variable	UHR (n = 20), n (%)
Age, mean (sd)	21.7 (5.59)
Gender	Male 10 (50%)
Ethnicity	White British 20 (100%)
Marital status	Single 11 (55%)
	In a relationship (not married) 9 (45%)
Employment status	Full-time employment 2 (10%)
	Part-time employment 2 (10%)
	Student 10 (50%)
	Unemployed 6 (30%)
Highest qualification	Undergraduate degree 3 (15%)
	A-level 6 (30%)
	GCSE 4 (20%)
	BTEC 5 (25%)
	NVQ Level 2 1 (5%)
	No qualifications 1 (5%)
Living status	Lives on own 3 (15%)
	Lives with family 9 (45%)
	Lives with partner 3 (15%)
	Lives with friends 5 (25%)

2.4. Qualitative interviews

A qualitative design was employed using semi-structured interviews. Topic guides were developed by the study team based on previous research (Carney et al., 2016; Bradshaw et al., 2012) (available on request). Semi-structured interviews were conducted by the lead author and covered a range of pre-specified topics regarding participant's lifestyles. Interviews consisted of questions about diet, exercise, alcohol and tobacco use as well as questions about barriers and facilitators to living a healthy lifestyle. Interview schedules were adapted to be appropriate for the three groups of participants, and lasted up to 1 h. Interview guides were flexible using prompts and open questions to encourage participants to talk in depth about their perceptions and experiences. All interviews were digitally recorded and transcribed verbatim for analysis. Participants were assigned pseudonyms to maintain anonymity.

2.5. Qualitative analysis

The current study had several pre-specified areas of interest relating to identifying barriers and facilitators to living a healthy lifestyle. A thematic approach was taken to analyse the data in order to identify key themes for each topic. Thematic analysis is a systematic approach whereby patterns and common themes are identified to describe a data set and understand a given phenomenon (Braun and Clarke, 2006). Despite having pre-specified areas of interest, we adopted a bottom up approach to identifying recurring themes in the data. This was conducted according to the method specified by Braun and Clarke (2006):

1. Transcripts were read and re-read to familiarise the researchers with the data
2. Systematic line by line coding to identify common features in the data
3. Codes were reviewed to determine potential themes
4. Themes were reviewed for internal homogeneity and external heterogeneity and ensure they were coherent and distinctive
5. Themes were defined and names generated for each

To reduce the risk of bias, all researchers were involved in the analytic process and codes and themes were discussed throughout. Quotes presented within the results section are used to illuminate the findings and add context to each theme. The perceptions of all three groups were synthesised to identify overarching themes and factors

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