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When you don't get what you want—and it's really hard: Exploring motivational contributions to exercise dropout

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ABSTRACT

Objectives: Dropout is a pervasive, yet understudied phenomenon in exercise behaviour. The purpose of this study was to explore the perceived individual, behavioural, and environmental influences experienced by 35–65-year-old adults who dropped out of a structured exercise programme.
Design: This research took a qualitative description approach, with social-cognitive theory providing a guiding framework.
Method: Semi-structured interviews were conducted with 17 participants (13 females and 4 males), with an average age of 49 years (*SD* = 6.8). The interviews were audio-recorded, transcribed verbatim, and analysed using qualitative content analysis.
Results: Findings are represented by four themes: (1) feeling good but disappointed, (2) scheduling issues, (3) trouble prioritizing exercise, and (4) exercising for/with someone else.
Conclusions: These themes highlight the fragile nature of motivation for exercise. It seems the decision to continue exercising depends on a deliberate weighing of benefits against barriers. Unrealistic outcome expectations, low scheduling self-efficacy, and an unmet desire for social support and accountability can all influence this process in favour of drop out.

1. Introduction

Initiation and maintenance of exercise is key for 35-65-year-old adults, a time when adults begin to show early signs or even established symptoms of chronic disease (Public Health Agency of Canada, 2016). In fact, rates of chronic disease are rising faster in 35–64-year-old Canadians than for those over the age of 65 (Elmslie, 2012). This age range also encompasses the "sandwich generation" (those supporting children and also caring for their parents), a designation that has been associated with increased health problems (Do, Cohen, & Brown, 2014). Many studies have been conducted with a focus on exercise adherence in one specific population, such as menopausal women, cancer survivors, or individuals with Type 2 diabetes (e.g. Casey, De Civita, & Dasgupta, 2010; McArthur, Dumas, Woodend, Beach, & Stacey, 2014); however, there is a lack of research examining exercise adherence and non-adherence within the general population at this stage of life. The public health and economic impact of preventing or reducing the impact of chronic diseases in this age group is significant, making this an appropriate focus of study (Elmslie, 2012).

A large body of research focuses on exercisers' perceived barriers to adherence. Recently, a systematic review was conducted to determine factors that interfere with adherence to exercise referral schemes in the UK (Morgan, Battersby, Weightman, Searchfield, Turley, et al., 2016). The authors reviewed 33 studies (24 of which were qualitative) published between 1995 and 2013 that examined barriers to exercise programmes experienced by sedentary adults. Some common personal barriers identified included not enjoying the prescribed activities, lack of comfort with using gym equipment, and the fear of injury or exacerbation of an existing condition. Participants described the challenge of needing to fit sessions around their work schedules, but finding that times before/after work were normally busiest at the gym and, therefore, too intimidating or too crowded to complete their exercises. These data were collected from participants who completed the prescribed exercise programme, and it is possible that some of these same barriers caused others to drop out of the programmes completely. However, there may be other influences also at play, including different types of barriers, (e.g. winter weather, lack of social support), or particular combinations of personal factors (e.g. disappointment with a lack of weight loss) and external factors (e.g. busy season at work) that lead to drop out.

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Bandura (2004) notes that perceptions of barriers are influenced by self-efficacy. Defined as the belief in one's capabilities to execute a specific behaviour, self-efficacy has been ranked as one of the strongest predictors of physical activity (van Stralen, De Vries, Mudde, Bolman, & Lechner, 2009). Self-efficacy receives a good deal of attention from researchers due to its primacy in social-cognitive theory (SCT; Bandura, 1986) and presence in other theories of health behaviour (e.g. theory of planned behaviour; Ajzen, 1991). Bandura also proposes that self-efficacy will not predict behaviour in the absence of necessary skills and incentives. According to SCT, the expected outcomes of a behaviour and the value placed on those outcomes provide an incentive for performing the behaviour (Bandura, 1986; Rodgers & Brawley, 1996). If a behaviour does not result in the expected outcomes, or if environmental barriers are more pronounced than environmental facilitators, behavioural cessation may occur even though self-efficacy is strong. It is also possible that self-efficacy strong enough to initiate behaviour is either mistaken (i.e., overly optimistic) or insufficient to maintain behaviour. A qualitative exploration of the exercise experience of dropouts can provide in-depth insights into these possibilities.

A phenomenological investigation of men and women's exercise experiences at a small gym in England uncovered differences between adherers and nonadherers. While adherers were inspired and motivated by seeing very fit exercisers at the gym, nonadherers were intimidated and turned off. All participants described habit as necessary for adherence, but some of the adherers describing dedication to exercise that was akin to addiction, taking priority over significant others and employment (Pridgeon & Grogan, 2012). However, these participants were childless, mostly in their twenties, without the responsibilities and challenges associated with being in the "sandwich generation." Another qualitative study investigated differences between women who continued exercising and those who did not, after completing a 12-week physical activity intervention (Huberty et al., 2008). They found that adherence or non-adherence to exercise was related to participants' self-worth. Nonadherers described feelings of self-doubt, negative self-talk, poor body image, worries about how others perceived them, as well as guilt over their lack of exercise. In contrast, adherers displayed more positive body image and also had less traditional views about the role of women, which made them more likely to prioritize exercise in the face of competing responsibilities at home and within their families (Huberty et al., 2008). Finally, Kinnafick, Thøgersen-Ntoumani, and Duda (2014) conducted interviews with women before, during, and after a 16-week walking intervention, and analysed their findings within a self-determination theory (SDT; Deci & Ryan, 1985) framework. Psychological need satisfaction emerged again as a key factor in distinguishing between those who adhered to the intervention and those who did not, as did internalized motivation.

It has been estimated that about 50% of people who begin exercise programmes stop participating within the first six months, thus missing out on important health benefits (Biddle & Mutrie, 2008). Dropout in exercise is very difficult to study because, once people drop out of a research project, they are reluctant to engage with the researchers. It is difficult to determine whether participants dropped out of the research, the exercise, or both. This tends to limit our understanding of dropout to a single point-in-time occurrence when it might be a developmental process with predictable antecedents. A more comprehensive study of dropouts might yield a stronger understanding of how motivation failed to develop (or more specifically, how the 'right kind' of motivation failed to develop) or how behavioural attempts might have been thwarted. The qualitative studies described above added valuable insights to the literature, but further exploration is needed into the perspectives of men and women in middle adulthood who have dropped out of structured exercise programmes. It is also important to examine dropout in more realistic settings, rather than in the context of interventions that specifically target motivational components. Because SCT includes consideration of perceived individual, behavioural, and environmental influences on behaviour, it is helpful in furthering our understanding of dropout from exercise. The purpose of this study was to explore the perceived individual, behavioural, and environmental influences experienced by 35–65-year-old adults who dropped out of a structured exercise programme.

2. Method

This research was guided by a qualitative description approach, as delineated by Sandelowski (2000). A key feature of this approach is the summarization of information about a phenomenon in plain, everyday language. It is less interpretive than other qualitative approaches, with language being seen as a form of communication, not a structure to be analysed. Another term used to describe this approach is "data-near"—findings are not transformed to the same extent as one might see in grounded theories or narrative inquiries (Sandelowski, 2010). This process of staying near to the data allows for "largely unadorned" answers to questions relevant to practitioners and policy makers—such as how to prevent dropout from exercise (Sandelowski, 2000, p. 337). This does not mean that this research approach lacks depth; on the contrary, resulting themes are often detailed and nuanced. Qualitative description has been used successfully to better understand complex and understudied phenomena in exercise, sport, and physical activity (e.g. Barnett, Guell, & Ogilvie, 2013; Coppola, Dimler, Letendre, & McHugh, 2017; Figgins, Smith, Sellars, Greenlees, & Knight, 2016).

2.1. Theoretical framework

In qualitative research, theory may be used in a variety of ways. According to Sandelowski (1993), theory may serve as the impetus or rationale behind a project, it may arrive as the result of the project, or it may be brought in towards the end to aid in organizing and interpreting findings. While qualitative description is one of the least theoretical qualitative approaches, Sandelowski (2010) notes that it is impossible to put aside theoretical leanings and approach a study naively, without preconceptions. Rather, researchers need to acknowledge their starting point and be ready and willing to move away from it if necessary. The first and second authors, who were responsible for the analysis, are PhD candidates with a strong interest and background in SCT and self-determination theory (SDT; Deci & Ryan, 1985). In the present study, SCT provided a basis for the overall study design, with a focus on individual, behavioural, and environmental influences in an exercise context. As well, SCT informed the types of questions included in the interview guide. However, because there is little qualitative research dealing with dropout from exercise, we decided to analyse the data inductively, rather than focusing solely on SCT constructs. SCT was then brought in again as a guide to support the interpretation of findings.

2.2. Procedures

Recruitment began after obtaining approval from the authors' university research ethics board. The first author contacted potential participants by email and/or phone. Participants were eligible for this study if they were between the ages of 35 and 65, and had dropped out of a larger study involving a one-year structured exercise programme. Exclusion criteria comprised dropout due to major health events (i.e. a cancer diagnosis) or moving away. As part of the programme, 35-65-year-old non-exercisers were recruited from the community (using newspaper ads, posters, and email listservs) and asked to exercise three times per week at a monitored fitness facility on a university campus. Participants had free access to this facility for as long as they were involved in the study. They were informed that missing three weeks of scheduled exercise would constitute dropout from the study and would thus end their access to the facility.

Participants either had no health conditions precluding participation in exercise, as assessed by a PAR-Q, or were asked to have a physician complete a ParMed-x form as permission to exercise while