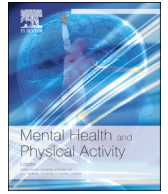




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## The barriers to participation in leisure time physical activities among Iranian women with severe mental illness: A qualitative study

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## ABSTRACT

**Background and objectives:** Sedentary behavior and physical inactivity are known risk factors for poor health and increased mortality in patients with severe mental illness. Identifying the barriers to participation in leisure-time physical activities among these patients can be helpful in planning effective interventions aimed at increasing activity level. Prior to the present study, the barriers experienced by female patients in Iran were unknown.

**Materials and methods:** This was a qualitative study using conventional content analysis. Participants were 32 women with severe mental illness who were hospitalized at women's psychiatric wards of Farabi Teaching Hospital in Kermanshah, Iran, from September 2015 to March 2016. Data were collected through four focus group discussion sessions and were then analyzed.

**Results:** Participants had a mean age of 42 ( $SD = 7.8$ ) and an active diagnosis of schizoaffective disorder ( $n = 10$ ), schizophrenia ( $n = 8$ ), a chronic bipolar disorder ( $n = 8$ ), or major depression disorder ( $n = 6$ ). Two main barrier categories emerged: Personal experience of disease and Non-supportive context. Within the former, stigma of disease, signs and symptoms of disease, and medication side effects were the constituent subcategories. Non-supportive context subcategories consisted of family, cultural, environmental, and medical staff barriers that influenced non-participation in leisure-time physical activities. **Conclusion:** Iranian women with severe mental illness face a number of barriers to participation in leisure-time physical activities including the stigma, symptoms, and treatment of mental illness; and contextual barriers such as family expectations, societal perceptions, environmental factors, and lack of medical staff support. It is recommended that providers consider these factors when developing therapeutic plans for similar patient populations.

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### 1. Introduction

Patients with severe mental illness (SMI) such as schizophrenia, schizoaffective disorder, major depression, and chronic bipolar disorders have poorer physical health and a reduced life expectancy (i.e., 20–30% lower) when compared to the general public (Colton & Manderscheid, 2006; Daumit, Pratt, Crum, Powe, & Ford, 2002). Rates of mortality, due to all causes, and suicide are also elevated among individuals diagnosed with a mental illness (Chesney, Goodwin, & Fazel, 2014). Walker, McGee, and Druss (2015)

reported that 8 million deaths each year can be attributed to mental illness. Studies suggest that the increased mortality rate in these patients is not solely due to higher risk of suicide; rather, cardiovascular diseases (CVD), such as myocardial disease, are among the most common causes of mortality in this group (Miller & Bauer, 2014; Ringen, Engh, Birkenaes, Dieset, & Andreassen, 2014).

Researchers have reported that CVD accounts for 40–50% of deaths among individuals diagnosed with schizophrenia (Ringen et al., 2014), and 35–40% of deaths among individuals diagnosed with a bipolar disorder (Miller & Bauer, 2014). Factors such as obesity, tobacco smoking, diabetes, hypertension, lack of physical activity, the use of second-generation antipsychotic medications (associated with the risk of weight gain and metabolic syndrome), and the lack of access to health systems contribute to the higher risk of CVD among individuals with SMI (Baxter, Charlson, Somerville, & Whiteford, 2011; Carliner et al., 2014; Scott,

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Platania-Phung, & Happell, 2012). Concerns about the physical health of these patients have prompted the creation and implementation of lifestyle interventions that have become one of the pillars of the recovery process (Silverstein & Bellack, 2008). Participation in physical activities, weight control, healthy and balanced diets, and participation in health-promoting activities are the main components of these interventions (Fernández-San-Martín et al., 2014; Verhaeghe, De Maeseeneer, Maes, Van Heeringen, & Annemans, 2011). The present study focuses on physical activity in particular.

Multiple categories of physical activity have been identified, including occupational physical activity (i.e., activity completed in the course of one's occupation), incidental activity, commuting activity, and leisure-time physical activity (LTPA), which is the focus of the present study. LTPA includes all forms of aerobic activities, structured endurance exercise programs, resistance-training programs, and sports (Howley, 2001). LTPA is considered a main component of a healthy lifestyle and its positive health effects (i.e., improved cardiovascular function, increased respiratory capacity, weight control, depression prevention, and reduced psychiatric symptoms (Hamasaki, 2016; Takahashi et al., 2012) have been demonstrated. As suggested above, evidence indicates that patients with SMI tend to have sedentary lifestyles and experience significant barriers to participation in LTPA (Faulkner, Cohn, & Remington, 2006; Vancampfort, Probst, Knapen, Carraro, & De Hert, 2012b; Vancampfort et al., 2011), despite evidence that exercise is safe and improves health outcomes among individuals with SMI (Mason & Holt, 2012; Richardson, Avripas, Neal, & Marcus, 2005; Stanton & Happell, 2014).

Several researchers have investigated the reasons for inactive lifestyles among patients with SMI. Roberts and Bailey (2011) conducted a narrative review of quantitative, qualitative, and mixed method studies, and reported that lack of support, symptom illness, treatment effect, and negative staff attitudes are common barriers. Vancampfort and colleagues (2012a) also reported that side-effects of antipsychotic medications, negative psychiatric symptoms, lack of knowledge about cardiovascular risk factors, disbelief in the positive effects of physical activity, and social isolation reduce physical activity among individuals with SMI. Recently, Firth et al. (2016) conducted a meta-analysis of motivating factors and barriers to exercise among patients with SMI. Low mood, stress, and lack of support were the most common barriers. The authors concluded by emphasizing the critical role of providers in reducing barriers and maintaining patient motivation (see also Soudy, Kingstone, & Coffee, 2012).

Research on barriers to LTPA is critical for the development of effective interventions, yet to the best of our knowledge, no studies to date have been conducted in Iran as *per* the review of reliable databases (i.e., Pubmed, Google scholar, Ovid, and Iran doc). Given the unique cultural influences experienced by patients and providers in Iran, research into this area is necessary. Further, females experience unique socio-cultural barriers, thus research focusing on women is warranted (Joseph, Ainsworth, Keller, & Dodgson, 2015; Persson, Mahmud, Hansson, & Strandberg, 2014). Lastly, the use of qualitative methods are well suited for capturing and exploring barriers to participation because non-participation in LTPA is a subjective experience that can be affected by many factors. Therefore, the present study was conducted using a qualitative approach to elucidate the barriers to participation in LTPA among females with SMI being treated in Iran.

## 2. Methods

### 2.1. Study setting and participants

Participants ( $N = 32$ ) consisted of adult females diagnosed with

SMI being hospitalized in the women's psychiatric wards of Farabi Teaching Hospital in Kermanshah, Iran, from September 2015 to March 2016. At this hospital, patients are admitted for treatment during periods of acute symptom presentation for a maximum of 2 months. Patients return to their respective communities after remission. Individuals were recruited using purposeful sampling and sample size was based on the principles of data saturation (Palinkas et al., 2015). The inclusion criteria consisted of a diagnosis of SMI made by a psychiatrist based on a set of psychiatric evaluations, willingness to participate in the study, and stabilization of psychiatric symptoms (i.e., the symptoms of illness had subsided and the patient was ready for discharge as confirmed by the psychiatrist). The exclusion criteria consisted of having received electroconvulsive therapy in the past three months because it can interfere with recall, symptoms of paranoia because they can impact group attendance/participation, and debilitating medication side effects (i.e., alogia, dizziness and drowsiness) that can interfere with active participation. It is estimated that approximately 40 patients were excluded, though the exact number was not recorded. Table 1 presents participant demographic characteristics.

This research was carried out with the approval of the research council of Kermanshah University of Medical Sciences after obtaining permission from the ethics committee of the university. The participants were given full and clear explanations about the study objectives and the confidentiality of their data/identity. All participants provided their verbal consent to the researcher.

### 2.2. Data collection

Data were collected through focus group discussion sessions held in the women's ward's occupational therapy unit. Focus group discussion is a qualitative data collection method that leverages group dynamics to promote a candid discussion of topics (Napolitano, McCauley, Beltran, & Philips, 2002). In this study, four focus group discussion sessions were held, each with 8 participants in attendance. The first author, who had sufficient experience in holding focus group discussions, facilitated these sessions.

At each meeting, the participants were first briefed on the study objectives, the group members were introduced to each other, and questions were then posed in accordance with the research objectives. These questions had already been established by the

**Table 1**  
Participants' demographic characteristics.

Variable	<i>N</i>
Age	42 ( <i>M</i> ; <i>SD</i> = 8.7)
Duration of Illness (years)	9 ( <i>M</i> ; <i>SD</i> = 2.1)
Marital Status	
Single	8
Married	17
Divorced	7
Education	
Illiterate	7
Primary school education	5
Below high school diploma	12
High school diploma	4
Advanced diploma and above	4
Occupation	
Housewife	22
Corporate employee	3
Unemployed (Non-students)	7
Diagnosis based on the Patient's Records	
Schizophrenia	8
Schizoaffective disorder	10
Chronic bipolar disorder	8
Major depression	6

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