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Social Support For and Through Exercise and Sport

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Published as: Carless, D. & Douglas, K. (2008). Social support for and through exercise and sport in a sample of men with serious mental illness. *Issues in Mental Health Nursing*, 29, 1179-1199.

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Abstract

Social support is important for people experiencing serious mental illness and is also important during the initiation and maintenance of exercise. In this article we draw on interpretive research into the experiences of 11 men with serious mental illness to explore four dimensions of social support both *for* and *through* exercise. Our findings suggest that informational, tangible, esteem, and emotional support were both *provided for* and *given by* participants through exercise. We conclude that experiences of both receiving and giving diverse forms of support in this way are significant for some people living with and recovering from serious mental illness.

Keywords: social support, mental health, serious mental illness, recovery, physical activity

Social Support For and Through Exercise and Sport

In his review of research which has examined the effects of exercise on mental health and well-being, Callaghan (2004) concluded that exercise may be a neglected intervention in mental health care. Callaghan reported that existing research suggests exercise reduces anxiety, depression, and negative mood while improving self-esteem and cognitive functioning. He also noted that regular exercise can provide numerous physical health benefits (see Department of Health, 2004). Broadly positive conclusions have also been drawn concerning the therapeutic potential of exercise for people with serious mental illness¹ in several more recent studies (Beebe, Tian, Morris, Goodwin, Allen, & Kuldau, 2005; Carless, 2007, in press; Carless & Douglas, 2004, 2007, in press; Carless & Sparkes, 2007; Fogarty & Happell, 2005) as well as in recent reviews of the exercise and mental health literature (Carless & Faulkner, 2003; Faulkner, 2005; Saxena, Van Ommeren, Tang, & Armstrong, 2005; Stathopoulou, Powers, Berry, Smits, & Otto, 2006). Callaghan (2004) goes on to observe however that “there is little or no mention of exercise as a treatment option in most standard mental health/illness texts or reports published by authoritative groups in mental health” (p. 481). We suggest that his conclusions, alongside those of other recently published work, provide some good reasons why psychiatric and mental health nurses might consider, for some clients at least, offering exercise activities alongside more commonplace interventions.

Supporting Exercise Participation in Mental Health

A key ingredient in any successful exercise programme in mental health settings is effective social support. Social support is widely recognised as an important factor in recovery (e.g., Corrigan & Phelan, 2004; Davidson, O’Connell, Tondora, Lawless, & Evans, 2005) and, as Anthony (1993) has observed, “most first-person accounts of recovery from catastrophe (including mental illness) recount the critical nature of social support” (p. 22). Social support is also an important factor in successful exercise initiation and maintenance among the general population as well as people referred to exercise programmes on the basis of physical health concerns (Crone, Smith, & Gough, 2005). Among people with serious mental illness, the provision of adequate social support has been documented as a fundamental requirement for initiation and sustained participation (Carless, 2007). As Carless (2007) notes, “the symptoms of mental illness combined with the side-effects of anti-psychotic medication make the initiation and maintenance of new activities such as exercise challenging for mental health service users and mental health professionals alike” (p. 18).

In recognition of these challenges, Richardson, Faulkner, McDevitt, Skrinar, Hutchinson, and Piette (2005) emphasise the need for exercise leaders to be skilled providers of social support. As these authors put it, “enthusiastic, knowledgeable, and supportive exercise leaders are as important as the actual exercise prescription itself” (p. 327). In a similar vein, through focus group research with outpatients in psychiatric rehabilitation, McDevitt, Snyder, Miller, and Wilbur (2006, p. 53) identify three ways in which support can help individuals overcome the barriers to regular physical activity: (i) *motivational leadership* in the form of “the right kind of leader, someone who would believe in them and that they could do it”; (ii) *relevant information* which “participants noted could ‘give you the drive to do things’ if they understood how following health recommendations could help”; and (iii) *group support, individual options* through provision of group activities which increase motivation and fun without sacrificing individual choice and flexibility.

In our view social support is likely to be a prerequisite for successful exercise initiation and maintenance for most people. Little research currently exists, however, to provide guidance for psychiatric and mental health nurses concerning how social support may be most effectively offered to people with mental health problems who wish to become involved in regular exercise. Specifically, we still do not know much about the qualities of effective and helpful social support in the context of exercise and mental health.

A Multidimensional Model of Social Support

Rees and Hardy (2000) propose a multidimensional model of social support through which they identify and define four distinct forms of social support. Rees, Smith, and Sparkes (2003, p. 137) describe these four dimensions of social support as: (i) *informational support*, “providing the individual with advice or guidance concerning possible solutions to a problem”; (ii) *tangible support*, “concrete instrumental assistance, in which a person in a stressful situation is given the necessary resources (e.g., financial assistance, physical help with tasks) to cope with the stressful event”; (iii) *esteem support*, “the bolstering of a person’s sense of competence or self-esteem by other people. Giving an individual positive feedback on his or her skills and abilities or expressing a belief that the person is capable of coping with a stressful event are examples of this type of support”; and (iv) *emotional support*, “the ability to turn to others for comfort and security during times of stress, leading the person to feel that he or she is cared for by others.”

To date, the model has provided insights into the social support needs of spinal cord injured (SCI) men (Rees et al., 2003) and elite sportspeople (Rees & Hardy, 2000). For example, Rees and colleagues (2003) have drawn conclusions concerning the way in which

different types of social support are valued at different times, from different persons (i.e., medical professionals, family members, friends, carers), and with differing results. In addition to providing insights into the support needs of men with SCI, these findings provide valuable guidance for health professionals who wish to provide the most effective and constructive support for men who have experienced SCI. Similarly useful practical implications are also apparent in Rees and Hardy's (2000) work in the context of the support needs of elite sportspeople. On this basis, we suggest that an exploration of this multidimensional model of social support has the potential to provide useful insights to assist psychiatric and mental health nurses in planning and providing effective social support for people with mental health problems who might consider engaging with exercise or sport.

The Purpose of this Study

The purpose of this study was to explore, in the context of exercise and serious mental illness, the multidimensional model of social support proposed by Rees and Hardy (2000). To do so, we utilised an interpretive approach incorporating some principles of ethnographic research. According to Quimby (2006), this approach has the potential to "provide understanding of the perspectives of participants and targeted groups from their points of view and based on their structural conditions and cultural dynamics" (p. 860). It is also, Quimby notes, an effective way to "generate information useful for developing or informing hypotheses, theories, and intervention models" (p. 860). With these points in mind, we sought to elicit participants' accounts of the ways in which they experienced social support in the context of their involvement in exercise or sport and augmented this data through participant observation and supplementary interviews with mental health professionals. Through analysis of these narrative materials, we aimed to: (i) explore the relevance of each form of social support to exercise and sport participation in the context of serious mental illness; and (ii) provide examples of how diverse support processes take place.

Method

Participants

The participants were 11 men² aged between 24 and 43 who had been diagnosed with a serious mental illness. Participants were identified on the basis of: (i) their willingness to take part in the research; (ii) mental health professionals' assessment that the individual was sufficiently mentally well to participate³; (iii) their personal experience of both serious mental illness and exercise/sport participation. Participants were involved in a variety of exercise or sport activities which included golf, five-a-side football (soccer), badminton, tennis, swimming, walking groups, gardening, gym-based exercise, and running. The rehabilitation

centre had its own rudimentary gym containing an exercise bike, rower, and treadmill; all other activities took place in community facilities. Mental health professionals were closely involved in each activity session in an organisational capacity and followed professional guidelines for safe working practice. Two participants also independently took part in community-based exercise activities (running and gym-based exercise). The research received ethical clearance from the local NHS Trust research ethics committee, all participants provided informed consent, and to protect anonymity all are referred to by a pseudonym.

Procedures

Drawing on the principles of ethnographic research, three methods of data collection were utilised in an effort to gain a rich and comprehensive understanding of the background and context of each participant's experiences. These methods were: (i) *Participant observation*. During sport and exercise activities and day-to-day life at the rehabilitation centre field notes were independently compiled by both authors to document observations, interpersonal exchanges, and personal reflections; (ii) *Interviews and focus groups with mental health professionals*. To augment and enrich our understanding and to explore alternative perspectives, we conducted 7 interviews and 3 focus groups with 7 mental health professionals (a clinical psychologist, a senior physiotherapist, two care workers, two occupational managers, and an exercise leader) who worked with and knew the participants well; (iii) *Semi-structured interviews*. The primary form of data collection was semi-structured interviews with the participants. A total of 16 interviews were conducted and each participant took part in between one and three interviews each lasting from 20 to 90 minutes in duration. Participants were invited to talk about: (i) their experiences in and through sport and exercise; (ii) particularly memorable sport or exercise-related moments; (iii) their previous sport and exercise involvement; (iv) any ways in which sport or exercise affected them. Where necessary, the interviewers used prompts and clarification questions to further explore issues the participants raised. The interviews were conducted within the familiar settings of the day centre or physical activity venue and were audio recorded and transcribed verbatim with the exception of an interview with one participant who did not want a tape recorder to be used.

Analysis

The first stage of analysis involved both researchers engaging in several close readings of the interview transcripts and field notes to become immersed in the data. Next, we conducted a content analysis using quotations as the unit of analysis (Sparkes, 2005) and following the process described by Lieblich, Tuval-Mashiach, and Zilber (1998) as

categorical-content analysis. One approach to this kind of analysis allows themes to be developed from the data in an inductive manner without reference to existing theory or previous research. The findings of these types of inductive analyses have been published elsewhere (see Carless, 2007; Carless & Douglas, 2004). While an inductive approach boasts many strengths (see Bluff, 2005), it is not well suited to the exploration of the ways in which existing theory might operate within different contexts. In order to make theoretical assertions of this kind, Bluff (2005) suggests that a deductive approach to data analysis is at times also necessary. This kind of analytical approach permits concepts derived from theory to be applied to the data in order to explore the ways in which predefined themes were manifest (Rees et al., 2003). A key strength of this approach is that it allows an explicit focus on pre-determined theoretical issues while a key weakness is that, by implication, it therefore fails to explore issues beyond the confines of the pre-determined theoretical focus. Given that issues outside social support were *not* the focus of this study, we deemed a deductive analysis to be appropriate for this investigation.

In conducting this analysis, we focussed exclusively on sections of text (from interview transcripts and field notes) in which reference was made to the experience of receiving/giving support from/to others. Having identified sections of text which made reference to support, we then analysed each quotation in turn in order to deduce the type/s of social support that was being described. To do so, we continually referred to the definitions of informational, tangible, esteem, and emotional support provided earlier and compared the content of each excerpt to each of these definitions. Through this process we were able to assign each quotation to one of the four dimensions of social support. In order to check our interpretations throughout the analysis process, regular team meetings took place between the authors which allowed us to reach consensus in terms of the assignment of each excerpt to a particular dimension of social support.

Criteria for Rigor

Four criteria for rigor for qualitative research in nursing settings, proposed by Leininger (1991), are appropriate for this study: (i) *credibility* refers to the accuracy and believability of the informants' accounts. Credibility was suggested by (a) participants' personal first hand experience of the phenomena (exercise in the context of serious mental illness) and (b) mental health professionals personal experience of practising in the context of exercise and mental health; (ii) *confirmability* refers to the availability of repeated, direct, and documented evidence alongside repeated explanations from informants concerning specific phenomena. Consistency between participants' accounts of their experiences, the perceptions

and observations of mental health professionals shared during interviews and focus groups, and the two researchers' independent field notes (which document periods of participant observation) provide evidence of confirmability; (iii) *recurrent patterning* in terms of instances, sequences, or experiences that recur over time was evidenced by a degree of shared or common experience within participants' accounts; and (iv) *saturation* was suggested by the identification of no alternative forms of social support through the analysis process.

Findings

In what follows, we address each of the four types of social support in turn. To illustrate the role of each form of social support, and the ways in which it was experienced and enacted, we provide illustrative exemplars taken from the transcripts of interviews with participants and mental health professionals as well as excerpts from our reflective field notes.

Informational Support

Informational support was usually the first form of support to be offered most often on a one to one basis and typically before an individual became involved in a particular sport or exercise activity. In this guise, social support was provided for potential exercisers through the provision of information about the benefits of the exercise which might be relevant to the individual's needs. The information provided was usually simple and practical as one participant's description of how he began an exercise programme suggest: "They [two physiotherapists] made a programme for me and I started ... I think they asked me what I wanted to do, but they just told me what was available and what I could fit in, like a school programme". One physiotherapist described how she provided initial informational support:

Well what we do with everybody who comes is I just sort of go and have a chat with them and I've got a, I showed you it before, a fit to begin questionnaire and go through that with each person and see if they want to join in any sports groups or use the exercise equipment here.

As this excerpt illustrates, the purpose of this initial informational support was to present the activity as possible, potentially beneficial, and personally relevant in some way. Through raising awareness of the potential benefits of the activity, informational support helped generate participants' interest and motivation to get started with a particular exercise or sport activity.

Informational support was also in evidence during activity sessions in the form of teaching which helped individuals make progression by improve their own skills and technical knowledge. Participants generally valued this support as the following remarks from three members of a golf group illustrate:

Interviewer: What about the teaching ... has that been a good thing or would you rather you didn't get that?

Chris: Yeah, it's been quite helpful. I wouldn't have figured out on my own about keeping your arm straight, and the way to hold the club. So I think it's helpful. Just want a few tips and then try them out.

Interviewer: Can you just tell me about the teaching, particularly, that you received?

Harry: Yeah. It was very good tuition actually cause it helped me improve my driving shots.

Interviewer: The teaching, has that been helpful to you?

Andrew: It has yeah (pause). There are certain things I couldn't, there's only one thing I couldn't handle, and still can't, that's to do with the small finger.

In addition to the participants' accounts of the value of teaching, mental health professionals added their observations that informational support of this type had contributed to group members achieving success as the following excerpt illustrates:

I think the people that played before improved their game somewhat because of the tuition and perhaps looking at some things that they've never thought of before. But also the people that had never played before had an opportunity and they found that they could do it and I think that was an achievement for some of them as well, people that perhaps had never picked up a golf club could actually do it.

The provision of personally relevant and accessible informational support through appropriate teaching input seemed to be important as it provided participants with practical strategies which allowed them to improve their ability and skills and, subsequently, increased their confidence and enjoyment of the activity.

Significantly, was also noted how informational support was not only given *to* participants *by* a health professional but also *shared between* participants. We noted several occurrences where participants provided informational support to each other through, for example, talking about a particular problem or temporarily assuming the role of "teacher" by providing technical input to another group member. This type of sharing was observed by one care co-ordinator who described how one of her clients gained informational support concerning financial issues such as managing his credit card, through talking with others he knew through playing football. At times, informational support was provided *by* a participant *for* a mental health professional. One mental health professional described how William (a client) helped Julian (a mental health professional) with his golf: "Last week he [William]

played with Julian and was coaching him all the way round. So he was in his element ‘cause ultimately that’s what he wants to do. It worked out really well.” This two-way sharing – giving and receiving – of informational support is, we suggest, potentially significant but has not been explored in previous research. It is a point to which we will return later.

Tangible Support

Tangible support had a simple but powerful effect on involvement in and exercise sport activities. Its importance was most clearly evidenced in the form of financial assistance and the provision of basic needs such as transport which served to minimise the barriers participants faced in accessing exercise and sport facilities. The central importance of tangible support is illustrated in the following exchanges with two members of a golf group:

Interviewer: How do you think that we could develop the golf project? What would you like to see done?

Harry: Um (pause). I don’t know really. Uh (pause). Cause it’s the transport side really.

Interviewer: So for you, what are the difficulties that you face in playing? (pause)
Transport’s one of them.

Harry: Transports one of them ... getting out there. That’s the main thing. And the fees is another one.

Interviewer: How much it costs?

Harry: How much it costs.

Interviewer: You don’t want to join a golf club?

Peter: It’s too expensive isn’t it, yeah.

Interviewer: Do you think that’s the main problem that you face?

Peter: Yeah, yeah.

These examples draw attention to the unavoidable impact of a *lack* of tangible support: the participants communicated the view that exercise or sport would simply not happen without the provision of a basic level of tangible support. Most often, the support they required was assistance with transportation and a fairly modest level of funding to cover the direct costs of participation in the activity (i.e., entry to the exercise facility, hire of equipment).

Two mental health professionals held the view that the provision of free transport probably helped to increase participation in one sport group: “It was made quite easy for them, you know, they were, a minibus was provided and so they just had to kind of turn up”. According to the other,

The minibus was probably very important ... 'cause our client group just won't, well they do, people do get to places on their own but they don't ... certain people like Ronnie and William probably wouldn't have got there if they hadn't had a lift from their home to the centre.

The withdrawal of tangible support, through an absence of ongoing funding, was seen by staff and clients alike as the primary reason why participation in golf might be threatened when the funded programme came to an end. As one staff member put it,

Money is a major thing and they wouldn't go out and do it 'cause of money basically. Yeah, one comment was, can't remember who it was from, they wouldn't do this because it would cost too much and they wouldn't be able to afford it.

We suggest that tangible [financial] support is likely to be an essential form of social support as a result of the socioeconomic obstacles faced by many people with severe and enduring mental health problems. It is likely too that certain forms of exercise or sport will necessitate more in the way of tangible support than others. This point is evident in one participant's comments regarding the cost of playing golf, particularly at member-only clubs: "I don't know if they let people play up there for free or, because of the membership, members, like. They only allow certain people to go up there to play".

Esteem Support

One participant's description of the support he received from staff during his initial exercise sessions provides a clear illustration of the importance and value of esteem support:

If it wasn't for Sarah and Catherine [*two physiotherapists*] I don't think I'd have got back into it. Well, I would have got back into it, but not so soon ... I think it was important for them to be there first of all. It gave me a bit of confidence. Because I was so unwell, I wouldn't have had no confidence, thinking I was gonna have a panic attack, stuff like that ... somebody there I could chat to and take my mind off it and stuff.

This excerpt provides a powerful illustration of the importance and value of esteem support, and how a knowledgeable person (in this case a physiotherapist) can instil confidence and security for an activity which an individual is afraid may lead to "a panic attack". Just by being there, the physiotherapists provided this individual with "a bit of confidence".

Additionally, by being, in this participant's words, "somebody I could chat to" the physiotherapists had an opportunity to offer esteem support in the form of *verbal persuasion* which has been shown to promote self-efficacy for that particular activity. Thus, through the

provision of esteem support provided by two physiotherapists, this individual's doubts and concerns are mitigated and he is able to participate successfully in the exercise activity.

Another participant illustrated the powerful effects of this type of esteem support saying he was, "a bit slow to start with. But Sarah said you'll improve as you go along ... it was true". For many participants, these types of comments from exercise leaders were valuable, particularly during the early stages of involvement, because they served to boost an individual's sense of competence while increasing confidence in his ability to perform the task successfully. At other times esteem support was invaluable as it helped some participants remain confident and motivated when their skills were not improving as quickly as they might like. One participant described how believing our assurances that his golf would eventually improve was helpful:

getting that confidence, just giving it time, and obviously like you said it'll gradually come. So when you actually do it like on here I suppose it came in one piece. It all came together. It worked out OK. I'm pleased with that.

Often, receiving esteem support directly brought personal pleasure or sense of pride as the following excerpts from our field notes illustrate:

Richard's face brightened when I talked about him looking athletic on the golf course, he seemed really pleased to have positive input about how he had played. He smiled a lot when I gave him encouragement and said a very warm 'thank you'. (25 June)

On the 3rd, following his tee shot, Andrew asked Julian "Am I improving?" and was visibly pleased when both Julian and I enthusiastically replied "Yes!" On the green, I asked him to make a shorter, slower swing and, taking the ball away, asked him to make a practice swing. "Perfect! Now do the same swing again when I replace the ball" was my advice. That is exactly what Andrew did and, from 9-10 feet off the hole, the ball rolled straight in. "Yesssss! Great shot!" was the general reaction from the group ... Andrew's reaction was fantastic: he visibly tensed, clenching his fists, rising taller by three inches, and grinning a huge beam. (18 June)

While documenting the effects of esteem support offered by staff members, the second excerpt also hints at a potentially significant exchange, or sharing, of esteem support *between* participants. An exercise leader described how an unexpected exchange of esteem support occurred between two members of the golf group:

The following day after the second session we went swimming with Ali and he met Jerry in the changing room and first thing he said, out clearly and precise, cause Ali mutters and is really hard to understand sometimes: "Jerry! You're the one who hit the

170 yard shot! That was a fantastic shot!” Like that, so precise and so clear. He looked at the person and said it and it was absolutely amazing. And then he just went like that [*mimes dropping head to look at floor*], he turned around to his locker and was all quiet again ... I’ve never seen Ali speak so clearly and so precise as that. Before that he would mutter and he probably wouldn’t speak to Jerry so precisely like that cause he hardly knew him.

A similar dynamic is demonstrated by the following excerpt from our field notes:

While we sat having a drink at the picnic tables, Chris asked Richard ‘What was your favourite shot? That last putt for the three? That was a great shot!’ Chris described the putt to me (‘it was at least as far as from here to that bin’ – about 20 feet) smiling, presumably at the thought of it. (*16 July*)

These excerpts document what to us was a mutual giving and receiving of reinforcement and support. That is, it was not only that individuals benefited from being the *recipients* of esteem support, but many also *gave* esteem support to others through positive comments or exchanges.

Emotional Support

Several participants talked of how emotional support, usually from family and friends and sometimes in the context of sport and exercise activities, had been important to them. One described the support he received from his parents when he competes in races: “My dad was there like. My parents used to go, parents go with me too on all these runs, they go with me and sort of cheer me on at the end”. In the words of another participant,

Family as well, friends, they supported me since I was ill really ... used to come round, make sure I was up or I went out with them they asked how I was. You know just good friends really... Yeah. Yeah. Just care, care, care like. Care.

Alongside emotional support being provided by outsiders, we also observed that emotional support, like esteem and informational support, was at times shared *between* members of exercise and sport groups. In this way, participants both received and gave emotional support to each other through sport. The following excerpt provides an example of this process in the context of a weekly football group:

Well I’m sort of supported. I feel supported with other people there yeah. Its people that I know mainly, especially like with the football team, its people that I never knew before but I got friendly with, made good friends, and we all just participated in sport like ... This is why I still come to [*name of day centre*] cause of the sports activities and what have you. I think it’s important to keep it going like.

While being difficult to document in a research setting, we witnessed subtle processes of mutual interpersonal emotional support taking place within the context of some sport groups which served to help bind group members together and, we suggest, create a sense of community. Intrinsic to this sense of community, we feel, was group members' willingness to give and accept emotional support to and from each other. The following field note excerpt provides an example of this process in action as several group members respond to photos one participant took of a previous week's golf session:

As we sat around waiting for the mini bus to be organised Peter said he had brought his photos. I was thrilled and asked to see them. He had gone to the trouble of getting a set done for us. The photos were of the group playing on the first week out on the golf course. I looked at them and wished we could use them. I passed them on to others who were interested. Jerry looked at them and particularly looked at photos of himself. He said that he needed to lose some weight. The words were said without withdrawing or looking overly concerned. Then he said 'I need to come off of medication.' The others sat around were listening. Peter agreed, he said he had reduced or come off his medication then he said 'I keep some just in case like.'

Andrew had been listening too, he joined in affirming what the others had said, 'I keep some just in case too'. (16 July)

This account provides an example of the dynamic and complex nature of social support systems and particularly the delicate and unpredictable nature of emotional support. If one participant hadn't been enthusiastic about documenting the activity, the photos would not have been taken. If he had not wanted to share them with the group, or the group had been unavailable, they would not have been shared communally. If they had not have been shared, there would have been no spontaneous opportunity or catalyst for the group to comment and encourage each other about a concern that was relevant to them all. We suggest that at times like these, when individuals engage with and support each other in talking about shared personal issues, a valuable exchange of emotional support takes place. On this occasion it was made possible through participation in a sport group.

Discussion

Clearly, any research has inherent limitations. There are two limitations which we feel are particularly relevant to this research. First, we have focussed exclusively on men's experience of sport and exercise. Further research is needed to explore the ways in which social support may be important to women with serious mental health problems who are taking part, or wish to take part, in sport or exercise. In light of generally lower participation

rates among women, and the different socio-cultural significance of sport and exercise for women, (see for example, Department of Health, 2004; Game Plan, 2002) we suspect that the social support needs of women may differ markedly from men's. Second, we have focussed on the experiences of people who have already made the decision to engage in some form of sport or exercise. We suggest that interpretive research focussing on people who are physically *inactive* has the potential to provide much needed understanding of: (i) how more appealing and personally relevant exercise and sport opportunities might be provided; and (ii) how social support provision might be more effectively made for those who are currently inactive but would like to become more active.

As Corrigan and Phelan (2004) suggest, social support is a multi-faceted and complex construct. In presenting here examples of how and when four specific dimensions of social support have been manifest in the exercise and sport experiences of men with serious mental illness we have attempted to shed some new light on this complexity. In keeping with the ethos of interpretive research, we aim to *illuminate* rather than *finalise* the ways in which social support processes operate in the context of exercise and serious mental illness. We hope that our findings can assist psychiatric and mental health nurses who may wish to offer and/or promote exercise opportunities for their clients in planning and implementing effective social support on the basis of the four types we have discussed.

Our findings share some common ground with existing exercise and mental health research. In their study of a pioneering community gym for people with mental health problems, Raine, Truman, and Southerst (2002) identify five qualities of effective gym staff: (i) skilled fitness instruction; (ii) personal encouragement; (iii) progress monitoring; (iv) practical support; (v) emotional support. For us, these five qualities emphasise the individual's skills in providing varied forms of support and suggest that exercise leaders need to be multi-skilled and aware of the diverse ways by which they can assist individuals in meeting the challenges of exercise initiation and maintenance. While these qualities would ideally be present in *any* exercise leader, coach, or personal trainer, we suggest that they are *particularly* important in mental health contexts given the specific challenges that exercise participation in this context may present. As Crone and colleagues (2005) have noted, it is likely that exercise leaders will need to draw on both professional skills and personal qualities in order to provide the most effective support. We suggest that the provision of effective informational, tangible, esteem, and emotional support also depends upon the deployment of a combination of professional and personal skills by mental health nurses.

While considering separate dimensions of social support provides insights into how provision can be more effectively made, it risks suggesting that each form of support is discrete or separate from the others. This was not the case in our research. Instead, we found that oftentimes more than one type of social support occurred in combination. For example, Carless (2007, p. 22-23) identifies three stages of intensive social support provision in the context of physical activity and mental health: (i) *awareness raising*, “a preliminary social support strategy where the potential benefits of physical activity are highlighted”; (ii) *engagement*, during which time “a form of exercise is identified which suits the personal needs and appeals to the interests of the individual”; and (iii) *practical facilitation*, which often involves a long term commitment to the organisation of physical activities alongside offering a combination of encouragement, direction, motivation, and reassurance. We suggest that while informational support tends to dominate the first stage of “awareness raising”, “engagement” can best be characterised by a combination of both informational and esteem support. “Practical facilitation”, we suggest, is very often a combination of all four types of support in a dynamic process which is sensitive to the particular needs of the individual.

One extended excerpt from an interview with an exercise leader relays a sense of the dynamic process of social support provision in action. This excerpt focuses on the process of supporting initial exercise involvement:

Interviewer: So once you’ve had an idea of someone, how do you approach it, how do you broach the subject with them?

Julian: Just basically ask if they’re interested really. It’s either a yes or no. And then –

Interviewer: Really? As simple as that?

Julian: Yeah. Maybe they just think about it and then over time they ask us if they can.

Interviewer: You don’t consciously, don’t deliberately sell it to them then as being a good thing?

Julian: Yeah, but we’re low input. We don’t want to push it cause we don’t want to, well I never do push them cause they usually back off sort of thing. They don’t want to be put too much under pressure. The way I put it is just, oh, “You’ll meet people”, or “Your mate comes along”, you know, like if you know they get on with somebody they buddy up sort of thing and um, yeah, I just, and fresh air and learn something new. But I don’t really “high pitch” it cause they’re bound to back off, a lot of people back off.

Interviewer: OK, so there's a threat generally with this client group that if you come on too strong you're going to turn them off it and drive them away type thing?

Julian: Yeah. They just feel pressurised a bit. And then it's got to be their decision ... So I think the best approach I always find is just gently bring it up and ask a few times, "Have you thought any more about the golf?" sort of like, you know?

Interviewer: Yeah OK, so a sensitive, friendly, type of "matey" approach almost?

Julian: Yeah, exactly. Its not, its not going to be over-judged on it, its not going to be part of their care plan or something like, its going to be a gathering of people for a good golfing, a good session to do basically ... I just put it to them basically, make the suggestion, "Hey! It's going to be good fun!" But at the end of the day it's down to them.

As this excerpt makes clear, a high level of sensitivity to the needs of the individual, combined with a respect for individual autonomy and choice, is likely to be critical to the effective and ethical provision of social support for exercise.

One point of particular interest which has emerged from this study, but has not been explored in previous research, is the way in which participants both *received* and *gave* social support *for* and *through* exercise and sport. This sharing of social support, for us, has two implications. First, as Crone and colleagues (2005) have observed, it implies that individuals are able to draw potentially valuable support from not only mental health professionals but also other members of the exercise group. Second, while research has tended to focus on what individuals need to *receive* in terms of social support (e.g., Corrigan & Phelan, 2004; Davidson et al., 2005; McDevitt et al., 2006; Rees et al., 2003), there is also, we suggest, a need to consider what participants are able to *give* to others in support terms. For us this point is particularly noteworthy as, according to Deegan (1988), the opportunity to give is in itself important in recovery terms. Deegan draws parallels between the experiences of people with mental health problems and people with physical disabilities to emphasise the importance of recognising

the gift that disabled people have to give to each other. This gift is their hope, strength and experience as lived in the recovery process. In this sense, disabled persons can become role models for each other. During the dark night of anguish and despair when disabled persons live without hope, the presence of other recovering persons can challenge that despair through example. (p. 18)

Frank (1995) argues that giving, through acts of generosity to others, be recognised as an ethical responsibility of living with serious illness. For him, while ill persons may share what

they have learnt through their experience of illness with another *for the benefit of the other*, something about the act of giving in this way also provides personal benefits. One possible and significant benefit might be an enhanced sense of community. According to Deegan (1997),

community, *real community*, is not a place. It is not the place outside the institution.

Community is not the buildings and streets that surround us out here. Community is not a place. Community is a way of being in relationship with one another. (p. 13-14)

With this point in mind, we ask whether the opportunity to provide social support *for* others, in the ways discussed here, might provide a valuable opportunity to experience real community through a different way of being in relationship with one another. This opportunity may in itself come to be seen as a valuable and life enhancing experience by some people with mental health problems.

Conclusion

In this article we have explored how four types of social support – informational, tangible, esteem, and emotional – were experienced by men with serious mental illness in the context of exercise and sport. On the basis of participants' and mental health professionals' accounts of their experiences, we have given examples of these support processes in action to provide mental health nurses with ideas and stimulation concerning the kinds of social support they might consider offering their clients. We have shown that while different types of social support are very often a prerequisite *for* exercise participation among men with mental health difficulties, they can also be potentially beneficial outcomes which arise *through* involvement in sport and exercise groups. In this guise, we suggest that social support in the context of mental health is not a "one way street"; it is not only the case that people with mental health problems benefit from *receiving* social support but that at times they can also benefit from *giving* social support to others through shared membership of an exercise or sport group. This sharing process may be a valuable way of rebuilding a sense of community among people who are living with and recovering from serious mental health difficulties.

Acknowledgements

Thanks to the mental health professionals who facilitated this research and the two anonymous reviewers for their comments. Most importantly, a big thank you to the participants for generously sharing with us stories of their sport and exercise experiences.

¹ Serious mental illness (SMI) has been defined as “a diagnosable mental disorder found in persons aged 18 years and older that is so long lasting and severe that it seriously interferes with a person's ability to take part in major life activities” (United States Department of Health and Human Services, n.d.).

² We initially hoped to include women in the research but two factors conspired to result in an all male sample. First, few very women were engaged in sport or exercise groups at the centre where the research was conducted. For complex socio-cultural reasons, sport and exercise participation is generally lower among women. On this basis, it should not be surprising that this is reflected in mental health settings. The ways in which sport and exercise can be tailored to better appeal to female users of mental health services is, we suggest, a worthwhile topic for future research. Second, of those few women who were engaged in sport or exercise at the centre, none were prepared to take part in this research.

³ As researchers we liaised closely throughout the project with mental health professionals (care co-ordinators, clinical psychologist, consultant psychiatrist, centre manager, physiotherapist, exercise leaders) who worked with the participants. In the interest of the well-being of the participants, we respected mental health professionals' judgments regarding whether or not individuals were sufficiently well to be approached to take part in the research. Particular consideration was given to whether the interviews might be distressing for some participants in light of Stone's (2004) observations on the risks of revisiting potentially traumatic moments during an interview.

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