Assessing Sustainability of InSHAPE Participants’ Fitness Activities in a Community Mental Health Setting

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ABSTRACT

InSHAPE (Self Help Action Plan for Empowerment), an exercise and nutrition wellness program, is gaining national recognition for its success in helping individuals with serious mental illness (SMI) improve physical fitness and dietary habits. Although gains have been reported in objective measures of fitness as participants progressed through the year-long program, there is little information about what happens with participants after program completion. To address this gap in knowledge, the authors conducted a longitudinal qualitative study in which 11 InSHAPE participants were interviewed both near the end of their year in the program and 9 months later. Participants identified the trainer’s ability to contain their initial feelings of distress and form a working alliance as factors that contributed to their exercise persistence. Current findings suggest that individuals with SMI may need a longer period of time working closely with fitness trainers to sustain physical activity levels achieved during the program. [Journal of Psychosocial Nursing and Mental Health Services, 53(2), 46-53.]

Finding ways to improve physical fitness for individuals with serious mental illness (SMI) is of paramount importance because sedentary lifestyles are typical and chronic medical diseases are rampant in this population. Community mental health (CMH) agencies have begun to address these concerns by implementing programs aimed at health promotion and increasing physical activity for their clients. A program of this nature that is designed to help individuals with SMI is InSHAPE (Self Help Action Plan for Empowerment). A profile of this innovative individualized health promotion
and physical fitness program is available online from the Agency for Healthcare Research and Quality (AHRQ; 2014). Although several evaluation studies have assessed InSHAPE program outcomes and reported increased exercise capacity, weight loss, and improved mental health status (Bartels et al., 2013; Shiner, Whitley, Van Citters, Pratt, & Bartels, 2008; Van Citters et al., 2010), no post-program follow-up studies have been reported. The authors do not know if participants who successfully completed the year-long program were able to sustain gains in physical activity and fitness levels.

The current study consisted of personal interviews with InSHAPE participants from the Lapeer County CMH agency in Michigan that were conducted at two time points, including 6 months after program completion, that aimed to fill this gap. The goal was to deepen understanding of factors that contribute to or detract from persistence with physical fitness activities when participants with SMI transition out of the InSHAPE program. The current study is important because part of a health promotion program’s effectiveness is its ability to lay groundwork for permanent behavioral changes.

The current study represents the culmination of years of collaborative work involving nursing and physical therapy faculty and students from the University of Michigan-Flint’s School of Health Professions and Studies in conjunction with administrators, staff, and service users from the Lapeer County CMH agency. The first author (M.L.L.), who has psychoanalytic training, guided the enterprise from a “people helping people” partnership perspective; she was known to many of the InSHAPE participants prior to conducting interviews for the current study due to interactions during earlier focus group research conducted by nursing graduate students under her supervision at the Lapeer CMH-sponsored clubhouse (Hammond, Seering, Tinklepaugh, & Waldrup, 2011) and other activities leading to the implementation of the InSHAPE program (Lesley et al., 2013). Having a psychoanalytically oriented nurse researcher (M.L.L.) involved in all aspects of the collaborative work enhanced the therapeutic nature of the project.

Psychoanalytic insight helps expand understanding of the human experience and the psychic needs, strivings, and motivations that influence human behavior (Michigan Psychoanalytic Institute & Society, 2014). The participants’ willingness to be interviewed across two time points speaks to their personal investment in the success of InSHAPE. The process of reflecting on their own efforts to improve their physical fitness and diet that occurred during the interviews was therapeutic and may contribute to positive actions on their part going forward.

Disparities in mortality between the general population and individuals with SMI are well documented, and the gap in lifespan has widened during the past few decades (De Hert et al., 2011). A technical report published by the National Association of State Mental Health Program Directors (2006) revealed that individuals with SMI die, on average, 25 years earlier than the general population. Cardiovascular disease contributes most to the excess mortality, particularly for individuals ages 25 to 44 (Colton & Manderscheid, 2006). Increased physical activity is known to have a cardioprotective effect that is independent of other risk factor modifications and perhaps more profound (Joyner & Green, 2009).

**InSHAPE HEALTH PROMOTION PROGRAM**

InSHAPE was originally developed in 2002 by Ken Jue, Chief Executive Officer (CEO) at Monadnock Family Services, Keene, New Hampshire, for individuals receiving mental health services. The program has been replicated in CMH agencies in Rhode Island and Massachusetts, and may soon be implemented statewide in New Hampshire (AHRQ, 2014). The Lapeer County CMH agency was the second Michigan agency to implement the program, which is partially funded by the Michigan Department of Community Health and Medicaid. The first author (M.L.L.) brought the program to the attention of the Lapeer County CMH agency CEO after earlier focus group research findings from members of the Lapeer County CMH-sponsored clubhouse suggested that InSHAPE “fit” with their physical fitness needs and interests.

Although they were relatively young (mean age = 42.6, range = 25 to 58 years), only four of 12 focus group participants (6 men, 6 women) did not have high blood pressure; diabetes; or heart, kidney, or respiratory disease. Five (42%) participants had diabetes, and only three engaged in moderate levels of physical activity (Lesley et al., 2013). The Lapeer County CMH agency Board of Directors approved the InSHAPE program protocol, and participants began enrolling in December 2010.

**Lapeer InSHAPE Program Specifics**

InSHAPE consists of individualized physical fitness training and nutrition counseling during one-on-one sessions between the participant and a health mentor. Participants are eligible to participate if they are 18 or older; have SMI and a chronic physical condition, such as cardiovascular disease, high blood pressure, high cholesterol, diabetes, or obesity; and receive psychiatric services at the CMH agency. Case managers; members of the ACTS team, including nurses, social workers, and psychologists; and clubhouse staff help publicize the InSHAPE program and identify potential participants. Health mentors are certified fit-
ness trainers with at least a bachelor’s degree who have received training in motivational interviewing and nutrition counseling, and completed a Recipient Rights Training Course. They are also provided with basic education about how psychiatric symptoms may affect a fitness client’s behavior. The Lapeer County CMH agency CEO and management team members interview, hire, and evaluate the fitness trainers.

Initially, 1-hour long, one-on-one sessions take place twice per week within the main CMH facility in an exercise room designated for InSHAPE that is outfitted with fitness equipment including exercycles, treadmills, and weights. Each participant works with a health mentor to develop a fitness and healthy eating plan during the initial session. Progress toward individualized goals is assessed at each session and plans are adjusted as needed. Objective measures of health and fitness (e.g., weight, body mass index, and before and after exercise heart rate and blood pressure) and the 6-minute walk test (Bellet, Adams, & Morris, 2012) are obtained at regular intervals and logged by the health mentor.

Per program protocol, after the first month, the frequency of individualized instruction sessions gradually decreases to weekly, then biweekly, and eventually monthly sessions. At the end of 1 year, one-on-one activities transition to onsite group activities led by the trainer. Participating in activities in mainstream community settings, such as the local community recreation center, CURVES®, and a local yoga center, is encouraged. A quantitative evaluation of the Lapeer InSHAPE program outcomes (e.g., the objective measures of fitness) is not included in the current article, but is being prepared for future publication. The current study specifically focused on InSHAPE participants’ physical fitness experiences as they transitioned out of the year-long program and during the following 6 months.

**METHOD**

**Study Design**

A qualitative design was used for the current longitudinal study. The nurse researcher conducted personal interviews with InSHAPE participants at two time points: (a) when participants had been in the program for 9 months and (b) 8 to 9 months later (Table). The study was approved by the University of Michigan-Flint Institutional Review Board and Lapeer County CMH agency CEO. A University of Michigan-Flint Research and Creative Activities Award provided funding for the study.

**Sample**

Convenience sampling was used to recruit study participants. Inclusion criteria required that participants be (a) an active member in the InSHAPE program at Lapeer CMH (as defined by program parameters), (b) approaching the final 3 months of program participation, (c) intending to remain in the geographical area for the next year, and (d) willing to have interview sessions audiorecorded. At the time of recruitment, there were approximately 39 active InSHAPE program members, with 20 being in the final 6 months of the program. A recruitment flyer was posted in the exercise room with the first author’s (M.L.L.) contact information. Trainers verbally explained the study to eligible participants and obtained their written permission before providing contact information to the researcher.

When the current study began, one fitness trainer was working with all of the participants. Several months later, a second trainer was employed. Some participants stayed with the original trainer for the entire year, whereas others shifted to the new trainer. Eleven participants completed the first interview and only one declined to meet with the researcher for the second interview.

**Data Collection and Analysis**

The nurse researcher conducted one-on-one audiorecorded interviews with participants in a private room at either the CMH agency or CMH-sponsored psychosocial rehabilitation clubhouse. A psychoanalytic approach, in which the interviewer is empathically immersed in the other individual’s subjective experience (McWilliams, 1999), to interviewing was used. During each interview, several topical questions were asked; however, participants were encouraged to freely share their thoughts

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<td>18</td>
<td>1. What are your thoughts about the InSHAPE program?</td>
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and ideas and to take the lead in discussing the topic of interest. The interview was intended to elicit information as to what aspects of the program helped participants follow their individualized fitness plan and healthy eating goals. Participants were encouraged to reflect on circumstances and factors that either helped or hindered their ability to maintain a physical fitness regimen and healthy eating plan as the program’s one-on-one sessions decreased and eventually ended. By using psychoanalytic interviewing principles, a richer return of data was expected.

Audio recorded interviews were sent electronically to a professional transcription service. The principal investigator (M.L.L.) and research assistant (K.L.) were the only individuals with access to the transcripts. The first stages of data analysis were performed using ATLAS.ti version 7.1.6, a qualitative research management software program. Preliminary themes were identified and assigned search phrases using query strings for each theme. All transcripts were searched via auto-coding of the themes. As keywords were identified by the auto-coding function, the surrounding dialogue was reviewed by the research assistant so that the selections for each theme included the full context. The resulting thematic categories and corresponding quotations were then compiled and reviewed.

The nurse researcher used a psychoanalytic approach for the next phase of data analysis, which “supplies a context, a narrative about an individual patient within which isolated pieces of his behavior come to be understood, fitted together, and organized into a comprehensive whole” (Holden, 1991, p. 388). The current study aimed to discover principle reasons why individuals were able or unable to sustain established fitness regimens when their year in the InSHAPE program ended. With greater insight, program planners may be able to anticipate these needs and potential barriers ahead of program completion and create strategies for effectively addressing them. Credibility was enhanced by reading the transcriptions multiple times, aggregating coded segments from ATLAS.ti, and integrating quotes in this report.

RESULTS

All participants had a diagnosis of SMI and at least one chronic physical health condition and were receiving psychiatric services at the Lapeer County CMH agency. Nine participants were female and two were male, and all were 18 or older and adhered to the InSHAPE program protocol for frequency of one-on-one sessions with the trainer, beginning with twice weekly sessions and decreasing to monthly sessions. Initial interviews were conducted from October 2011 to August 2012, when participants had been in the InSHAPE program for approximately 9 months. At this time, the frequency of one-on-one visits with the trainer had decreased to once every 2 weeks or once per month.

When sharing anecdotal comments about their progress in the program, most participants focused on weight loss. Almost all participants identified themselves as overweight or obese, and most stated that they had lost significant amounts of weight at the time of the interview (some in the range of 50 to 60 pounds). Several participants reported feeling they had improved stamina, and several were aware that they had achieved lowered heart rates by the end of their year in the program.

Three main themes emerged from the data from the initial interviews: (a) expectancies/containment, (b) working alliance, and (c) intentions going forward.

Expectancies/Containment

When participants were asked during the first interview to share their thoughts about the InSHAPE program, many expressed initial concerns regarding their experience expectations. One participant said:

I was very nervous. I mean, honest, I remember the first day I walked in. Oh boy, here we go. And I really liked how she calmed me right down and asked a bunch of questions first. I like how she told just—you know, just don’t worry about this.

One participant stated, “At first I didn’t want to participate in InSHAPE. I was heavy and inactive.” Another participant expressed concerns about being judged negatively for being “non-athletic.” Others had preconceived ideas and fears about the trainer. Some participants verbalized fears that the trainer would yell at them. One participant referred to the ridiculing behavior of trainers she had seen on the TV show, “The Biggest Loser,” saying she did not want to be treated similarly. Another participant commented: “Well I’ve never really actually been with a workout guy like at fitness training or a gym or something so I don’t have anything to compare it to, but from what I understand of those things, they’re very, like, intense, in your face, and they, you know, don’t let up unless they see you like falling to your knees and hyperventilating, I guess.”

Participants were quick to point out that the InSHAPE trainers did not confirm these imagined expectancies and were able to contain the participants’ fears and anxieties while demonstrating a different, friendlier approach to fitness training. Comments included, “They are here to help you, not hurt you,” and “They’re not mean like you’d think a trainer would be. They’re really nice.”

Working Alliance

When asked what it was like to work with a fitness trainer, participants identified components of a working alliance that were important to them. Bordin (1979) defined a working alliance as a bond between a person seeking change and a change agent, and mutual agreement on goals and tasks necessary to achieve these goals. Although working alliance is generally thought of as a concept from the realm of psychoanalysis, Bordin (1979) stressed the universality of its application, such as between student and teacher, a community action group and its leader, and child and parent.

Bonds. All participants spoke about the bond that they formed with the trainer. Many described the trainer as a friend. Examples of comments included: “[The trainer] treats me like a friend”; “We work out together”; “[The trainer] is a companion,” “a partner,” and “a
cheerleader”; “We dance and take walks together”; and “They exercise right along with you.” One participant commented, “But sometimes she lets me dance. Like her and I will go in there and she'll put on music and her and I will do dance and we'll go outside when the weather is nice and walk around.” Another common description was of a teacher: “[The trainer] makes a plan,” “explains what to do,” “introduces new activities,” and “They educate you about diet, explain how diet and exercise works.” The trainers were also described as motivators to increase exercise intensity and lose weight: “[The trainer] pushes me to go one step further,” “gives pep talks,” and “tells us you can do it.”

Almost all participants interviewed identified their trainer as a bridge to activities outside the CMH facility. Ten of 11 participants mentioned that when the frequency of training sessions decreased, the trainer accompanied them to public fitness facilities including CURVES and the local recreation center to introduce them to activities outside of the InSHAPE program. Venturing to fitness facilities in the community was a new experience for most participants and the trainers’ presence was welcomed. When one participant was asked if she had been to the local recreation center without the trainer, she responded, “To be honest, no. I don’t know why. I guess I like a partner to be with me to do different things.” Another participant commented:

“I did go to CURVES for a week. I didn’t really find it all that enjoying. I think if I would have had a person to go with me it might have been different. But I just didn’t feel like that was the niche for me.

The following comment demonstrated that the trainer was aware of participants’ concerns about “going it alone”:

She likes to motivate you to continue individually. It started with me and her there [the local recreation center] instead of here [the CMH facility]. Then as we became—as the time went on and the sessions had decreased, she motivated us to continue there and now she encouraged us to group up with peers.

Participants verbalized reciprocal respect and a caring attitude toward the trainer:

Knowing that I had somebody that was counting on me to come and, you know, it helped keep me motivated even when I was “oh I don’t feel like exercising today”. … [The trainer] is great… she’s a real bubbly and highly motivated person so she’s good. I’ve been going to the Rec more with one of my friends, her and I, because [the trainer], bless her heart, told me—she said that she wants me to go to the Rec more often. So I’ve been trying to do that.

Goal Sharing and Tasks to Accomplish Goals. Participants articulated the personalized approach used by the trainers in developing a weekly plan. One commented, “We meet, starting off there’s an intake interview where she tries to assess the client and...come up with an individual plan and then we get started pretty quickly after that.” Another participant stated, “They encourage you to make goals for the week for home, nutritional goals, exercise goals. You may start a little and then increase over time.”

Intentions Going Forward

The nurse researcher conducted the first interview when participants were decreasing the frequency of their one-on-one sessions with the fitness trainer. Most participants were seeing the trainer only once every 2 weeks or once per month at the time of the first interview. When asked what physical activity they expected to do during the next year, several voiced concerns about their ability to persist with their fitness activities. One participant added:

I wish there was more than a year because I’m afraid that when my—I only have three more months and I’m afraid that when that’s up I’m going to—I don’t think it’s going to happen, but I’m afraid I’m going to go back to my junk food eating and not exercising. But I don’t think it’s going to happen.

When asked why, the participant said, “Because I really want to be thinner.”

Another participant said, “I wish somebody else would be there [at the recreation center] that I know but then there’s times I don’t know anybody that’s there that I know. So I just make myself go, I have to force myself.” Another participant commented:

What I have to do is I have to get another program in place before I go to once a month or I’m not going to make it. So that kind of scares me a little bit. Hopefully, I’ll have something in place like CURVES or you know before then so I’ll be accountable to somebody I guess. Yeah, it has been difficult to go from once a week to once every other week.

Many participants verbalized awareness of group activities available at CMH agencies, such as organized sports games (e.g., basketball, volleyball), circuit training, kickboxing, and walking groups. Several had previously attended some of these activities. Other participants stated that they would continue or consider continuing with group fitness activities at the CMH facility led by the trainers. Some participants cited barriers to attendance, such as conflicts with other scheduled activities, difficulties with transportation, or both. When asked what activities they may be interested in doing when the one-on-one sessions ended, one participant stated:

Well, even when it gets cold out I have my treadmill. So I mean I have a treadmill and I have a bike and that. And who knows, I might join a gym. If the finances are there it might happen. I don’t know yet. I really haven’t put too much thought into it because you know I just got this new job.

Two participants stated that they would continue to go to the community recreation center when their year in the InSHAPE program ended. One participant did not want to think about the end of her year in the program and stated that she would be continuing with twice weekly sessions with the trainer indefinitely, saying, “They want me exercising.”

Findings from the Second Interview

The nurse researcher re-interviewed study participants approximately 9 months after the first interview. This time period allowed for 6 months to elapse after pro-
gram completion. The second set of interviews took place between August 2012 and April 2013. One participant was unavailable for the second interview.

Participants were asked what they were currently doing for physical activity. Six of 10 participants stated that they were not engaged in any structured exercise program. One participant initially “volunteered” at a CMH agency with group fitness activities but stopped when hours conflicted with a new job. Another participant moved from the immediate area and was busy adjusting to changes in living arrangements. Another participant fell while trying kickboxing and did not pursue other fitness activities. One participant said:

I had a free week at CURVES and CURVES was all right. I just didn’t think it was worth the money. I felt that I could do more at home instead of driving to go there. I mean it was 10 miles to go there and it’s not like I live in town. So you figure 20 miles round trip. And if you had a partner it would be more fun but it’s not really fun when you don’t have a partner.

One participant had a CURVES coupon but hadn’t used it, and another said, “I haven’t stayed connected with the exercise. I don’t exercise in winter. I don’t drive.”

The four remaining participants continued with structured group fitness activities supervised by the InSHAPE trainers at the CMH facility. One participant attended classes 4 days per week, including kickboxing, circuit training, basketball, and walking group activities. She also followed a Weight Watchers® diet and had lost 10 pounds, and commented:

I think it was easier to have [the trainers] there. But it’s kind of harder when I’m alone. You know? It was easier to have them there kind of rooting me on. They’re still there rooting me on but it was easier like going to them every week.

Another participant attended the walking group with the trainers in addition to a singing group sponsored by the CMH facility. She commented on the trainers, saying, “They like to walk with us. They walk and...when we’re dragging along they kind of tell us to go faster and kind of help us out a lot.” Another participant went to kickboxing and the walking group. The fourth participant stated that she goes to kickboxing and circuit training, but the home exercise program was “too much.” She thought that she had regained all of the weight lost in the InSHAPE program and explained that her diet was better when she wrote everything down and shared information with the trainer.

Interestingly, at the time of the second interview, none of the 10 participants were using the local recreation center or CURVES for exercise, citing feelings of isolation, high cost, and transportation difficulties. Above all, most participants stated that one-on-one with the trainer worked the best for diet and exercise adherence. Several participants stated that they would have continued attending one-on-one training sessions if the program had allowed it. One participant, who worked at a sedentary job, was not exercising, and had gained back the weight she had lost in the program, summed it up: “[The trainer] was a big encouragement. It’s like I need more than a year. I wasn’t ready for my year to end. I need a refresher.”

**DISCUSSION**

The aim of the current study was to explore participants’ experiences with the InSHAPE program and to learn about the major influences on their fitness activities during the program and the following 6 months. The findings from the first set of interviews bring into focus specific aspects of the interpersonal relationship between the participant and fitness trainer that contributed to participants’ desire to continue routine physical work-outs. Participants brought preconceived, anxiety-producing ideas about how they would be treated by the fitness trainers. They imagined that they would be subjected to ridicule for being overweight or non-athletic (or, although unstated, stigmatized for their mental condition), or that the trainer would be a “task master” who would push them to exhaustion. The InSHAPE trainer was able to “take in” participants’ fears and anxieties, refocus emotional energy on the tasks at hand, and demonstrate that these expectancies would not be fulfilled (Beebe & Lachmann, 2003).

Another major interpersonal influence on participants’ motivation to exercise was the development of a working alliance. Comments from study participants illuminate the profound nature of the bond that developed between them and their trainers. Trainers were “friends” and “partners” who celebrated their successes and offered encouragement when participants were discouraged; they were allies who accompanied participants to new places and exposed them to new experiences within the safety of a trusted relationship. Trainers helped participants set realistic fitness goals and actions to accomplish them. In return, participants regularly attended sessions with their trainer even if they were having “down days,” knowing that the trainer was counting on them to be there.

The literature is replete with examples of the importance of an interpersonal connection between individuals who are seeking change and their change agents. In an article about her relationship with her fitness trainer while preparing for a marathon, Hannah Curtis (2013), a psychotherapist, stated:

Within a short space of time the person of the trainer becomes almost more important than the goal of the marathon. What she thinks, how good her attention is, whether she can cope with the demands, these are just a few of the unspoken preoccupations that quickly begin to dominate the relationship. (p. 412)

Morrison & Smith (2013) identified a deepening alliance based on trust and respect that develops over time between a client and occupational therapist with repeated interactions. Clients gain confidence that their therapist is competent and has their best interests in mind. With this bond, clients may also feel an “impetus to act” (Morrison & Smith, 2013, p. 330) out of a sense of duty or respect for the therapist. InSHAPE program participants explained how they persisted with their scheduled appointments with the trainer due to feelings of loyalty or to satisfy a need to answer to someone.
KEYPOINTS

1. The InSHAPE program is helping individuals with serious mental illness (SMI) to improve their levels of physical fitness.

2. A nurse researcher acted as a therapeutic agent during the development of the InSHAPE program and while interviewing participants about their fitness experiences.

3. Some individuals with SMI may need a long-term, one-on-one relationship with a fitness trainer to sustain new health habits.

Do you agree with this article? Disagree? Have a comment or questions? Send an e-mail to the Journal at jpn@healio.com.

Several participants also described attempts to continue with activities at the local recreation center despite feelings of estrangement in part because the trainer was encouraging them to do so.

In an earlier study conducted with individuals enrolled in the InSHAPE program at Monadnock Family Services in New Hampshire, participants felt less intimidated at the local gym in the presence of their trainer (Shiner et al., 2008). Fear of being stigmatized is a key contributing factor in individuals with mental illness not using community resources (Lesley et al., 2013).

The findings from the second set of interviews conducted 6 months after each participant had completed the year-long InSHAPE program provide insight about the sustainability of physical fitness behaviors in individuals with SMI. The four participants who have continued with structured physical fitness activities chose to do so within the structure created by the InSHAPE program trainers. All of the activities are at the familiar CMH facility, led by the trainers, and open to all CMH service users, including “graduates” of the InSHAPE program and those on the waiting list. Individuals from the mainstream community are also invited to engage in the activities.

It is also worth noting that all four of the “physical fitness persisters” are members of the CMH-sponsored psychosocial rehabilitation clubhouse that is situated in a separate building approximately 3 miles from the CMH facility. The clubhouse is a meeting place for individuals who receive services at the CMH facility. Based on concepts of membership and belonging rather than treatment, the clubhouse is maintained by members and a small hired staff who are supportive of the InSHAPE program and provide transportation to and from scheduled fitness activities.

Of the six participants who were not engaged in any structured exercise program, two were in the process of starting or interviewing for new jobs and were driving on their own. The other four participants were dependent on other sources for transportation. One individual stated that the relationships formed during the InSHAPE program had been a big help socially. Most stated that they would have continued one-on-one sessions with the trainer if the program allowed them to go beyond 1 year.

Findings from the current study suggest that strong structural support is needed to sustain new health habits in individuals with SMI. One year of a one-on-one therapeutic trainer–trainee relationship may not be sufficient to support permanent behavior changes in individuals with severe illnesses, such as schizophrenia and major depression. Both fitness trainers at the Lapeer County CMH agency have therapeutic personalities. They are upbeat, encouraging, and nonjudgmental, and demonstrate an understanding and respect for the challenges and special problems of each participant as well as for the pace of progressive fitness activities that is acceptable and differs among individuals. The InSHAPE program has similarities to psychoanalytic approaches to therapy, in which long-term interventions can be useful to consolidate skills and increase self-confidence (Harder, Koester, Vallback, & Rosenbaum, 2014).

CMH agencies may help these individuals sustain physical fitness regimens by lengthening the time they work one-on-one with their trainer in the InSHAPE program. Addressing issues of access to group workouts, such as transportation services and scheduling conflicts, may also be indicated. Other strategies found in recent reports (Carless & Douglas, 2012; Rickard, Gubay, Hua, Schwodler, & Smith, 2014) could be explored, including finding ways to improve the social experience at the local recreation center and use of volunteers to augment the work of the paid trainers.

The cost of increasing resources to support continued trainer–participant interactions beyond 1 year while continuing to enroll new individuals should be weighed against the economic and personal burden of poor physical health and disability. Bartels et al. (2013) estimated that the health care savings achieved by preventing chronic disease would offset the annual per-person cost of the InSHAPE program. The trainer–participant relationship can be a model for other professionals working with individuals with SMI. The support of individuals with a shared mission to improve health and fitness sends a powerful message that says, “You are worth it.”

IMPLICATIONS FOR NURSING
Mental health nurses must be aware of specific exercise recommendations for individuals with SMI to support collaborative fitness efforts through exercise prescription (Stanton & Happell, 2013). However, research reported in the current article shows that nurses can be more directly involved in the development and evaluation of effective exercise interventions. The nurse researcher acted as a therapeutic agent throughout
the evolution of the collaborative work at the Lapeer County CMH agency that culminated in the implementation of the InSHAPE program.

In the current study, the nurse researcher used therapeutic interview methods that encouraged reflection and, during analysis of interview contents, recognized the significant effects of the fitness trainer on trainees’ views of themselves. Psychoanalytically oriented nurses can lay groundwork for therapeutic relationships to develop, flourish, and continue long enough to have lasting effects. Creating working alliances and listening with care as a means of containing emotional distress are important elements of mental health and general nursing practice (Jones, 1999; Shanley & Jubb-Shanley, 2007).

CONCLUSION

A psychoanalytic point of view can help nurse researchers create and contribute to therapeutic interventions intended to improve the physical fitness and overall health of individuals with SMI. Nurses working in mental health settings can partner with fitness trainers and other members of the health promotion team to tackle the growing crisis of chronic disease and its devastating effects on individuals with SMI. Programs such as InSHAPE signal a paradigm shift toward the creation of a healing community with an integrated focus on both physical and mental health.

REFERENCES


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