THE COMPLETE GUIDE TO

Debbie Lawrence and Sarah Bolitho

PHYSICAL ACTIVITY AND MENTAL HEALTH

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FOREWORD

As a physiotherapist working in the Mental Health sector for more than 10 years I have seen the increasing importance of exercise for these patients in counteracting the poor lifestyle, higher morbidity rates from cardio-respiratory problems and diabetes and other side effects from medication that affects weight management and physical abilities. Stigma, prejudice and a lack of understanding impacts upon the ability of patients (or service users) to access services that may help them and they often require additional support to make the necessary changes.

Within health there are limited opportunities to participate in exercise and can be compromised due to the acuity of their illness. There is now an increasing focus on the recovery model and supporting service users in the community, and it is important that all exercise providers are able to provide suitable support to help patients to achieve their general health goals as part of their recovery and a healthy lifestyle. It will be essential to work collaboratively with healthcare providers that have an overlapping role with other providers to make the best use of all appropriate resources. This will include joint training of dedicated staff and identifying the smooth transfer of patients from hospital care to community focused care, dovetailing resources to ensure optimal recovery for the individual.

In the Mental Health sector, the transition between specialist exercise services for service users in secondary care provides an initial safe and supportive environment to help them get into a routine of exercising with a tailored approach, which in turn builds confidence and provides motivation. The advanced training of Level 4 practitioners gives me more confidence that the greater percentage of people with mental health problems that do not necessarily come into secondary care are supported by staff who understand in more depth how mental health affects an individual and their life. It will help reduce stigma and prejudice and aid social inclusion. It will also ensure that the principles of recovery and empowerment are incorporated into the engagement of people using exercise to regain their health and well-being.

Liz John
Head of Physiotherapy in Mental Health, Cardiff & Vale University Health Board
Member of the Chartered Society of Physiotherapy
2011

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DEBBIE LAWRENCE

I give thanks to:

- My partner Joe for his patience, while I spent hours at the computer researching and writing this book.
- All the people (friends, family, clients) who have shared their own mental health and ill-health experiences and stories with me.
- My co-writer, Sarah, for working with me to produce this book.
- Fitness Wales for supporting the delivery of the Level 4 training programme, which this book supports.

'This book has been in the making for a long time, I hope it has arrived at a time when it can be most impactful and can make a difference to the way in which mental health is promoted and supported.'

SARAH BOLITHO

Thank you to:

- My family, especially my sister Anne who has been a strong support to me and my mother, who always looks out for the underdog.
- All the individuals and groups with mental health 'differences' that I have worked with over the last 20 years who have shown me that mental health problems are 'normal' conditions and something we need to accept not reject.
- My co-writer Debbie for making me do this!

'Having worked with individuals of all ages, backgrounds, abilities and disabilities with mental health conditions over the last 20 years, I hope that this book helps to both inform and encourage other instructors not only to work in this field, but also to learn more about their own mental health!'

INTRODUCTION

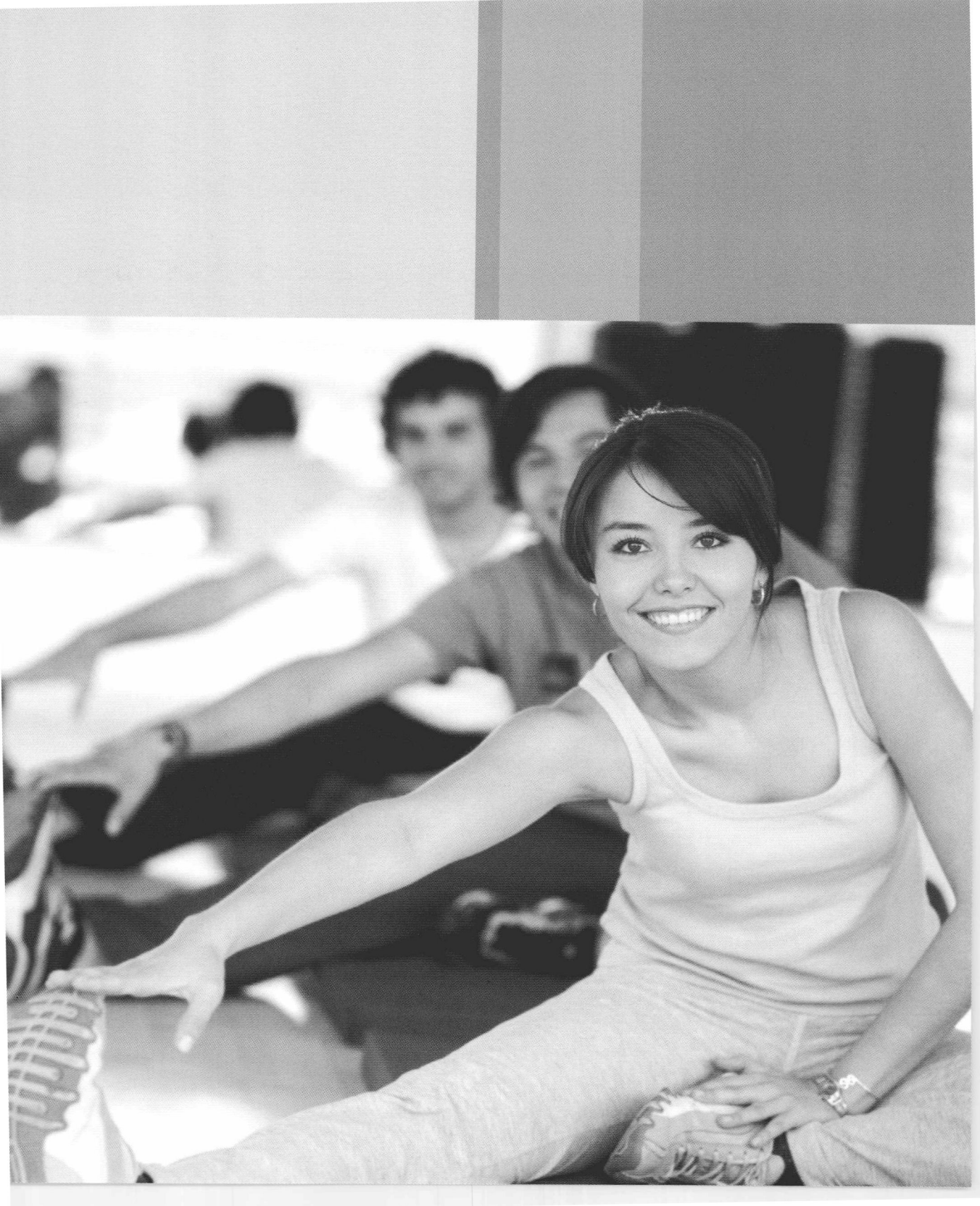
Over 300 people in every 1,000 experience mental health problems every year in Britain and of these 230 will visit a GP. From there, 102 people will be diagnosed as having a mental health problem and 24 will then be referred to a specialist psychiatric service with 6 becoming inpatients in psychiatric hospitals.

The aim of this book is to provide exercise professionals with the underpinning knowledge required to *design, agree, deliver and adapt physical activity and exercise programmes for persons with mental health conditions*.

The content is mapped to the National Occupational Standards at Level 4 (developed by SkillsActive 2010) and is designed to support the learning of exercise professionals who are working towards Level 4 qualification in Physical Activity for Persons with Mental Health Conditions.

The book does not provide explanations and descriptions of exercises or exercise programmes, as these are detailed in other books from the Complete Guide and Fitness Professional series published by A & C Black. It is expected that instructors working towards any of the level 4 qualifications would hold qualifications in a range of level 2 and 3 exercise disciplines, to enable them to work in a variety of ways to support this client group becoming more active. Rather, this book will provide an overview of a range of mental health conditions and will discuss considerations for working with persons with these conditions. It will build on models of motivation and behavioural change and communication skills and explore ways of working with clients, including roles, responsibilities and boundaries, initial assessment and information gathering and planning and delivery considerations.

Debbie Lawrence
Sarah Bolitho
2011



CONTENTS

PART **ONE**

MENTAL HEALTH AND PHYSICAL ACTIVITY

Mental health is an aspect of our total health that is often taken for granted. We share our happy days and good moods and we celebrate our successes and joys. However it is a different story when we are feeling sad, grumpy or in emotional pain. Somehow these equally valid and important emotions are considered wrong, unpleasant and shameful. People are keen to share their happiness but all too often the less 'happy' emotions become internalised and locked away, unwanted and untreated.

This part aims to explore the concept of mental health and mental ill-health and to examine some of the theories surrounding mental health conditions. Also discussed are the more frequently encountered conditions, possible causes and available treatments, including activity.

The benefits of activity for mental health and the recommendations for participation are discussed and also examined are the barriers that exist, both internally and externally, that hinder the adoption of and adherence to physical activity.

It is hoped that this section will inspire you to consider your own mental health and to investigate your feelings about mental illness. As fitness professionals we have a role to play not only in promoting activity among individuals with mental health problems but also in developing awareness and understanding in others.

> 'During depression the world disappears. Language itself. One has nothing to say. Nothing. No small talk, no anecdotes. Nothing can be risked on the board of talk. Because the inner voice is so urgent in its own discourse: How shall I live? How shall I manage the future? Why should I go on?'
>
> – Kate Millett (1991) *The Loony Bin Trip*, Virago Press Ltd, UK

> 'Mental illness is nothing to be ashamed of, but stigma and bias shame us all.'
>
> – Bill Clinton

1 WHAT IS MENTAL HEALTH?

This chapter introduces the concepts of mental health and mental illness. It outlines some definitions of mental health from varied and respected sources and introduces some of the factors that will affect our perception of what is considered normal and what is considered abnormal. With regard to mental health, this would include the beliefs, thoughts, attitudes, feelings/emotions, sensations and behaviours that are deemed as normal within our environment. These attitudes and beliefs will affect how we treat others with mental health conditions, also the regard in which we hold, and the value we place on, our own mental health.

This chapter also introduces some of the psychological models used to diagnose and treat mental health conditions. It outlines the criteria used by the medical classification system (DSM) and identifies some criticisms of this approach, setting the scene for a more integrative approach to working with clients with mental health conditions.

Ultimately, chapter 1 serves as an introduction to some of the themes and issues that will be revisited throughout the rest of the book.

OBJECTIVES

By the end of this chapter, you should be able to:

- recognise some of the factors that contribute to the perception of what is normal/abnormal (thoughts, beliefs, attitudes, emotions, behaviours etc.) mental health;
- recognise the psychological models and medical classification system used to define, diagnose and treat mental health conditions; and
- recognise the integrative model as a holistic method.

DEFINING MENTAL HEALTH AND MENTAL ILLNESS

The terms 'mental health' and 'mental illness' probably conjure up a variety of images and hold different meanings for different people. If asked to answer the questions 'what is mental health?' and 'what is mental illness?' we may struggle to find clear definitions. Although our minds may be drawn to media and movie images depicting acts of behaviour that we may define as normal or abnormal in our world, *Webster's New World Dictionary* (4th edn., 1998) offers the following definitions:

- Mental: 'Pertaining to the mind. Effected by or due to the mind'
- Health: 'Soundness of any living organism. General condition of the body or mind, as to vigour and soundness'
- Illness: 'The state of being out of health. An ailment, sickness. Badness; evil'

These definitions provide a starting point, but in no way capture the wholeness of mental health, which is the more modern concept. Arguably, they may capture the essence of some of the generalised beliefs that exist with regard to mental illness – that it is abnormal, bad, evil, a taboo of society. Indeed, mental illness is a concept that has been recognised for centuries and throughout all civilisations and has been attributed to numerous causes, including witchcraft and possession by demonic spirits.

A number of organisations have offered definitions of mental health. The Health Education Authority (1997:5) describes being mentally healthy as having: '... the emotional and spiritual resilience which enables us to enjoy life and survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own and others' dignity and worth'

The Mental Health Foundation defines mental health as: 'A state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.' (See www.mentalhealth.org.uk for more information.)

In keeping with these definitions, Jackson and Hill, eds (2006:5) emphasise good mental health as the ability to:

Good mental health (Jackson and Hill, eds, 2006:5)

- Start, keep and if necessary, end relationships
- Work or attend college/school
- Look after oneself and others
- Sleep
- Laugh and cry
- Eat
- Avoid problems with substances
- Deal with what others think about you
- Accept failure and deal with success
- Function sexually, if wished
- Learn
- Deal with loss
- Express good feelings
- Manage negative feelings

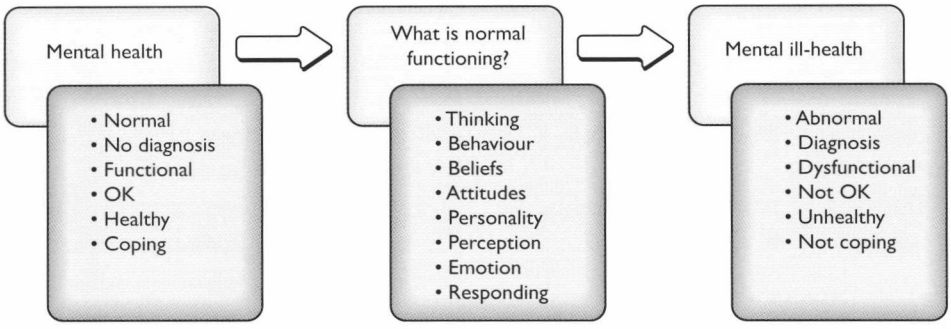


Figure 1.1 Single continuum model of mental health

NORMAL OR ABNORMAL MENTAL WELL-BEING

The continuum model indicates that mental health and mental ill-health are single dimensional entities. Using this model, classification of an individual's mental well-being would probably teeter somewhere between the polar extremes of what psychiatric experts might refer to as being *functional* (healthy) and *dysfunctional* (not healthy). This relates to thinking, perception, responding, behaviour, personality, intellect and emotion; those aspects of functioning that are not specific to a bodily or physiological system, such as gastro-intestinal and respiratory functioning (Daines et al., 1997) (see Figure 1.1).

However, there is no clear, single boundary that creates a defining point between what is considered positive mental health and what is considered mental ill-health or mental illness.

A psychiatrist generally uses the term 'mental illness' when there are a clear range of signs and symptoms (referred to as a 'syndrome') present and where there is a distinct deterioration in the person's functioning (Daines et al., 1997). Some of the factors that contribute to the controversy of defining where the 'cut-off point' is are introduced later in this chapter (see page 16), along with references to the classification systems currently used to assess mental health.

An alternative model to the single continuum model is the dual continuum model. This model reflects a shift in awareness in that health is not merely the absence of disease or illness; it is more than that. This model accepts that a 'mentally healthy person can become depressed under certain circumstances; just as a physically healthy person can acquire an injury or infection' (Jackson and Hill, 2006:3). It also indicates that a person with a diagnosis of a mental health condition can function quite *normally*, provided they receive appropriate care and support, as would a person with a physical health condition. From this perspective, mental health is therefore a *dynamic state* that can change in response to circumstances within our world and includes our subjective personal experiencing and the impact of our environment (community) on our experience. It is not something that can be exclusively classified by only external measures alone (diagnosis) (see Figure 1.2).

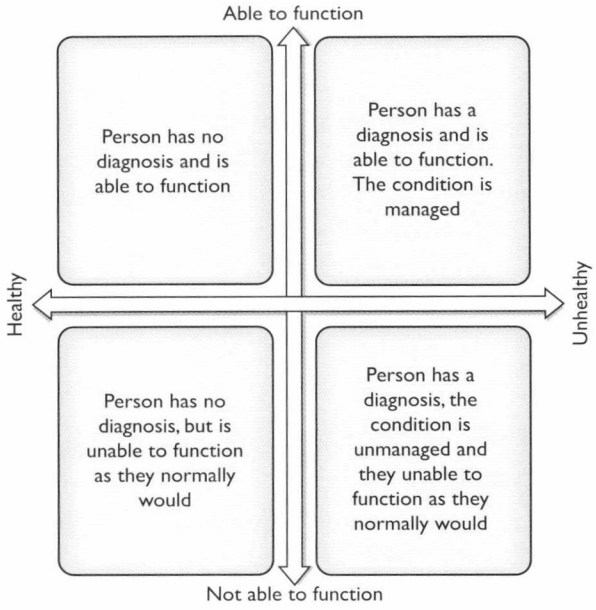


Figure 1.2 Dual continuum of mental health

PREVALENCE OF MENTAL HEALTH CONDITIONS

It may be a common belief that mental health conditions affect only a few people, making it their own problem, rather than a broader issue. Unfortunately this is not the case. In fact, the World Health Organisation (WHO) forecasts that depression will be second only to coronary heart disease as the leading contributor to the global burden of disease by the year 2020 (MHF, 2007:10).

To offer some perspective of the prevalence of mental health conditions, the Mental Health Foundation (2007/2010) reported the following statistics:

- 1 in 4 British adults experience at least one diagnosable mental health problem in a year.
- Mixed anxiety and depression is the most common condition in Britain, affecting approximately 9 per cent of people.
- Between 8 and 12 per cent of the population experience depression in any year.
- Women are twice as likely to experience anxiety as men are.
- An estimated 121 million worldwide will experience a depressive episode in a year.
- 60 per cent of people with phobias or obsessive-compulsive disorder (OCD) are female.
- Phobias affect 22 in 1,000 women and 13 in 1,000 men.
- 2–3 per cent of people will experience obsessive-compulsive disorder during their lifetime.
- Approximately 1 in 200 adults experience probable psychotic disorder in the course of a year, with the average age of onset of psychotic symptoms being 22.
- Schizophrenia is the most common of the psychotic disorders, affecting between 1.1 per cent and 2.4 per cent of people at any single time.
- 25 per cent of people with schizophrenia will make a full recovery, while 10–15 per cent will experience severe long-term effects.
- 1.7 per cent of adults worldwide have an alcohol-use disorder.
- In the year 2000, a quarter of adults in the UK were assessed as consuming alcohol at 'hazardous' levels.
- 80 per cent of persons dependent on alcohol, 75 per cent of people dependent on cannabis and 69 per cent of those dependent on other illegal drugs are male.
- 1 in 4 unemployed people has a common mental health problem.

- 1 in 10 children between the ages of 1 and 15 has a mental health disorder.
- It is estimated that approximately 450 million people worldwide have a mental health problem (WHO, 2001).
- Women are more likely to have been treated for a mental health problem than men.
- Depression is more common in women than in men.
- Dementia affects 5 per cent of people over the age of 65 and 20 per cent of those over 80.
- Mental health problems are thought to be higher in minority ethnic groups than in the white population, but these groups are less likely to have their mental health problems detected by a GP.
- Rates of mental health problems among children increase as they reach adolescence.
- Depression affects 1 in 5 older people living in the community and 2 in 5 living in care homes.
- In 2004 more than 5,500 people in the UK died by suicide.
- British men are three times as likely as British women to die by suicide.
- Suicide remains the most common cause of death in men under the age of 35.
- The suicide rate in prisons is almost 15 times higher than in the general population.
- The UK has one of the highest rates of self-harm in Europe, at 400 per 100,000 population.
- More than 70 per cent of the prison population has two or more mental health disorders. Male prisoners are 14 times more likely to have two or more disorders than men in general, and female prisoners 35 times more likely than women in general.
- Anorexia nervosa will be experienced by 1 per cent and 0.2 per cent of men in any year.
- Bulimia affects between 0.5 per cent and 1 per cent of women.

Statistics on Mental Health are from the MHF website 2010 (www.mentalhealth.org.uk/information/mental-health-overview/statistics/) and MHF Fundamental Facts (2007).

With these statistics in mind, mental health conditions may be more common and more 'normal' than we may initially think they are.

PERCEPTIONS OF MENTAL ILLNESS

Whether we know it or not, it is highly likely we will all know someone who has experienced or is experiencing a mental health condition – with an estimated 1 in 4 adults experiencing a condition in any year, we arguably would not need to look outside our family or workplace.

Unfortunately, mental health conditions are still taboo for many people. While most people would comfortably visit a personal trainer to help them get their body fit, speak with a GP about a medical condition, or ask for help from a dietician to improve their eating habits and diet, very few would have the same willingness and enthusiasm for visiting a counsellor or psychotherapist to help with their mind and emotions. Yet mental and emotional fitness are important aspects of our overall health, well-being and total fitness.

There is still much stigma attached to mental health and mental illness. It seems that physical ill-health or illness is OK whereas mental ill-health or illness is *not* OK. Modern campaigns, such as time4change (a campaign in England) supported by Mind, the Mental Health Foundation and

other organisations, is attempting to change this general attitude.

STEREO-TYPING/LABELLING

Classifying and diagnosing a person as having a specific mental condition is intended as a guide and starting point to assisting with the planning of their treatment. However, there appears to be a general lack of awareness, fear, discomfort and ignorance around the experience of persons with mental and emotional distress. When a person is classified or diagnosed as having a mental illness it can often lead to others adopting stereotypical views towards that person(s), which can cause them to feel separated and excluded (see Figure 1.3).

The Mental Health Foundation (2005) reports that 70 per cent of persons with mental health conditions have experienced discrimination (56 per cent have experienced discrimination from family and 52 per cent from friends, 44 per cent from their GP and 32 per cent from a healthcare professional). It is therefore perhaps not unsurprising that 42 per cent choose not to tell friends or family about their condition, which means they are lacking crucial support at a time when they most need it (see Figure 1.4).

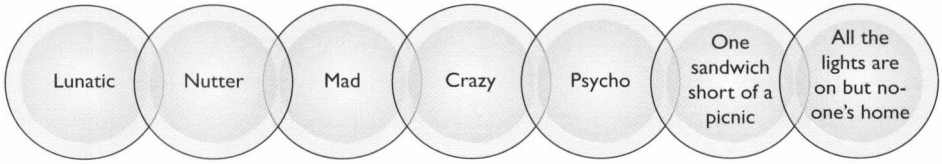


Figure 1.3 Negative labelling

'Mental health problems are for weak people'
Err ... what about Winston Churchill, Abraham Lincoln, Stephen Fry, Ruby Wax, Alistair Campbell...

'You won't get anywhere in life with a mental health problem'
Tell that to the people mentioned above and to Patsy Palmer, Billy Joel, Woody Allen, Charles Dickens, John Lennon...

'I don't know anyone with mental health problem'
One in four people in the UK will experience a mental health problem so it is likely that you actually know several people who have, or have had, a mental health problem

'Mental ill people are violent'
In fact violent acts are rarely committed by people with mental health problems, they are far more likely to hurt themselves than others or be attacked by members of the public because of their condition

'Once you have a mental health problem you can't get rid of it'
Not true, with appropriate treatment it is possible to overcome many mental health problems and return to a 'normal life'

Figure 1.4 Common misconceptions about mental health disorders

Figure 1.4 tackles some of the common misconceptions about mental health disorders.

Unfortunately, it is still a sad fact that disclosing a mental health disorder – even from the distant past – can result in a job offer suddenly being withdrawn or downgraded, or a current employee being suddenly made redundant. The MHF (2005) indicates that 39 per cent of adults with mental health conditions were unemployed compared with the general unemployment figure of 7.7 per cent. This is another reason that many people hide mental health problems when applying for work, but this in itself can lead to further problems if they are under stress or have a relapse, as they may not want to approach the organisation for help or support.

Indeed, mental health issues, such as depression and stress, are now the largest condition group where absenteeism and incapacity benefit are concerned. This is despite the Health and Safety Executive (HSE) guidelines on stress management in the workplace and the requirements of the Equalities Act 2010, which includes long-term mental illness as a category of disability.

MENTAL ILLNESS, THE MEDIA AND CRIME

The media has frequently been criticised for the way in which it reports and portrays persons with mental health conditions, and especially its tendency to link mental illness with criminal violence. It has been suggested that this compounds some of the discrimination and prejudice that people with mental health conditions face.

In fact, there is evidence to suggest that this is not an accurate representation. The National Institute of Mental Health (NIMH, 2010) indicates that persons with schizophrenia are not prone to violence; with the exception being those persons who have a criminal record before becoming ill or those with substance and alcohol abuse problems. They add that people with schizophrenia are not usually violent, preferring to be left alone, and that most violent crimes are committed by persons who do not have schizophrenia. NIMH (2010) suggests that substance abuse may raise the rate of violence, but this applies to people both with and without schizophrenia.

In reality, most violent offences are committed by individuals who do not have a mental health disorder. Of the 757 homicides in the UK in 2005, fewer than 10 per cent were committed by a person with a mental illness. In contrast, MHF (2005) reported that 1 in 7 persons with mental health conditions had been physically attacked and 50 per cent had been abused or harassed. In reality, most people with a severe mental health problem are more likely to harm themselves than another person. Unfortunately, the perception that someone with a mental health condition is 'dangerous' persists and serves only to increase stigma, prejudice and discrimination.

Further perceptions held by the general public towards persons with one of the more common mental health problems were reported in a survey by the Royal College of Psychiatrists. It was found that:

- 74 per cent rated drug addicts as dangerous while 71 per cent thought schizophrenics were a threat and 65 per cent believed alcoholics to be a danger.
- 49 per cent of people thought those with severe depression should 'pull themselves together'.

- 47 per cent thought drug addicts were to blame for their illness while 33 per cent thought the same of alcoholics and 39 per cent thought the same for people with eating disorders.
- 81 per cent of people thought alcoholics were unpredictable, compared with 78 per cent for drug addicts and 77 per cent for schizophrenics, and around 56 per cent of people with severe depression and 50 per cent of those suffering panic attacks were described as unpredictable.
- A majority believed the condition of people with dementia will not improve with treatment; 16 per cent believed depression could not be treated, compared with 15 per cent for schizophrenia, 14 per cent for panic attacks, 12 per cent for drug addiction, 11 per cent for alcoholism and 10 per cent for eating disorders.
- Many people still think it is difficult to communicate with people with mental illness.

Stereotyping, labelling and prejudice are not helpful as they can contribute towards impeding a person's recovery. They can also prevent people from seeking the help they need when experiencing mental and emotional distress. Interestingly, stereotyping in itself can also be viewed as 'pathological' (Gross and McIlveen, 1998:456). Indeed, many of the stereotypes portrayed are often 'contradicted by ordinary peoples' experiences of mental health problems affecting themselves, their family members, friends or work colleagues,' according to the MHF (Mental illness factsheet, 2000).

FACTORS INFLUENCING PERCEPTION

The beliefs and attitudes we hold in relation to 'being okay' are influenced by a number of factors, some of which are outlined in Figure 1.5.

Social and cultural factors

The way a person thinks and feels about and behaves towards issues of mental health and mental illness, and the way they respond to specific life events and circumstances, is highly influenced by the cultural and social group to which they belong and the way they react to the experience of life and living.

Social and cultural 'norms' influence many things including how we dress (the burkha, the bikini or body piercings), how we speak (voice tone and volume, the words we use, whether it be

Case study

'My uncle Bob had schizophrenia. On reflection, I always found his behaviour really odd. His eyes usually had a glazed look (probably the medications) and he was for the most part 'expressionless', which made it harder for me to understand him. He chain-smoked, rarely went out, usually drank too much at Christmas and was dependent on family for care for all of his life. He recently died, in his late seventies, after spending the last few years of his life undergoing kidney dialysis.

He was different, but he was never violent. In fact, my Mum reported a number of occasions when his home was robbed and he was conned out of money (to clean windows or do gardening) by tricksters. These stories get less if any mileage in the media!'