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The role of serious mental illness in motivation, participation and adoption of health behavior change among obese/sedentary Latino adults

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Abstract

Objective: Serious mental illness (SMI; e.g. schizophrenia, schizoaffective disorder, delusional disorder, bipolar disorder, severe major depressive disorder, and psychotic disorders) and Latino ethnicity can produce a compounded health disparity, placing individuals at particularly high risk for excess morbidity and premature mortality. In this study we sought to identify the role of SMI in motivation, participation, and adoption of health behavior change among overweight Latino adults.

Design: Qualitative, semi-structured interviews were conducted with 20 overweight Latinos with SMI who were enrolled in a randomized trial evaluating the effectiveness of a motivational health promotion intervention adapted for persons with SMI, In SHAPE. The interviews explored the complicated role having an SMI had in the lives of the Latino participants.

Results: SMI had both positive and negative impact on Latino participants' health behaviors. The nature of their mental illness along with medication side effects (e.g. lethargy, weight gain, etc.) negatively impacted their ability to making lasting health behavior change. However, the regular appointments with various specialists provided them with structure that they otherwise would have lacked and gave them a reason to get out of the house.

Conclusions: This exploratory research provides insight into the experience of overweight Latinos with SMI and the ways in which SMI impacts their participation in health behavior change. An understanding of the positive and negative effects of SMI on health behavior change will inform the development of health promotion interventions targeted at Latinos with SMI.

Keywords

health behavior change; Latino; serious mental illness

INTRODUCTION

Adults with serious mental illness (SMI; e.g. schizophrenia, schizoaffective disorder, delusional disorder, bipolar disorder, severe major depressive disorder, and psychotic disorders) have a 25–30 year reduced life expectancy and disproportionately greater rates of medical comorbidity compared to the general population (Druss, Zhao, Von Esenwein, Morrato, & Marcus, 2011). Premature mortality in adults with SMI is most often linked to cardiovascular disease (CVD) caused by sedentary lifestyle, obesity, and poor dietary habits (Colton & Manderscheid, 2006). Additionally, Latino adults with SMI have a greater prevalence of CVD risk factors, such as obesity and metabolic syndrome, as compared to non-Latino whites with SMI (Kato, Currier, Gomez, Hall, & Gonzalez-Blanco, 2004). Latinos with SMI also experience a disparity in access to healthcare and utilization of services (AHRQ, 2011). Together, Latino ethnicity and SMI are likely to result in a compounded health disparity, placing this group at particularly high risk for excess morbidity and premature mortality.

The increased morbidity and mortality rates in people with SMI are often attributed to preventable health behaviors associated with obesity and poor fitness (Colton & Manderscheid, 2006). People with SMI may argue that these behaviors are not preventable. Rather, they are the physical, psychological, social and environmental consequences of having an SMI and the treatments prescribed for them. Depression or the negative symptoms of schizophrenia may make it difficult to get motivated to lead a more active lifestyle. Antipsychotic medications have enabled people with SMI to live productive lives, but their side effects have had a deleterious impact on physical health. The sedating effects of some medications make it more difficult to be active (Correll et al. 2014; Haddad & Sharma, 2007). Atypical antipsychotics have been associated with significant weight gain, hyperlipidemia, impaired glucose tolerance, and reduced pain sensitivity (Allison et al., 2009). There are also socio-economic consequences of suffering from a mental health disorder, such as poverty, poor housing, reduced social networks, lack of employment and meaningful occupation opportunities, and social stigma – all of which impact on the physical health and the health behaviors of people with SMI (Robson & Gray, 2007).

To date, few studies have focused on addressing the challenges of health promotion for Latino adults with SMI. Latinos with SMI present unique challenges with respect to engagement and participation in health behavior change. Latinos experience social and cultural influences (i.e., diet, family networks, access to care, language barriers) that can affect their health behavior habits. Prior research focusing on Latinos with SMI has shown that preventing negative health consequences; receiving positive reinforcement; and having someone (either a professional or significant other) to hold them accountable for engaging in healthy behaviors were identified as facilitators of health behavior change. In contrast, unhealthy social environments, cultural influences on food, and financial resources were seen as the biggest barriers (Jimenez, Aschbrenner, Burrows, Pratt, Alegría & Bartels, 2015). However, the role of SMI in the participation and adoption of health behavior change in overweight Latinos has yet to be examined. We conducted semi-structured interviews to inform the development and delivery of culturally appropriate health behavior change and health promotion interventions for Latinos with SMI. The aim of this study was to identify

the role of SMI in motivation, participation, and adoption of health behavior change among overweight Latino adults.

METHODS

Latino participants who were enrolled in a randomized trial evaluating the effectiveness of a motivational health promotion intervention (In SHAPE) were asked to participate in this qualitative study. In SHAPE is an integrated health promotion program designed to improve physical fitness through dietary change and increasing exercise in adults with SMI (Van Citters, Pratt, Jue, Williams, Miller, Xie, & Bartels, 2010). The program provides each participant with a 1-year membership to a local fitness facility (YMCA) and access to a health mentor who develops personalized fitness plans for each participant and meets with them weekly for 45–60 minutes at the fitness facility. The nutrition component consists of individualized instruction during each meeting with the health mentor emphasizing healthy eating.

Participants were randomized to either (a) In SHAPE, or (b) a comparison condition consisting of a 12-month YMCA membership, on-site introduction to the exercise equipment and facilities, and educational materials on exercise and healthy diet. To be eligible for the randomized trial, participants had to meet the following criteria: age 21 or older; diagnosis of major depression, bipolar disorder, schizoaffective disorder, or schizophrenia (based on the Structured Clinical Interview for DSM-IV); overweight as indicated by BMI >25 or failure to adhere the US Department of Health and Human Services Physical Activity Guidelines for adults, i.e., at least 2.5 hours/week of moderate or 75 minutes/week of vigorous activity in more than one session.

This qualitative study included a purposive sample of 20 Latinos living in the Boston metropolitan area with a mean age of 40.3 (SD=10.4). For a description of the sample, see Table 1. Four Institutional Review Boards (IRBs) approved the research across three sites. All participants provided either verbal or written consent depending on the requirements of the IRB affiliated with the organization from which they were recruited. Twenty individual, semi-structured interviews were conducted. An interview topic guide was used that followed the “funnel structure” described by Krueger (Krueger, 1994). Broad questions were asked at the beginning, with the facilitator gradually proceeding to more specific questions within each domain. Sessions lasted 60 to 90 minutes, and participants were given \$25.00 in cash as compensation for completing the interview. All interviews were audiotaped and transcribed. The transcribed interviews were then analyzed using thematic analysis, which emphasizes pinpointing, examining, and recording patterns (or “themes”) within data (Braun & Clarke, 2006). Thematic analysis is performed through the process of coding in six phases to create established, meaningful patterns. These phases are: familiarization with data, generating initial codes, searching for themes among codes, reviewing themes, defining and naming themes, and producing the final report (Braun & Clarke, 2006). Transcripts were coded independently by the authors. Impressions and observations were discussed between the two coders until consensus was reached on the prominence of themes within each domain listed in the results. This method of multiple coding is an important step in reducing investigator bias (Whitley & Crawford, 2005).

RESULTS

Participants described a complicated role that having an SMI has had in their lives. SMI had both positive and negative impact on Latino participants' health behaviors. SMI had a negative impact on their adoption of health behavior change due to symptoms of their chronic mental illness such as lack of focus, agoraphobia, and amotivation/anhedonia. They also frequently reported that medication side effects of lethargy and weight gain negatively impacted their health behaviors. However, receiving treatment for their SMI had a positive impact on participants' health behaviors by creating structure, "forcing" participants to get out of the house, and by providing psychoeducation and support from mental health providers. A summary of each theme, the domain to which it is related, and an operational definition of each theme are presented in Table 2 and described below.

Negative Impact

Symptoms of SMI.—Participants cited a lack of focus, inability to concentrate, or racing thoughts as reasons they were unable to make it to the gym or follow through with plans to engage in health behavior change. One participant noted that perhaps "different medication [would help] to make me more active, more focused. It's hard for me to concentrate sometimes... Sometimes I feel like I'm a slave because of my illness... Sometimes I can't concentrate good." Another participant voiced that the reason he had not been going to the gym was because "My thoughts would be racing and everything. I guess that why I'm trying to be more single-minded and more focused now."

Many participants experienced agoraphobia which made it difficult for them to leave their homes. One participant stated that she rarely made it to the gym because she didn't feel safe leaving her house: "I guess I kind of struggle with being outside a lot. I feel safer inside." Another participant explained that "When you leave out of the house, you don't know what you come across." Anhedonia or lack of motivation was frequently cited by participants as a barrier to health behavior change. One participant explained: "Sometimes it just takes me a long time to get out of the house. I'll just watch TV or sleep. It's hard because with depression you lose your motivation to do things, even the things you enjoy, like you can't see the point to something." Another participant explained that "Sometimes I'm tired, I'm lazy... I just don't feel like getting out the house. That goes with my mental illness."

Medication Side Effects.—Lethargy and weight gain were the two most cited side effects that negatively impacted participants as they attempted to engage in health behavior change. One participant noted sleeping a lot more since being on psychotropic medication: "I sleep a lot. I don't know if it's the medications I take or what but I sleep like 12 hours a day." Another participant explained that his medications made him feel sluggish to the point of not being able to move: "My medication makes me tired and lazy... You are more relaxed than what is normal." Participants reported that medication made it more difficult for them to lose weight, a fact which often discouraged them from even attempting to make diet changes or exercise. One participant noted that he was "trying to eat better but the medication also changes your metabolism." Another participant complained "The

medication gives me the munchies.” A third participant explained how “In 2001 I lost a significant amount of weight but they put me on a medication that made me gain it back.”

Positive Impact

Structure.—Several participants noted that regular mental health appointments or participation in a day program helped them to have some structure in their life which overall helped them with health behavior change. One stated “I’m not good at creating my own structure. I have to kind of answer to outside structure in order to get things done.” Another participant explained that without participating in a day program she tended not to leave her house and therefore would not go to the gym: “Three times a week I’m home with my cat. The other four times a week I’m out. I go to a day program. That gives you some structure for the day.”

Getting Out of the House.—Participants noted that having appointments of any kind helped motivate them to get out of their homes. Once outside the home, participants found it easier to go to the gym. Participants frequently voiced a sense of commitment to appointments that motivated them to leave the house when they otherwise would not: “If I make an appointment I usually try to keep it... I feel responsible to go.” One participant explained “I figure it’s kind of like having a job. You have responsibilities to people around you, stuff like that, so I get going and say ‘I’ll feel better once I get there for reasons A, B, and C.’” Another participant cited the In-SHAPE appointments with the health mentor as his motivation for leaving the house: “It gave me something to do, something to get out of the house. You see, when I got an appointment or something I’m very faithful to that.”

Psychoeducation and Support.—Many of the participants noted that their mental health providers were critical in educating them about the benefits of diet and exercise and encouraging them to engage in change. One participant who was concerned about the cost of a gym membership noted “Even my psychiatrist and my primary care physician told me that if I exercise, the benefits of exercising outweigh the money you pay.” Another participant cited encouragement from her mental health providers as her reason for exercising: “‘If you lose weight you’re gonna feel better.’ My therapist tells me that, my psychiatrist tells me that.”

DISCUSSION

To our knowledge, this is the first study to examine the role of SMI in the participation and adoption of health behavior change in overweight Latinos. The causes of poor physical health in people with SMI are complex. Much of the previous literature has focused on the negative impact that SMI has had on physical health, specifically how SMI contributes to physical health disparities. Consistent with previous literature (Robson & Gray, 2007), we found that illness-related factors such as lack of focus, agoraphobia, and amotivation/anhedonia along with medication side effects of lethargy and weight gain negatively impacted their adoption of health behavior change. This highlights a dilemma. Medications enable patients to live productive lives in their own homes, in their own communities and avoiding long inpatient hospital stays. The tradeoff comes at the expense of the patient’s

quality of life. As a result of taking antipsychotic medications, patients often develop serious physical illnesses, or they are so sedated and overweight that they cannot leave their home or participate in meaningful social interaction (Bresington & White, 2015). Adding to this complexity, we found that receiving treatment for their SMI had a positive impact on participants' health behaviors by creating structure, "forcing" participants to get out of the house, and by providing psychoeducation and support from mental health providers. These results along with the cultural component of the study represent a unique contribution to the literature.

There is growing interest in the use of lifestyle interventions that focus on weight loss, physical activity, and health-promoting behaviors to help people with SMI reduce their risk for CVD and other chronic medical illnesses (Allison et al., 2009). Results from previous studies indicate that lifestyle interventions show promise in helping people with SMI reduce their weight and risks for cardiometabolic conditions (Cabassa, Ezell, & Lewis-Fernandez, 2010). Modifications to these interventions to address the unique needs of Latinos with SMI are needed to enhance the relevance, acceptability, and effectiveness of such interventions. Understanding how SMI impacts participants' engagement in health behavior change interventions is an important step in tailoring these interventions.

It is also important for clinicians to understand and recognize the impact of SMI on participation and adoption of health behavior change in Latinos. By understanding patients' perceptions about their SMI and health behavior change, clinicians may be in a better position to address their patients' needs in a relevant and culturally sensitive manner. The participants in this study indicated that clinicians had a positive impact on health behavior change by providing psychoeducation and support. These findings suggest that providers' interventions have a meaningful impact on the motivation and behaviors of patients.

Several limitations should be considered when interpreting the results of this study. First, participants were a convenience sample of Latinos with SMI who were already enrolled in a health promotion study. As such, this group represents a select subgroup and conclusions drawn may not be generalizable to the Latino SMI population at large. A second limitation is the relatively small sample size; however, a sample size of N=20 is consistent with exploratory qualitative methods aimed at identifying descriptive findings (Miles & Huberman, 1994). Third, the Latinos in this study were treated as a homogenous group when they actually comprise different subgroups of varying nationalities (predominantly Dominican and Puerto Rican). This grouping could mask meaningful variations. Fourth, the point in the study in which participants were interviewed was not uniform. They could have been at the beginning, middle, or nearing the end of their time in the study. The length of their time in the study could possibly impact their perceptions of how SMI affected their participation in health behavior change.

In sum, we found that SMI played a complicated role in the lives of Latinos with SMI. SMI negatively impacted participants' engagement in health behavior change due to symptoms of mental illness as well as medication side effects. Conversely, there were also benefits associated with receiving treatment for SMI in that appointments created structure and got participants out of their homes, and providers were a source of psychoeducation and support

for participants. The importance of addressing health behavior change among Latinos with SMI is heightened by the health disparities experienced by this population (Jimenez et al., 2015; Jimenez et al., 2016; Kato et al., 2014). These factors should be taken into consideration by primary care and mental health clinicians treating this disadvantaged population. The findings can inform the development of health promotion interventions specifically targeted at Latinos with SMI. Allowing consumers to respond freely in their own words and about their unique circumstances is a promising approach to improving the health and well-being of this increasingly large number of underserved individuals.

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Table 1.
Sociodemographic Characteristics

Characteristic	n (%)
Sex	
Male	11 (55%)
Female	9 (45%)
Country of Origin ^a	
Puerto Rico	9 (45%)
Dominican Republic	6 (30%)
Colombia	1 (5%)
Language Preference ^b	
English	17 (85%)
Spanish	2 (10%)
Randomization	
In SHAPE	13 (65%)
Comparison Condition	7 (35%)
Diagnosis	
Schizoaffective Disorder	10 (50%)
Schizophrenia	5 (25%)
Severe Major Depressive Disorder	3 (15%)
Bipolar Disorder	2 (10%)
Marital Status	
Single	17 (85%)
Married	1 (5%)
Separated	1 (5%)
Divorced	1 (5%)
Living Situation	
Living Independently	10 (50%)
Assisted/Supported Housing	7 (35%)
Living with family member or significant other	3 (15%)
Time Spent in the Study	
Beginning: waiting for their 12-month gym membership to begin	6 (30%)
Middle: >3 months with gym membership	12 (60%)
End: Completed the study	2 (10%)

^aCountry of Origin: 3 participants did not report their countries of origin, and 1 reported being “half Puerto Rican and half Dominican.”

^bLanguage Preference: 1 participant preferred to speak in “Spanglish” – half in English and half in Spanish.

Table 2.
Perceived Impact of SMI to Engaging in Health Behavior Change: Qualitative domains, related themes, and operational definitions of each theme

Domain	Themes	Operational Definition
Negative Impact	Symptoms of SMI	Symptoms of their chronic mental illness such as lack of focus, agoraphobia, and amotivation/anhedonia.
	Medication Side Effects	Medication side effects of lethargy and weight gain.
Positive Impact	Structure	Regular mental health appointments or participation in a day program helped them to have some structure in their life
	Getting out of the House	Having appointments of any kind helped motivate them to get out of their homes.
	Psychoeducation and Support	Education about the benefits of diet and exercise and encouragement from providers.

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