Determinants and strategies for physical activity maintenance in chronic health conditions: a qualitative study

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Cardiovascular diseases (CVD) are the primary cause of death globally, accounting for more than 30% of all deaths.\textsuperscript{1} Thirty minutes a day of moderate physical activity is recommended to prevent or manage CVD and comorbidities (e.g., diabetes and hypertension).\textsuperscript{2} For ongoing health benefits, moderate intensity activity needs to be maintained in the long-term, which is defined as consistently engaging in physical activity for six months or more.\textsuperscript{3,4} Nevertheless, evidence suggests that adults with health conditions are less likely to maintain physical activity than "healthy" adults.\textsuperscript{4} Additionally, physical activity disengagement typically occurs six months after interventions cease.\textsuperscript{5} Consequently, there is an increased emphasis on the development of interventions to promote physical activity maintenance\textsuperscript{3} and attention is warranted to explore the mechanisms for this behavior within adults with CVD and comorbidities.

It is suggested that behavior change interventions are more effective if derived from theory.\textsuperscript{6} Physical activity interventions are typically informed by social cognition models, such as the transtheoretical model and social cognitive theory.\textsuperscript{7} However, many theories are criticized for largely focusing on the determinants for the initiation phase (e.g., self-efficacy), which could differ to that of the maintenance phase (e.g., perceived satisfaction) of behavior change.\textsuperscript{8} The transtheoretical model is an exception which defines the stages of change from pre-contemplation to maintenance and relapse.\textsuperscript{7} Despite this, interventions derived from the model are no more effective than a control group for promoting physical activity maintenance after intervention cessation.\textsuperscript{9} A suggested explanation for this is that the transtheoretical model was largely developed for behavioral cessation (e.g., smoking cessation) and, therefore, fails to consider the mechanisms associated with behavioral adoption (e.g., physical activity).\textsuperscript{10} Consequently, the specific determinants for physical activity maintenance are
unclear which limits the development of effective interventions. A previous review of the literature has recommended that research should focus on distinguishing the determinants that differentiate successful and unsuccessful physical activity maintenance to develop better long-term interventions.

Studies specifically focusing on the determinants for successful and unsuccessful physical activity maintenance within chronic health conditions are scant. In healthy adults, evidence suggests that cognitive-behavioral processes distinguish between successful and unsuccessful maintainers, such as decreased perceived cons (e.g., physical activity is too time consuming), increased perceived behavioral control, and increased perceived satisfaction. Additionally, maintainers are more likely than unsuccessful maintainers to have enhanced self-efficacy for overcoming barriers, such as boredom, and inclement weather. Only one study confirmed that increased self-efficacy, increased outcome expectations, and enhanced self-determination led to successful maintenance in adults with CVD risk factors. The lack of research within adults with CVD and comorbidities warrants further exploration into the determinants for physical activity maintenance.

In addition to determinants, the appropriate behavior change techniques need to be implemented in interventions to successfully promote change. The 40-item taxonomy of behavior change techniques outlines the cognitive-behavioral strategies used to promote physical activity and healthy eating. Specifically, self-monitoring, feedback on performance, and goal-setting have been shown to be effective. It is unclear, however, if such strategies promote physical activity maintenance. Furthermore, the taxonomy focused on 'healthy' sedentary individuals, which limits its generalizability to chronically ill adults, as additional strategies have been found to promote physical activity, such as pain management and relaxation techniques. Thus, successful physical activity maintenance in adults with chronic
PHYSICAL ACTIVITY MAINTENANCE

health conditions is likely to be dependent on additional strategies not outlined within the
existing taxonomy and warrants further exploration.

When existing literature and theories inadequately explain the mechanisms for
behavior change, qualitative methods are called upon in the developmental phase of an
intervention.¹⁸ Thus, the aims of the current study were to qualitatively explore the
determinants and strategies used by successful and unsuccessful maintainers after completion
of a primary care physical activity referral scheme (PARS). Such insights will inform the
development of future physical activity maintenance interventions for adults with chronic
health conditions. Additionally, the findings will inform health professionals of the strategies
to encourage continual exercise engagement and subsequent health benefits.

Methods

Participants

With institutional ethics approval, purposive sampling was used to recruit participants
from physical activity referral schemes (PARS) in South Yorkshire, UK. A comprehensive
description of PARS can be found elsewhere.¹⁹ Sedentary patients with stable chronic health
conditions (e.g., stable angina), are referred to PARS for 24 sessions of moderate-vigorous
physical activity across 12 weeks. No specific behavioral or maintenance strategies are
employed. Each hourly session consists of gym-based aerobic and resistance training. For
study eligibility, participants were aged 18+, started the scheme 12 months prior to study
commencement, increased their moderate-vigorous exercise to at least 90 minutes a week,
and reported maintaining at six months post PARS. Since PARS do not measure physical
activity status (at baseline), attendance rates of ≥ 75% of sessions was used to ensure activity
levels were increased. Incentives were offered to maximize recruitment, such as entry into a
prize draw offering two participants gift certificates to a local store. Theme saturation
occurred (where no new themes or information emerged from new participants) at 15 participants for successful maintainers but 20 were obtained to adhere to recommendations for achieving saturation. The response rate was low for unsuccessful maintainers and so purposive sampling ended when theme saturation was achieved resulting in 12 participants.

**Instrumentation**

To categorize participants as successful or unsuccessful maintainers, the Physical Activity Stages of Change Questionnaire adapted from the Scottish Physical Activity Questionnaire (SPAQ) was used. The questionnaire invites participants to choose one statement from five that best described their physical activity over the previous six months (e.g., "I am regularly physically active and have been so far longer than six months"). While there is consensus that maintenance is defined as sustaining a behavior for six months or more, there is no consensus on what constitutes unsuccessful maintenance. For the purpose of this study, if participants stated to have engaged in physical activity for six months or more, they were considered to be in the maintenance phase. If participants reported engaging in no physical activity, or had done so for less than six months, they were considered to be unsuccessful maintainers given that a lapse would have occurred after the referral scheme.

Current physical activity status was also measured to validate participant categories using the International Physical Activity Questionnaire (IPAQ) long-form. It was assumed that successful maintainers would perform more activity than the unsuccessful maintainers. The IPAQ measures vigorous-intensity, moderate-intensity, walking activity, and sitting time based on metabolic equivalent of task per minute (MET-minute). The scale has acceptable test-retest reliability (spearman's p = 0.80) and has been tested in a range of populations.

The interview schedule consisted of approximately 20 open-ended questions focusing on participants' activity participation, strategies, and related experiences before, during, and after the referral scheme (e.g., 'Tell me about your experiences of physical activity before the
referral scheme?' 'What strategies do you use to stay active?'). This included an exploration of their most recent experiences and reasons for physical activity participation (e.g., 'What prompts you to exercise (or not exercise) now?'). Two pilot interviews were conducted to ascertain the appropriateness of the interview schedule. Repetitive questions were removed and included a question on the use of technology as a strategy because this was an emerging theme from the pilot interviews (e.g., ‘What do you think to using technology such as pedometers to help you stay active?’).

Procedures

PARS completers were identified from a database owned by the PARS coordinator, which contained information on attendance and physical activity status at six months post-PARS (e.g., 'yes, I'm still active' or 'No, I'm not as active'). Recruitment packs, consisting of study information and questionnaires were distributed by the PARS coordinator to eligible participants. After obtaining informed consent, each participant engaged in a one-hour semi-structured face-to-face audio-recorded interview, which was transcribed verbatim. Pseudonyms were used to ensure confidentiality. Telephone interviews were conducted if participants could not attend a face-to-face interview. The interviews were conducted by the principal researcher who used a combination of open-ended questions, reflections, and paraphrases to elicit relevant information.  

Data Analysis

Framework analysis was used to analyze the data and is a popular method employed in health-related research during intervention development. Data analysis consists of five inter-connected but distinct stages. In Stage 1 (familiarization), each transcript was read through and uploaded to QSR-Nvivo (Version 9). Notes were made for potential themes using the memo and annotation tool. In Stage 2 (identification of a thematic framework), a thematic framework was developed based on a random selection of the transcripts and
PHYSICAL ACTIVITY MAINTENANCE

consisted of a hierarchical structure of higher-order and lower-order themes (Table 2). In Stage 3 (indexing), the thematic framework was applied to the remaining transcripts and new or similar themes were integrated. Frequencies of successful and unsuccessful maintainers for each theme were obtained to aid the analysis. All investigators conducted theme triangulation until agreement was reached. Inter-coder reliability was conducted with an independent researcher and achieved 86 percent and deemed acceptable. In Stage 4 (charting), charts were created to highlight associations between determinants and strategies, which were identified using the coding tool in QSR-Nvivo. In Stage 5 (mapping and interpretation), the association charts were transformed into process maps and the mechanisms were understood by applying existing literature on behavior change theories and strategies. Meetings were held with all investigators to reach consensus on interpretations of themes.

Descriptive statistics were calculated for IPAQ scores, which were computed in SPSS version 19. The total median METs-minute for all activities was used. Data was not normally distributed and a Mann-Whitney U test was performed to compare the level of activity between successful and unsuccessful maintainers.

Results

Participant Characteristics

Thirty-two participants were interviewed and participant characteristics are outlined in Table 1. The median METs-minute for total activity performed in an average week for the sample was 3244.5 ± 4948.3. The successful maintainers performed nearly 8-fold more activity (Mdn = 6203.5 ± 4940.7) than the unsuccessful maintainers (Mdn = 777.0 ± 2655.9) and this difference was statistically significant (U = 22, p < .001, r = -.67).

Determinants and Strategies for Successful and Unsuccessful Maintenance.
PHYSICAL ACTIVITY MAINTENANCE

The thematic framework outlined in Table 2 reports the 11 major themes and associated lower-order themes that emerged for both successful and unsuccessful maintainers. These include: (1) outcome expectations; (2) outcome experiences; (3) core values; (4) attitudes towards physical activity; (5) trial and error; (6) social and practical support; (7) psychological barriers; (8) physical barriers; (9) environmental barriers; (10) physical activity self-management strategies; and, (11) condition management strategies. Each theme will be described in relation to successful and unsuccessful maintenance.

****INSERT TABLE 2 HERE****

**Physical Activity Outcome Expectations and Experiences**

All participants, including unsuccessful maintainers, reported expectations of gains from physical activity, such as improving health and functional independence \((n = 32)\). This is illustrated by a male maintainer, "I expect to get fitter and healthier" and a male unsuccessful maintainer, "I want to put five years on my life …of being fit… It's not how long you live it’s the quality of life."

By engaging in physical activity through the referral scheme, the majority of participants reported experiences of benefits by observing physiological or psychological improvements \((n = 31)\), receiving compliments from others \((n = 9)\), or observing improvements in others \((n = 5)\). One male successful maintainer stated, "I struggled with bending down to put my socks on but I'm not now". Nevertheless, physical activity disengagement was still reported by the unsuccessful maintainers. The lower-order theme 'no experience' confirmed that the majority of unsuccessful maintainers \((n = 8)\) reported experiencing little or no improvement in a prioritized outcome expectation, as one female discussed, "the main thing is to lose weight and I enjoyed it [physical activity] when I was there. I used to think to myself, this is better than sitting down, but I never noticed any [weight loss] really." The lack of experienced benefit for a prioritized outcome appeared to
result in incongruence between physical activity outcome expectations and experiences leading to disappointment and disengagement. Furthermore, unrealistic expectations about one's own ability, effort, and length of time needed to experience benefits appeared to contribute to this incongruence in unsuccessful maintainers ($n = 5$). For example the length of time needed to lose weight appeared unrealistic as a female unsuccessful maintainer mentioned, "Well I'd probably do it [physical activity] for a couple of days and then go off it and think 'oh, I've done it now'."

Strategies associated with outcome expectations and experiences included goal setting ($n = 15$), and self-monitoring ($n = 9$) of physiological changes, such as improved blood pressure and fitness. Technological devices, such as the internet and heart-rate monitors were used, which provided feedback on performance, thus enabling self-management of a health condition. A male successful maintainer recovering from a heart-attack, triple bypass, and angina discussed the use of a heart-rate monitor to observe fitness progress and manage his heart condition, "I got it to a hundred and four today. I could feel it [angina] coming on and I don't want to push it so each day I try and go as long and hard as I can." Condition management strategies also appeared to encourage positive experiences by managing unpleasant symptoms and allowing continual physical activity engagement. For example, pacing ($n = 16$) involved engaging in enough activity and rest so to avoid pain, fatigue, and other symptoms. One male successful maintainer stated, "You've got to pace yourself. If I went out of here and dug a garden, I'm going to be knackered the next day and I think…next time, I'm only gonna do half of that." These techniques were mainly used by successful maintainers compared to the few unsuccessful maintainers (cf. Table 2).

Core values

Core values, such as a health value, family value, or independence value, appeared to influence both successful and unsuccessful maintainers ($n = 31$). A core value existed
independently to physical activity (e.g., family or health) and was reported to be a "means to an end" that could be influenced by exercise participation. For example, since the diagnosis of a chronic health condition, one male successful maintainer stated, "I value health more than anything". If congruence existed between physical activity expectations, experiences, and a value, then successful maintenance occurred. For example, successful maintainers discussed the impact of exercise on fitness levels and the importance (value) of family since the onset of a health condition ($n = 10$), "I like to think being active is helping me since the operation…I'd like to think I can keep helping the family…which I can still do so that's the important part as far as I'm concerned." In contrast, if incongruence existed between physical activity expectations, experiences, and values then exercise was perceived as a barrier resulting in disengagement. For example, unsuccessful maintainers also reported a family value ($n = 6$) but was seen as more important than exercise, "If one of my kids wanted me to do something I'd do it…and then I think 'no I really need to go [to the gym]' I put my family first, which I think is the most important thing."

**Strategies Associated with Core Values** were a range of time management strategies, such as planning ($n = 15$), prioritizing ($n = 8$), developing a routine ($n = 9$), flexibility ($n = 8$), and planning “me time” ($n = 7$). Only successful maintainers reported using the strategies to negotiate competing demands between exercise and core values. One female successful maintainer discussed managing her health condition, prioritizing exercise, and her family value, “I look after the family a lot but I manage by having a day off. I get to do some exercise and recharge my batteries... I have to prioritise what I do." In contrast, only unsuccessful maintainers ($n = 5$) reported being unable to manage disruption of an exercise routine, "I’ve had to cover some holiday to work so that’s totally sent my routine out".

**Trial and Error**
A "trial and error" learning process appeared to be a method by which both successful 
\( (n = 11) \) and unsuccessful \( (n = 6) \) maintainers learned their physical limitations, capabilities, 
and strategies for physical activity engagement. The process appeared to involve "pushing 
yourself" which leads to a "knowing" of physical limitations and capabilities. The difference 
between successful and unsuccessful maintainers appeared to be that the maintainers 
accepted their limitations and worked within them but the unsuccessful maintainers were still 
in denial. For example, a male maintainer described, "You just keep pushing and pushing…In 
the past I've pushed myself too much and felt it for the next week but now I get to a point 
where I KNOW I can push myself to that level." Alternatively, the inability for unsuccessful 
maintainers to accept their physical limitations led to over exertion and exercise 
disengagement, despite knowing their capabilities, "I still think I'm nineteen and I can do 
what I did then, and I'd try that and suffer for…the conscious argument isn't there…and I 
suppose the trick is to maintain that level of consciousness."

**Strategies Associated with Trial and Error** were pacing \( (n = 15) \) and graded activity 
\( (n = 3) \) which appeared to be learnt through this process. Only successful maintainers 
reflected on the strategies. One female successful maintainer discussed learning the necessity 
of pacing and graded activity after an operation, "I was impatient and I started walking too far. 
I got quite ill because my body was trying to tell me to stop. After that, I was very careful to 
gradually just do a bit and pace myself." In contrast, unsuccessful maintainers had not learnt 
to pace \( (n = 5) \), "I tried to do things too quickly… but I was angry with myself for not losing 
the weight…so I would go at it too hard…always trying to prove myself."

**Social and Practical Support**

All participants reported receiving social and practical support \( (n = 32) \). During the 
referral scheme, both successful \( (n = 8) \) and unsuccessful \( (n = 4) \) maintainers reported a 
cathartic effect from receiving support from group exercise and compared it to "group
therapy”. One female unsuccessful maintainer said, "I met other people who had the same problems I had…so seeing other people cope gave me a boost." Once the scheme ended, however, the majority of successful maintainers ($n = 13$) appeared to receive social support from health professionals or family as one male stated, "my wife keeps pushing me to come to the gym". Additionally, group exercise classes appeared to provide a substitute for the loss of routine, purpose, and structure during retirement that was once gained from past employment largely for successful maintainers ($n = 8$), "the work has gone now so therefore I’ve got to look at something as a substitute …when you’ve finished work, you think 'what am I going to do now?'" In contrast, fewer unsuccessful maintainers ($n = 5$) received support from family which would prevent total sedentary behavior; "I do go to the gym sometimes when I feel guilty and get shouted at by my son or daughter". Additionally, unsuccessful maintainers ($n = 5$) discussed that the loss of support and monitoring was demotivating as "once you’ve left the referral, you don’t have to produce anything to say what you're doing. You’ve got to do it all yourself and that's hard". Successful maintainers also expressed a concern about support ending ($n = 7$), accompanied by limited confidence to independently continue with exercise. It was reported, "I want to know what’s going to happen when Derek does pack the class up because…I just don't motivate myself unless there's something there."

**Strategies Associated with Social Support** from health professionals and significant others included encouragement ($n = 19$), health advice ($n = 16$), monitoring by others ($n = 15$), and a reminder to pace activity ($n = 10$). A successful maintainer explained the benefits of encouragement and monitoring, "the staff encourage you and I think knowing that somebody is going to keep checking up on you helps motivate you". These strategies were experienced to a similar extent for both successful and unsuccessful maintainers (cf. table 2).

**Attitudes for Physical Activity Maintenance**
Positive attitudes, such as commitment, and self-responsibility were held largely by successful maintainers (cf. Table 2) who stated it was "commitment more than anything" that helped maintain physical activity and stated, "you should take responsibility for your own health". Nevertheless, some unsuccessful maintainers also held positive attitudes that appeared to be negatively influenced by other factors, such as the referral scheme terminating, not experiencing benefits, and depression. For example, a female unsuccessful maintainer mentioned, "It's only me who can get myself there...but I've been feeling very low and I just can't motivate myself to do much". Also, only unsuccessful maintainers ($n = 7$) held negative attitudes as they reported feeling "fed up", and "can't be bothered" as a reason for not engaging in physical activity.

**A Strategy Associated with Attitudes for Physical Activity Maintenance** appeared to be cognitive reframing to overcome negative attitudes by successful maintainers ($n = 10$). For example, similarities were drawn between commitment for maintaining physical activity and work as it was stated: "I've always enjoyed my job but you always get that day where you don't want to go but you just do it and it's the same with going to the gym, you just do it.”

Unsuccessful maintainers had not reported any strategies specifically for overcoming negative attitudes.

**Barriers to Physical Activity Maintenance**

Both successful and unsuccessful maintainers experienced barriers ($n = 32$; cf. Table 2). These were categorized into physical (e.g., illness), environmental (e.g., accessibility), and psychological barriers (e.g., boredom). The difference between successful and unsuccessful maintainers was their ability to overcome barriers. For example, all unsuccessful maintainers ($n = 12$) discussed barriers, such as illness, currently preventing exercise participation as it was stated,"I've not been going [to the gym] since before Christmas because of how ill I've been". In contrast, the majority of successful maintainers ($n = 17$) discussed a barrier that
occurred in the past and had been overcome, such as a past caregiver duty, "In the day time I was looking after my wife so I didn’t have time to do anything else… but now I find the time".

A physical barrier labeled "the plateau" also emerged and was experienced by some maintainers ($n = 5$) and unsuccessful maintainers ($n = 2$). It was defined as a point in an exercise regimen where physiological or psychological improvements would "taper off so you're not seeing any extra benefit". This appeared to result in dissatisfaction with any experiences of physical activity leading to disengagement, "When I first came doing things [physical activity], I was losing weight, looking better and feeling better but after I had plateaued, what is the reward?"

**Strategies Associated with Overcoming Barriers** were those outlined in Table 2. Although all participants mentioned using strategies at some point, only successful maintainers mentioned strategies specifically for overcoming barriers ($n = 17$). Maintainers appeared to use different strategies to overcome the same barrier. For example, cognitive reframing helped some participants to manage a health condition, "I've got diabetes and I can sit there at home and feel sorry for myself or I can…say 'what can I do?'” where other participants used graded exercise: "I do the exercises to the limit it [the gout] lets me and try and push me that little bit further each time.” Furthermore, the same strategy appeared to have more than one purpose. For example, finding alternatives for exercise helped some participants overcome exercising alone, "the chap I used to play [squash] with dropped out and we both stopped coming…then I took up scuba diving,” whereas the same strategy helped others deal with pain, "I've tried the gym but I'm in too much pain…I can hardly move but swimming and water aerobics I'm fine.” Only two successful maintainers had knowledge of strategies to overcome the plateau, such as goal setting and adding variety to an exercise
routine, “Because I knew what was happening, I wasn’t de-motivated…you set yourself new goals and change what you do in the gym like adding an extra set...”

**Discussion**

This qualitative study explored the determinants and strategies that promote physical activity maintenance or relapse in adults with chronic health conditions. The results demonstrate that physical activity maintenance is a complex trial and error process where both successful and unsuccessful maintainers have expectations, experiences, values, social support, attitudes and barriers. This study adds by highlighting the factors which determine maintenance or relapse.

**Determinants**

Consistent with previous research, the current study suggested outcome expectations and experiences play a role in physical activity maintenance in adults with chronic health conditions. Moreover, the findings suggest that congruence between prioritized outcome expectations and experiences of physical activity benefits determines whether one maintains or disengages with exercise. This is consistent with expectancy-value theory whereby physical activity disengagement is found to be the result of violations for a prioritized outcome expectation, often due to unrealistic expectations. This study also provides further evidence that outcome experiences play a larger role in maintenance than outcome expectations. Health professionals could promote physical activity maintenance by eliciting prioritized outcome expectations, identifying unrealistic expectations, and tailoring interventions to encourage congruence between expectations and experiences to prevent relapse.

Additionally, while all participants have core values, the level of congruence between core values (e.g., family), outcome expectations, and experiences appeared to influence successful or unsuccessful maintenance. For example, if physical activity was seen to
enhance fitness (outcome expectation) and such fitness was perceived to allow the individual to spend time with the family (core value) then maintenance occurred. The values identified in this study are consistent with existing theories and definitions of value priorities. Moreover, the finding supports existing evidence that congruence between underlying values and beliefs, attitudes, or intentions towards physical activity leads to maintenance. This further highlights the need for health professionals to elicit values and identify any incongruence between values, outcome expectations, and experiences to prevent relapse. An example technique is motivational interviewing, which has been found to be effective in value matching for physical activity, but is yet to be tested for promoting behavioral maintenance in those with chronic illness.

Social and practical support from significant others and health professionals could influence physical activity maintenance as it provided encouragement and a cathartic outlet when living with a health condition. Although both successful and unsuccessful maintainers received social support whilst participating in PARS, those who maintained after completion of the scheme sought further support as opposed to becoming de-motivated. Existing research has indicated that social support is influential for behavioral initiation and could be influential for behavioral maintenance, which is supported by this study. Nonetheless, the results in this study also indicated that a reliance on social support can encourage a dependency that is detrimental for long-term physical activity. Thus, approaches are needed to encourage autonomy so individuals are equipped to continue exercising after support ends. Both motivational interviewing and cognitive-behavioral strategies (e.g., action planning and goal setting) are found to encourage autonomy and increase self-efficacy for physical activity initiation. Future research, however, needs to explore whether such strategies could promote behavioral maintenance.
Previous research has indicated that attitudes, such as commitment and self-responsibility are associated with increased adherence to exercise programs. Within this study, successful maintainers largely held positive attitudes, while negative attitudes were only expressed by unsuccessful maintainers. Additionally, some unsuccessful maintainers also held positive attitudes but other circumstances, such as support terminating, meant that the attitude did not influence behavior. Consequently, interventions need to do more to increase and challenge the factors which negatively interfere with positive attitudes towards physical activity. For example, previous research has indicated that health education and behavioral contracts can foster commitment and increase activity. The current research also adds that cognitive reframing can help overcome negative attitudes. Nevertheless, further research is needed to test the direct effect of such strategies on enhancing long-term commitment to physical activity.

Trial and error emerged as a process where individuals would initially push themselves too hard with activity resulting in exacerbated symptoms and activity disengagement. Although both successful and unsuccessful maintainers reported the process, maintainers had learnt their limitations, capabilities and effective condition management strategies, whereas unsuccessful maintainers had not. Pacing appeared to be a strategy learnt through this process that helped manage any excessive physical activity, thereby limiting pain and fatigue, thus facilitating continual exercise engagement. These findings are consistent with previous research in chronic illness self-management. At present, research largely focuses on activity pacing in the context of pain or fatigue management. Further research is needed to directly test the role of activity pacing on physical activity maintenance.

Barriers to Physical Activity

A range of psychological barriers (e.g., boredom), physical barriers (e.g., illness, the plateau), and environmental barriers (e.g., time, appointments) were found. The factor which
distinguished between successful and unsuccessful maintenance was the ability to overcome such barriers. Maintainers largely reported implementing a range of strategies (e.g., self-management or graded activity) to overcome barriers. These findings are consistent with previous research, which suggests that such barriers can prevent physical activity initiation and increased self-efficacy is needed to challenge barriers for continual exercise engagement. Consequently, continual barrier identification is needed for physical activity maintenance.

One barrier new to physical activity maintenance research was the ‘plateau’. This was defined as a reduction in physiological gains over time, such as reduced weight loss. The plateau appeared to prevent experiences of benefits leading to dissatisfaction with the outcome unless strategies were implemented. While the plateau is a new phenomenon to physical activity maintenance research, it is consistent with periodization in sports training. Athletes are encouraged to incorporate monthly changes to a training program (e.g., implementing a new activity) to prevent the plateau and ensure continual improvement. Drawing from this, educating individuals in how to recognize a plateau and implement specific strategies could help patients to experience benefits and maintain activity.

Cognitive-Behavioral Strategies

A range of cognitive-behavioral strategies for self-management of physical activity (e.g., self-monitoring, goal-setting, and feedback) and condition management (e.g., pacing and acceptance of limitations) supported physical activity maintenance. The strategies found were consistent with the taxonomy of behavior change techniques, and self-management of chronic health conditions. Although successful maintainers mainly used strategies, unsuccessful maintainers reported using some strategies which suggests continual attempts at being active. These findings highlight the importance of supporting individuals by teaching self-management strategies for physical activity maintenance. Additionally, condition
management strategies are also needed for physical activity maintenance in adults with chronic health conditions.\textsuperscript{17} This presents a new challenge for those delivering interventions as training will be required to effectively deliver the range of strategies needed.

The current study also gave insight into the self-management strategies that regulated the determinants. For example, self-monitoring and goal-setting allowed physical activity benefits to be experienced. Consistent with previous research, such strategies for physical activity promotion have been found effective.\textsuperscript{15} Additionally, successful maintainers mainly used strategies whereas unsuccessful maintainers lacked the resources or knowledge needed in this study. This suggests that health care practitioners need to do more to focus on teaching self-management strategies.\textsuperscript{33} Furthermore, these findings support that strategies can be tailored to change specific determinants (e.g., tailor self-monitoring to prioritized outcome expectations).\textsuperscript{18} Nevertheless, it must be noted that the study was conducted within the UK healthcare system, which questions the effectiveness of these strategies across different cultural contexts. Further research is needed into the strategies which change specific determinants within different contexts.

**Limitations**

There were a number of possible limitations to this study. First, a bias in participant characteristics might exist because incentives were offered to boost recruitment to the study. Second, there was a low response rate from male unsuccessful maintainers and were under-represented in the study. Research has highlighted that males are more likely to complete PARS and adhere to physical activity than females and could account for this finding.\textsuperscript{36} Third, self-report measures were used to verify participant categories but are associated with over-reporting of physical activity which could produce a misclassification error and could explain the large difference between successful and unsuccessful maintainers.\textsuperscript{37} Fourth, the majority of participants had multiple health conditions of differing severities which produces a lack of
homogeneity in the sample. Although this also enhances the transferability of the findings, further research could benefit from replicating the research in specific health conditions, cultural contexts, and socio-demographic variables (e.g., gender). Finally, although present experiences of physical activity were discussed, the retrospective nature of inviting individuals to consider past experiences could introduce memory bias.

Conclusion

In conclusion, the exploratory qualitative study has identified the determinants and cognitive-behavioral strategies for successful and unsuccessful physical activity maintenance. Determinants that are found to influence the initiation phase in previous research were also found to influence physical activity maintenance in the present study (e.g., outcome expectations). However, determinants specific to maintenance also emerged, such as experiences of physiological benefits, and a specific physical barrier labeled 'the plateau'. Cognitive-behavioral strategies emerged for both physical activity self-management (e.g., self-monitoring) and condition management (e.g., pacing), suggesting health professionals need comprehensive training to successfully promote behavioral maintenance in the chronically ill. Future research is needed to explore successful physical activity maintenance determinants and strategies within specific health conditions (e.g., diabetes) and socio-demographic variables (e.g., gender and cultural contexts). Further implications for research and practice are made throughout. Overall, such findings provide guidance for commissioners, healthcare practice, and researchers promoting long-term physical activity in adults with chronic health conditions.

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References
from the four home countries’ Chief Medical Officers*. London, The Stationary Office; 2011
3. National Institute for Health and Care Excellence (NICE). Four commonly used methods
to increase physical activity: brief interventions in primary care, exercise referral schemes,
pedometers and community-based exercise programmes for walking and cycling. *Public
6. Rothman AJ. "Is there nothing more practical than a good theory?": Why innovations and
advances in health behavior change will arise if interventions are used to test and refine
7. Biddle S, Mutrie N. *Psychology of physical activity: Determinants, well-being and


PHYSICAL ACTIVITY MAINTENANCE


PHYSICAL ACTIVITY MAINTENANCE


