Adultspan Journal

Volume 9 | Issue 1 Article 5

4-1-2010

Midlife Women's Negotiations of Barriers to and Facilitators of Physical Activity: Implications for Counselors

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The authors investigated barriers to exercise and facilitators that enable midlife women to engage in an active lifestyle. Findings provide counselors with insight into the meanings that women ascribe to physical activity so they can better assist clients in making choices that enhance their overall health and wellness.

The Surgeon General's Report has identified physical inactivity as a major health risk factor in U.S. society (U.S. Department of Health and Human Services [DHHS], 1996). The health benefits associated with physical activity are related to reducing preventable risk factors associated with cardiovascular disease, such as obesity, high blood pressure, high cholesterol, and the development of Type II diabetes (DHHS, 1996). Furthermore, regular exercise is essential to healthy aging, because it not only reduces medical risks but also decreases the likelihood of physical injuries and prevents functional limitations that are associated with age (Fisher, Pickering, & Li, 2002). Current research shows that physical activity is particularly beneficial to older women, decreasing the risk of osteoporosis and certain types of cancer (Eyler et al., 1997).

There is also a strong body of research demonstrating the positive effects of physical activity on psychological health, and exercise is considered an important component of holistic wellness (Myers & Sweeney, 2005). Exercise is associated with significant psychological benefits, including increased energy, improved self-esteem, self-concept, and sense of self-efficacy (Chung & Baird, 1999; Kennedy, 2007; McAuley et al., 2008; Myers & Sweeney, 2005; Netz, Wu, Becker, & Tenenbaum, 2005). Furthermore, regular exercise reduces stress and is an effective treatment for mild anxiety, depression, and sleep disturbance. In fact, research has provided strong evidence for augmenting traditional forms of psychotherapy with exercise (Stathopoulou, Power, Berry, Smits, & Otto, 2006). One recent study of women experiencing panic disorder found that those who received cognitive behavior therapy (CBT) in addition to engaging

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in a home-based walking program had lower depression and anxiety scores than did those who received CBT alone (Merom et al., 2008).

Despite the well-documented benefits of exercise, women in particular are at a disproportionate risk for disease because they are reported to have a lower rate of physical activity than men (Centers for Disease Control and Prevention [CDC], 1995). According to Caspersen and Merritt (1995), older women have the lowest rates of physical activity of any demographic group. So that counselors can better understand why midlife women may choose not to participate in physical activity, despite its positive benefits for physical and psychological health, the purpose of this article is to describe the results of a qualitative study regarding women's perceptions of barriers to and facilitators of physical activity.

A considerable amount of research has focused on the ways that women's physical activity and leisure are constrained (Shaw, 1994). Eyler and colleagues (1997) identified lack of time; family support; concerns about safety; and personal factors, such as self-efficacy and self-motivation, as determinants of physical activity among women. Sociodemographic variables such as race, less education, low socioeconomic status, and being an older adult were also markers for inactivity. They also reported that women who are middle-aged or older were discouraged from vigorous physical activity in their youth and thus had little experience with physical activity. For these women, the social and gender roles that suggested that sports was "unladylike" or that women who participated in sports would develop a masculine appearance, deterred many women from participating in vigorous physical activity.

Other qualitative studies (Harrington, Dawson, & Bolla, 1992; Henderson & Allen, 1991) have suggested that women's "ethic of care" (Gilligan, 1982) constrained physical activity because women often provide for the needs of others, neglecting their own needs. This research suggested that women's roles central to the ethic of care, such as mothering, nursing, and familial nurturing, functioned as a constraint because women lacked a sense of entitlement to leisure. Other studies have also demonstrated that compared with men, women are much more likely to perceive that their free time should be consumed with activities such as child care and household chores (Iwasaki, MacKay, & Mactavish, 2005). In addition, when they allow themselves to take the time to exercise or do other self-care activities, women may not experience the same level of relief due to feelings of guilt or pressure to complete other responsibilities (Mattingly & Sayer, 2006).

In working with women clients, counselors can incorporate exercise as a therapeutic tool for promoting overall health and wellness (Hays, 1999; Okonski, 2003). In this article, we present the results of a qualitative study that examined perceived facilitators of and barriers to physical activity in 17 European American and 3 African American midlife women. The findings illuminate the importance of understanding the meanings that midlife women ascribe to exercise and physical activity in their lives. Next, we describe implications for counseling practice on the basis of these findings.

METHOD

A primary assumption of this research is that the norms that constitute commonly accepted understandings of physical activity have been based on the male life cycle and experience. Not only can it not be assumed that the meanings women give to physical activity are comparable to those of men but it also cannot be assumed that older and young women's lives are the same. Consequently, it is necessary to examine the lived experiences of older women. According to Henderson and Ainsworth (2000) "traditional quantitative methods often have been unable to uncover the complex nature of women's attitudes and practices" (p. 314). The use of qualitative research was deemed essential as a means for women to discuss their lives in their own voices. Using a case study design (Stake, 1994) to analyze women's narratives for the meanings they give to exercise and health, it was hoped that insights into the facilitators of and barriers to exercising would be illuminated so that counselors might better understand ways in which they can promote exercise in their women clients.

Participants

This research project began when the authors from a large public university in the South were approached by a physician who was interested in exploring ways to increase physical activity among older women. An interdisciplinary research team (the current authors) was formed. A total of 20 women from Louisiana, between the ages of 45 and 60 years, were interviewed. Participants in the project were volunteers recruited during routine check-ups at the physicians' Gynecology and Menopause Center at a major local hospital. The primary factor in determining the selection of participants was that they be perimenopausal to postmenopausal. Three of the participants were African American and 17 were Caucasian. Seventy-five percent of the participants were college educated, and all could be considered middle-class or above. Because this research was exploratory, our intent was not to be representative but rather to gain preliminary insights that would guide more focused research.

Procedure

Semistructured interviews were designed to encourage the interviewees to talk about the role of exercise and health in their lives. Participants were initially asked how they define health. Exercise and health histories were then elicited. Interviews then focused on ascertaining the motivators and barriers to exercise. Finally, participants were asked to define ideal health for themselves and describe what it would take to achieve that ideal. Follow-up questions were used for clarification, to provide examples, and to probe to allow the women's own perceptions to guide the course of the interview. Two pilot interviews were conducted and the interview questions were refined. In-depth interviews were conducted over a period of 8 weeks by two members of the research team (fourth and fifth authors). Interviews took place at the doctor's office and lasted from 30 to 90 minutes. All interviews were tape-recorded and transcribed verbatim.

Data Analysis

Each of the 20 interviews was read by the researchers to code the data by identifying facilitators and barriers to exercise. To allow for the themes to emerge from the data, no preconceived categories were considered. In analyzing the data using the constant comparative method, all possible patterns, categories, and descriptive units were explored. The data generated 39 facilitators and 46 barriers. These were then analyzed for similarities and differences, both within and across facilitators and barriers, to determine relationships and patterns, yielding three major themes.

The three themes that emerged encompassed both facilitators and barriers. The facilitators and barriers that emerged in these themes overlap and mirror each other, because factors that emerged as barriers for some women were facilitators for others. The first theme identified facilitators and barriers that women negotiated in relation to the medicalization of their bodies. The second theme related to how women negotiated sociocultural factors that reflected societal gender norms and expectations. The third theme revolved around how women's self-concepts enhanced or constrained their participation in physical activity. All names used in the sections below are pseudonyms.

FINDINGS

Negotiation of the Medicalized Self

The negotiation involved in women's internalization of traditional medical definitions of women's health acted as both a facilitator of and barrier to engaging in physical activity. One facet of this negotiation involved how the medical field determines and defines the health of women's bodies and women's responses to that definition. The medical establishment's notion of ideal weight as an indicator of overall health is an example of how medicalization does not capture the "grounded particularity of women's lives" (Morgan, 1998, p. 114). The primary negotiations of the women we interviewed with regard to medicalization were expressed in terms of weight, passivity, and menopause.

Weight as a risk factor. "Gaining weight . . . was a form of healing for me." According to the medical establishment, being overweight is categorically seen as negative. In the barriers to health and fitness that we identified, this pathologization of excess weight functioned in three ways: (a) resistance to the medical model, (b) internalization of the medical model with a loss of agency, (c) internalization of the medical model resulting in agency. Although Molly's weight of 255 pounds at 5′ 6″ yielded a high body mass index (BMI) of 41, she was adamant that she was justified in her choice to be overweight. As Molly's quote suggests, the meanings she gave to her excess weight were, in fact, positive. Molly, twice a rape victim, blamed her previously slender body for placing her in danger. Gaining weight served as a survival strategy for Molly and was not viewed as a health risk factor. She used her weight to protect herself because she believed it would be perceived as unattractive and place her at less risk for

assault. Thus, from a medical viewpoint, Molly's weight was a problem, but from her viewpoint it served an important protective role that was essential to her overall well-being. Consequently, it served as a barrier to exercise. Shirley, married to a doctor who exercised regularly, called her resistance to pursuing fitness her "way of being a little bit rebellious, defying the information that's at hand." Stephanie remembered being a thin and avid health club member at a time when she was depressed. For her, a sense of well-being was associated with gaining weight. Despite the medical profession's focus on regulating weight, these women rejected physical activity as a core component of their health and, in fact, saw it as detrimental to their well-being.

We also found women who submitted to the medical establishment's focus on weight as a primary indicator of health. These women were motivated to lose excess weight; however, the intention to lose weight did not always translate to an increase in physical activity. Cassandra is a case in point. Although she is 5′ 5″ and weighs 249 pounds, yielding a BMI of 42, she has no other indicators of ill health. Her blood pressure is 110/70 and she is able to follow a very busy schedule every day. A mother of an 8- and a 3-year-old, assistant to a congressman, and avid gardener, she has a high energy level and is "comfortable in [her] body." However, the medical establishment has termed her *obese* and *at risk*. Although she feels healthy, she has come to believe that she is unhealthy because of the medical establishment's determination that she is overweight and, thus, unhealthy. Because she has struggled with this issue for so long, she had decided at the time of the interview to take a prescription diet pill and weigh in at her gynecologist's office every Friday. Her submission to the medical model has not increased her physical activity and, in this case, the medical establishment's prescription of diet pills has in fact worked as a barrier to physical activity.

Wilma, like Cassandra, has a BMI of 41, and her blood pressure was somewhat high at 132/88, yet there were no other indicators of ill health. Also like Cassandra, Wilma accommodated to the medical establishment's definition of health. Unlike Cassandra, however, this process resulted in a sense of agency and served as a facilitator to exercise. She recalled, "I know people who are much larger than I am and they feel great. They can move, they can do a lot of things, but for my body I can't." This belief functions to regulate and determine her level of physical activity; she has begun riding a stationary bicycle and in her words is "moving a little bit more." She accepts the medical establishment's determination that she is "obese because of [her] body mass" and uses her weight to regulate her level of physical activity. Although the medical discourse around weight, exercise, and health appears to be straightforward, when viewed through the lens of women's particularities, it becomes a more complex issue.

Passivity/agency. "My mother is a very weak-minded individual . . . If she goes to the doctor, she can't ask questions; she just listens to what they tell her." Many of our participants expressed facilitators and barriers to physical activity in terms of passivity regarding their own health. For Tina, medicalization supports her complacency toward physical activity. According to the medical model of health, Tina is healthy. She is 111 pounds at 5′ 1″ tall, yielding a BMI of 19, with a blood pressure of 114/64. She exhibits no risk factors. She is able to follow the

tough schedule of a public prosecutor, so there is no compelling reason to exercise. Tina's doctor tells her to just keep doing what she's doing. Tina was knowledgeable about what a healthy lifestyle entails, because her mother "has had a heart attack or two . . . and has diabetes." Tina acknowledged the importance of exercise in reducing the risks for these diseases but had no concrete plans to include more physical activity in her daily regimen. For Tina, the medical definition of health as freedom from disease acts as a barrier to physical activity.

In contrast, the passivity of two other respondents' mothers was a facilitator of exercise. For Bonnie, her mother's lack of agency regarding her own health was what Bonnie said she had "run from so hard in [her] life." Bonnie's "most depressing thought" was being unable to care for herself, being dependent, or a "whiner." Accompanying her mother to the doctor's office led her to see her mother as "a weak individual [who] couldn't ask questions," but simply listens and does whatever they tell her to do. Bonnie said this was a "mold" that she had broken "completely" in her life. She is proactive in seeking knowledge, not waiting "for someone to come up to [her] and go, 'Oh, you know, you could do this for that.'" For Bonnie, her agency means self-management through taking responsibility for her own health and functions as a facilitator to exercise and fitness.

Shirley watched her mother die, unable to breathe, over the course of a few months. Her mother had been a smoker, but it was the doctor's inability to do anything for her mother that was most disquieting for her. She had already watched her father go through surgery and radiation treatments and still die from a tumor the doctors had missed. After her mother's death, she became obsessed with exercise and was "outside at 6:30 every morning, chopping wood for 30 to 45 minutes, running a mile, working out on an exercise machine." Although she did not want to be a "fanatic" and run to the doctor for "every ache and pain," she says that she will "immediately . . . go to the doctor and ask them" if she has a persistent problem. She relies on her own body and knowledge to tell her when she needs a doctor. Bonnie and Shirley both express a relationship with their own bodies that is not determined by the medical model of health but by the kind of life they want to live. It was their mother's passivity regarding medicalization and to their own health that inspired agency in these daughters, thereby functioning as a facilitator of physical activity.

Menopause and exercise. When menopause is perceived as a hormone deficiency disease, it functions as a barrier to exercise, as in Leslie's hope that "Dr. Griffith puts [her] on hormone therapy then the [symptoms she associates with menopause will] start mellowing out and I'll go back down [in terms of weight]." Like Leslie, Jody perceived menopause as a disease that must be diagnosed by a doctor and hormones as a way to keep her body in shape. Jody's appearance was very important to her, and both her general practitioner and her gynecologist have told her that "the balance of [her] hormones has a lot to do with the shapeliness of [her] body" so that exercise is not deemed necessary for maintaining her health or shape. These two women were unaware that hormone replacement therapy was not sufficient to prevent disease and that they still needed to exercise for overall health and wellness.

Because menopause occurs when children are growing up and leaving home, many women experience it as a time of newfound freedom. Alice pointed out that when her "kids were little, [she] couldn't take off for an hour and walk somewhere without [hearing], 'Mom, mom.'" Her daily hour of walking when she doesn't think about work, husband, or children, "or, you do think and you sort things out, is a gift." For her, turning 50 meant realizing that she didn't "know what kind of time" she had left, but she knew it was "finite" and this was a time when she was "going to be the way [she] wanted to be." In this way, menopause functions as a facilitator when women become active agents in determining the quality of their lives.

Negotiation of the Socially Imposed Self

The second theme concerns women's ability to engage in fitness and wellness activities in relation to societal cultural norms. Social norms and expectations influence what types and levels of physical activity are considered appropriate. Such societal impositions were reflected in the narratives of these women and revealed their ongoing process of balancing their own understandings of self with what social norms maintain women should be. These norms include ideologies as well as social structures that inhibit or promote women's ability to live their lives. The primary issues with which women struggled were related to expectations regarding family and mothering, work and women's responsibilities, and socioeconomic and class norms. Again, each of these socially mediated norms functioned as a facilitator for some women and a barrier to others in terms of physical activity.

Mothering and family. "I feel like I am very strong. It's because I have little kids." One of the most unexpected findings of the study was that the demands made by children and family were cited as not only one of the greatest barriers, but also as one of the strongest facilitators of physical activity. Although most of the women no longer had small children at home, they recalled the period in which they had children when they discussed their fitness histories and habits. In their traditional roles as mothers, wives, nurturers, and caretakers, they believed they were expected to subsume their needs and desires to others. Wilma described her struggles in the following way:

> And just the responsibilities that go with children, you know, the cleaning, the meetings at the schools, the homework, you know, just the family roles. And Dr. Griffith tells me all the time too. . . . I need to take time for me. And, of course, that's probably part of the problem, too, taking some of my time for me.

Traditional family roles, as Wilma suggested, assume a selfless mother who puts her own needs last. Many of the women reflected on how these expectations were barriers to exercise, how they felt they had to be "Super Mom," or "had to do everything," and were "maybe too involved with family life and kids." Bonnie summarized it by saying "There was no time for exercise. An exercise regime? That was a joke." The societal expectation that family comes first denies women the

permission to take care of themselves and not only leaves little time for exercise but also precludes the very concept of an autonomous self. Alice, who struggled with considering her husband's preferences while trying to prioritize her desire to eat in a healthier fashion, lamented: "I wish someone had told me a long time ago that I can think for myself. . . . I wish somebody would have said, You know what? You do get to be a person and you do get to have a life." She was only able to achieve her health goals after she realized that she could put herself first.

In contrast, various narratives conveyed how some women were able to incorporate self-care into traditional duties as caretakers. Kacey explained:

> One time I coupled taking ballet lessons with my daughter, who wanted to take ballet and that worked out nicely when I could fit in with something—it was an hour that I was going to be sitting out there waiting for her anyway. So, I was able to enter that class.

She continued,

> I feel like I am strong. It's because I have little kids and I'm lifting and carrying them around. My children are so much fun. And everything that we love doing, they do, too. So it's not like they are a barrier. I try to be a role model for my girls. My 9-year-old has many friends who are overweight already.

Kathleen experiences her children not as a barrier, but instead attributes her strength to them. She sees her daily activities and movements as exercise. Her view of exercise as integrated into her daily life allows her to conceptualize her exercise activities not as separate from, or as taking away from, her family. Instead, she views them as part of her mothering role so that by exercising she feels that she is a role model for her children.

Relationships with family members were also a powerful facilitator for many of the women interviewed. Wendy shared this in regard to family: "I want to be around for my grandchildren; yeah, I think physical activity is important. No, being a grandparent would make you want to be more healthy, to live longer, to be around them." Another way in which family served as a facilitator had to do with illness within a family. Belle's husband was diagnosed with a stroke and that became the impetus for changing their diet and beginning to exercise. Belle claimed that "he has to go on a low fat diet, lose a lot of weight, diet, and it's easier to just go along with him than to say, 'well, I am going to be fat and you lose weight.'" Having children involved in sports was also a motivation for the family to change their eating habits. Hanna maintained, "because I have a son that's going to play football. . . . And we, together decided that we're going to change our way of eating and doing things."

For these women, the importance of family became a facilitator. They appropriated the dominant ideology of "family first" in order to legitimate their own focus on fitness. Exercise and health were seen not as something that took time

and energy away from family. Instead, these women saw taking care of themselves and their families as part of their roles as good mothers and wives.

Time and women's responsibilities. "Time is a big factor, although, I could get up an hour earlier [to exercise], I don't choose to do that." Time and prioritizing one's time, especially with regard to balancing family, work, and self, emerged as the second sociocultural theme. Leslie described it like this:

> I think women just don't have as much time. And I think. . . . And that being the fact, in reality, you have to kind of restructure it then a little bit, still do the same things but find just a little bit of time and maybe put it all together in the evening at the end of the day and grab the dog and go for a walk.

As the quote suggests, time itself is not the barrier but rather it is an individual's choices around the use of time that can constitute a barrier to exercise. Kathleen maintained, "every minute I have I could be working." Although there was a perception that there was not enough time, many of the women acknowledged that it was a choice and that, in fact, exercise might even function to make them more productive. Bonnie maintained that she had no time but stated,

> If I weren't involved in so many different things as I am. . . . It's very unusual for us to have a week with no meetings at night, one of us or both of us. So, it's time, it's time to put into it, although you know, some people say, you know that helps to keep you going, you know . . . an active lifestyle.

Using exercise to increase productivity and ultimately yield more time was one way to reenvision time as a facilitator rather than a barrier to exercise.

Another way of reconceptualizing time so that it functioned as a facilitator was to integrate exercise into the day or make normal daily activities into exercise. Cindy commented, "I was busy and I didn't have time, didn't have time to think about exercise. I cut the grass. That was my exercise." Margaret remarked, "So you try to make your everyday activities harder and that's a form of exercise."

Clearly, integrating physical activity into their lives was facilitated by the availability and convenience of exercise. Taking the time to drive to the health club and work out for an hour was just not possible in many cases. What was apparent is that when exercise activities were defined as "working out an hour a day at the health club," many women will never be able to find or make the time because their lives just do not fit into this particular model of fitness. However, when women reconceptualized their daily activities as exercise, they could envision a way to integrate physical activity in a way that fit their lives.

Socioeconomic norms. "When it's dark when you get home, it's [exercise] not something you want to start." Regardless of reconceptualizations of time, opportunities to exercise were not available to all women, especially those from

lower socioeconomic groups. For example, a recurring barrier to exercise noted by several women was the lack of safety. As Leslie pointed out,

> I'm a little afraid of being alone, you know, particularly if you go in the evening, not only at dark, but early morning even. I mean, last year that woman was kidnapped and murdered.

Although women living in inner city neighborhoods felt a particular constraint, the recent murder of a White, middle-aged runner in this community made all the women extremely aware of their vulnerability. Hanna reported, "My kids were afraid to stay home. And so I had to be there." For some of the women, living in poorer neighborhoods restricted their sense of being able to go out and exercise. Interestingly, women living in more suburban settings also lamented that they did not walk as much because of the isolated nature of the settings. For these women, barriers outside their control inhibited their ability to exercise.

In addition to safety issues, another sociocultural construct that created barriers to exercise were issues related to class, specifically financial need. Cindy reported, "If I had a little money, I'd probably eat a little better." In several cases, finances were not the sole barrier to exercising but also the working class ideology that "working out" was "not working." One participant from a rural, working-class background pointed out that "I worked in the field. So, we naturally got plenty of exercise. You got natural exercise. I mean, it was just a way of life, you know." For the women from farming or working-class backgrounds, the idea of exercising after a long day of work made no sense. Also, for these participants, exercise and fitness were seen as leisure and not work, as a luxury and indulgence ("something lazy rich people did"). Cassandra commented,

> I have to be physically active and moving and doing things, but I don't think of it in terms of exercise; I think in terms of work. I mean, I can go out and clean the garage for relaxation because I like things orderly and neat and where they need to be, but where I take 2 hours to do that, I wouldn't think of going out and running for 2 hours because that's boring and mundane, you know, just running and thinking; I have to be constantly doing.

For many women in the study, exercise without a purpose made no sense and was a waste of time. Thus, class background contributed to women not participating in physical activities that they did not see as productive.

Negotiation of the Possible Self

While the first two themes revolved around discourses external to the self (e.g., norms set by the medical establishment, current sociocultural norms for women), the third theme that emerged centered around a woman's internal sense of herself as an individual who can or should engage in physical activity. The essence of

this theme is reflected in the questions "Who am I?" and, ultimately, "Who do I think I can be?" When the image of an active and fit self was not enmeshed in their identity, or when they did not envision being active as a part of a possible self, it was less likely that the women in this study would take a proactive approach to incorporating physical activities into their daily routines. Conversely, when physical activity and wellness behaviors were integrated into their sense of identity, the personal self served as an influential facilitator to physical activity. The issues women discussed were related to the subthemes of absurdity, social support, maintaining the status quo, and value and commitment to exercise.

Absurdity. "I would not want to jump up and down in a leotard." Several participants had concerns about the appropriateness of being active and engaging in many forms of physical activity. There were indications that the participants just did not see themselves as physically active, as illustrated by Bonnie: "I'm not athletically inclined at all. I'm the cheerleader, I'm not the player, that's just not me." Cathy echoed, "I don't think I will [exercise]. I'm just not, that's just not me. I'm more sedentary." Participants also did not want to be perceived as silly or extreme in the pursuit of exercise and fitness. As Belle pointed out, "Absurdity is a barrier. I would not want to jump up and down in a leotard. Yeah, that is a barrier. It is a real barrier. I really do not want to look silly and strange." When they perceive physical activity as extreme or outside of their level of comfort, it makes sense that some women avoid engaging in exercise.

Social support. "If I had someone to. . . ." Social support was a powerful influence in the acceptance of physical activity, and lack of a supportive network or companionship proved to be a barrier. Many of the participants identified social support as a facilitator of participating in some form of physical activity or wellness program. When asked what encouraged her to work out, Carol replied, "Comaraderie, the health club experiences, I like the comaraderie of the people there, and my best friend works out there, too." Sadly, the identification of social support from most of the women was either in past tense, or stated in hypothetical terms. Tina recalled:

> In law school, there was another student that we both jogged together. I think that's an important part. Later, another woman in the firm I was working at, we went to the "Y" and exercised, and then we joined a health club, then we both changed jobs and pretty much stopped going. I think part social, and part that you have someone kind of encouraging you and you encourage each other.

In these cases, social support facilitated physical activity by providing reinforcement to incorporate activity into one's sense of self. Social support, in fact, was central to bolstering one's sense of self, providing accountability, safety and a validation for putting oneself first.

Status quo. "Have a hamburger, you look just fine!" Acceptance of or dissatisfaction with the status quo proved to be a powerful barrier and facilitator. When women accepted their present status, or failed to find fault with their current weight, their

body image, or their ability to meet the demands of their daily lives, they were unlikely to indicate an intention to adopt or maintain an active lifestyle. Unless there was some level of dissatisfaction with the status quo, accompanied by a belief that exercise could mediate the dissatisfaction, it appeared unlikely that a behavior pattern would change. As Norma pointed out, "And so I probably don't think about . . . as much about trying to work in more exercise and trying to watch my diet more and those kinds of things, because I'm not having physical or mental problems." Belle's satisfaction with the status quo was reflected in this comment:

> I have this husband who keeps saying, "I like you this way." I mean he is wonderful, but he is bad in terms of a motivator, "Have a hamburger; I think you look just fine."

In contrast, when some level of dissatisfaction with the status quo was evident, it seemed that participants were much more likely to engage in physical activity and other wellness behaviors. Some participants began to incorporate exercise into their sense of self because of dissatisfaction or concern with the status quo and a belief that exercise can improve health and wellness. As Wilma explained,

> I am taking medication for blood pressure, and I know and I've read and the doctors have told me that if you walk or lose even 10% of your body fat, it may help your blood pressure. So everything always sends you to the exercise for the health.

Tina's dissatisfaction with the status quo was reflected in her realization of the aging process: "Because I feel, as I'm getting older, that it's become more important. There are risks, you know, osteoporosis, different health risks, that I know that it's something I need to do." For these participants, dissatisfaction with the status quo functioned as a facilitator to exercise, whereas acceptance of the status quo functioned as a barrier to maintaining a physical activity regimen.

Value and commitment: "If I valued it enough, I'd do it." Value of and commitment to exercise were also important to understanding the personal self. Ten of the 20 women interviewed either lacked commitment or did not value exercise, and this was a major barrier to changing their life styles. When women did not see themselves as active beings, they did not value exercise, and consequently did not commit to it. Tina admitted, "You know, like I said, it's not so much lack of desire, but prioritizing in that, I mean, if I really wanted to, I suppose I could get up earlier, but. . . ." As Cindy so aptly put it, "I don't know, I'm not trying to push it off on somebody else because I . . . Obviously, if I valued it [exercise] enough, I'd do it myself."

Other women demonstrated the value of and commitment to a healthy active life style, reflecting a sense of personal accomplishment. When they were able to see positive results from participating in some form of physical activity, the women in this study were more likely to indicate that they valued their activity. When asked what could get her to exercise on a regular basis, Cathy replied,

> Results. Feeling like my arms are strengthening, they're not as flabby, seeing my stomach go down a little bit and not be so uncomfortable when I sit down and have this big, old basketball feeling in here. That would make me feel better about what I'm doing. It feels like I'm accomplishing something.

Carol echoed that sentiment: "It just has kept my spirits up, and that's something that I'm really aware of with exercise, that it's really made a big difference in my own mental health."

Another form of value evident in the participants' voices was value reflected by the utility value of exercise. When exercise was viewed as a useful activity that could improve the quality of life, it was valued. Wendy recounted,

> The exercise, I feel like . . . because I think one of the reasons why it is so important is I know I don't have my nutrition in balance, and that if I mess up on the exercise, I'm going to be really bad off. I mean my health, physically and mentally.

Participants' perspectives provide insight into the importance of prioritizing fitness as part of one's overall sense of self.

IMPLICATIONS FOR COUNSELING PRACTICE

Counselors can recommend physical activity as an effective treatment strategy for a variety of mental health concerns with their women clients. However, the findings from this study indicate the importance of first understanding the meaning a client ascribes to the role of physical activity in her life. For example, Molly did not want to exercise and lose weight because she perceived that her extra weight was protection against being further victimized. A counselor who asks Molly to exercise might cause her to feel controlled and devalued. Until the issues related to Molly's fears are addressed and her need for autonomy is met through something besides her weight, it is unlikely that simply telling her to lose weight will have any effect on her activity patterns.

A counselor who simply tells a client to exercise also ignores the client's motivation for and commitment to changing her lifestyle. Although most clients are aware of the benefits of exercise for improving mood and overall health, they often remain ambivalent about making actual changes. If a woman is primarily satisfied with the status quo or feels uncertain about her ability to be successful, as were many women in the study, she will not be motivated to make the changes necessary for incorporating exercise into her lifestyle. In such cases, motivational interviewing (MI), a client-centered counseling style can help clients acknowledge, explore, and resolve their ambivalence toward change (Miller & Rollnick, 1991). Furthermore, MI has been demonstrated to be effective in helping clients to change lifestyle behaviors such as diet and

exercise (Rollnick, Miller, & Butler, 2008). MI is based on the principle that clients who are resistant to change do not need to be persuaded with arguments or logic but instead need a nonjudgmental therapeutic relationship in which they feel validated and understood. As a counselor demonstrates a desire to understand the client's worldview through the use of simple reflections and open questions, the client is better able to explore both the pros and cons associated with change. In addition, clients become more open to change when they attribute their actions to their own choices versus being controlled or mandated to change by external sources (Miller & Rollnick, 1991). Therefore, counselors should attempt to provide a client with opportunities for input and choice as much as possible so that she attributes change as something she is doing for herself and because she believes it is in her own best interest.

When a counselor has developed an alliance with a client by demonstrating an understanding of her worldview, it is then possible to help her change some of her beliefs that may be barriers to achieving her goals for health and wellness. The study findings illuminate the relevance of CBT strategies for helping female clients to reconceptualize how physical activity makes sense in their lives. Throughout the interviews, participant voices revealed the importance of their belief systems in determining whether or not they engaged in physical activity; for each of the identified factors, some women perceived the factor as a barrier, while others perceived the same factor as a facilitator. For example, motherhood was viewed by some as a facilitator of exercise because it provided an opportunity to model strength and fitness to children, whereas for others, it was viewed as a barrier because of time constraints and putting family first. Another example is some women viewed menopause as a disease that served as a barrier to exercise and others viewed it as a time of newfound freedom that functioned as a facilitator. Additionally, when women understood physical activity only in terms of sports and exercise at a gym, they viewed themselves as inactive and were not likely to exercise. However, when other forms of physical activity, such as gardening, housework, or walking, were viewed as forms of exercise and as contributing to positive mental and physical health benefits, women were more likely to perceive themselves as active. Because physical activity was viewed as expanding on activities in which they were already engaged, they were more motivated to find ways of increasing their energy expenditure throughout the day. These findings underscore the importance of helping women to recognize their automatic thoughts around exercise (e.g., "I'm too old to work out," "I'm not able to work out at a gym," "I'm just a sedentary person; "I have no time," and "I don't deserve to take the time") and to reframe them to reflect a more positive, realistic view of physical activity. In an atmosphere of support and understanding, female clients will begin to alter their belief systems so that they are able to experience a sense of power and control in their lives. As they reframe and restructure the meanings that they attribute to health and exercise, they will become empowered to make positive changes necessary for enhancing their overall wellness.

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