Part I

Setting the scene
Experiencing mental health problems

When Neil Armstrong set foot on the moon and spoke the legendary words, ‘This is one small step for man, one giant leap for mankind,’ his actions embodied the technological advances of his time. Donned in a space suit protecting him from a hostile environment, Armstrong’s walk on the moon also symbolised, in many ways, that while science may have made significant breakthroughs, there is still so much we don’t know, can’t change or control. This is not only with regard to outer space and the planetary constellations that surround us. The space within us – physical, psychological, emotional and spiritual – remains an elusive and fascinating area of exploration, and this is certainly the case as we seek to understand and sustain mental health.

For the teams of scientists that supported the Apollo trip, it was possible to record every minute detail of Armstrong’s physiology. However, the data recorded by some of the most sensitive equipment known to humankind was unable to inspire generations of children because this data, though complex and comprehensive, could not communicate to us what it felt like walking on the moon. In contrast, when Armstrong said, ‘It’s really pretty up here,’ those listening on earth began to get an understanding. Isn’t it amazing with all the tasks this astronaut had to accomplish that he took time to view the heavens and comment on their beauty? NASA’s aim, of course, was to put a man on the moon and bring him back safely. Their interest probably wasn’t on how this individual would describe his experience of the trip. Being human, however, means that collecting facts and figures only represented part of the complex picture of the journey, and gaining a more complete understanding of this journey required Armstrong to describe his experience. Understanding how Armstrong gave meaning
to his experiences might not have been essential to maintaining homeostasis, but it is essential if we are to understand the man and support other astronauts.

This kind of perspective informs our approach in the book: it is a perspective which recognises the difference between knowledge and wisdom. As Patricia Deegan (1996, p. 91) has observed in the context of mental health, ‘most students emerge from their studies full of knowledge but they lack wisdom or the ability to see the form or essence of that which is’. Wisdom of this kind is fundamental to understanding how physical activity and sport can contribute to recovery among people experiencing mental health problems. For us, this understanding starts with experience. We want to explore the question: ‘What is it like to experience physical activity and sport in the context of mental health?’ We also want to begin to appreciate meaning: ‘What does physical activity and sport mean to individuals living with mental distress?’ Science’s focus travelling deep into the brain with ever-more complex equipment, having a better grasp of the aetiology of mental health and looking for clues at a microbiological level, only provides part of the picture. At times, this focus can come to divert attention and interest away from the person and how he or she experiences the recovery process.

To start this opening chapter, we leave physical activity and sport aside to focus on mental health and illness. We want to focus initially on the question: ‘What is it like to experience mental health problems?’ To answer this question, the focus must be directed towards the individual, personal level. Some readers might be able to draw upon their own experiences of mental ill-health, but if you have no experience of mental illness the stories of people who have walked these particular paths can provide important insights. Either way, the following accounts hopefully begin to draw attention to the diverse nature of experiences of mental health difficulties.

Several books exist which are dedicated to presenting and exploring stories of the experience of mental illness (e.g. Karp, 1996; Davidson, 2003) and we recommend these sources as they provide more comprehensive collections than we are able to provide here. In addition to these books, several individuals who have themselves experienced forms of mental distress have written about their experiences and published their accounts in health or social science journals. It is these accounts that we draw on now to give a flavour of what it can be like to experience mental health problems. We present below brief excerpts from the stories of three individuals: Peter Chadwick (2001a), Brett Smith (1999), and Stuart Baker-Brown (2006). Other examples can be found in the work of Patricia Deegan (1996) and Brendan Stone (2009).

Alas there’s no privacy here … no privacy anywhere … the cracks in the wall plaster … hidden microcameras in them … the walls, people listening, listening through them, like they did in Bristol, all the time. The window … binoculars on it, cameras with zoom lenses … they can see me … people watching, watching. The world a prison wherever I go. Horror behind, terror in front … but what do they want of me?! Are they trying to puncture my pathetic bloated ego with their pranks, as Sherwin used to do at school? Teach me a lesson? Cure me of my evil sensuous ways? Make me ‘come down’? Under observation, always under observation …

But there’s a knock on the door. It’ll be Tony McAdam from downstairs. It is. He asks if I have any cigarettes. I say no. Tell him I’ve given up smoking, which I have. He launches into (yet another) anecdote about how he beat up this guy the previous night. I say quickly, ‘Oooh, fighting, even more frightening than homosexuality!’
He looks at me slightly surprised. I notice for the first time that I sound mad. What a thing to say. I really do, I really sound mad...

What a district this is. Hackney. How did I ever come to live here? Nowhere else in London will take you if you have a dog. You can’t get a room anywhere. Certainly not in West London anyway. Everybody’s business is everybody’s business. No privacy, no-one has any loyalty anymore. Slagging people off, slagging people off, that’s all it is... all the time. And I’m right in the middle of it. Transparent, invaded, betrayed. That’s my life.

(Chadwick, 2001a, p. 55. Copyright © 2001, SAGE Publications. Reproduced with permission.)

Upon pinching our pale skin, a barely audible question escapes from our mouth: ‘How are we doing?’

Silence. We listen to our breathing – it is shallow and pathetic. ‘Are we all right?’ Slowly we shake our head. We don’t want to speak – not today anyway.

‘Morning,’ we whisper. The word flickers in our consciousness. ‘How are we feeling today?’

‘Not the best,’ is the apathetic reply. ‘Today’s going to be another bad one,’ we say stoically.

We feel the violence of the vortex gather pace as it screams inside our body. We twist through its complexity and pound on our corporal self. As usual, questions concerning its authenticity bob up and down in our sea of pain. How do we really feel? The word doesn’t describe our feelings – does it? Surely it’s unimaginable to those who have not suffered with it? People walking down the street, students, friends – whatever – nonchalantly spew it out. It seems that the word, like a slug slithering innocuously through language and culture, leaves little trace of its intrinsic malevolence. Has it become so common in everyday language? Has it lost its depth, its meaning, and its feeling? Has it been hammered into banality? we think. As always, however, we struggle for answers while our mind becomes a cesspool of ominous thoughts. We become swamped in our(selves).

The torture continues in our head. How can life be filled with such torpid indifference? The little things like taking our dog for a walk in the park on a warm spring day or playing football with our friends just aren’t fun anymore. We breathe and walk, we just don’t live. We are detached and hollow. Under our blanket of suffocating darkness, we pretend that everything is fine, yet, we rot away from the inside. At times it swells bits out. At times it swallows us whole. At times both. No warning, bang! We move from pain to pain. We have only one future. Please God, help, we plead as our huddled body rocks back and forth.

Confused and afraid, we don’t want to talk anymore. ‘Please leave,’ we gently sob.

(Smith, 1999, p. 264. Copyright © 1999, SAGE Publications. Reproduced with permission.)

As I write these words, I can recall my paranoia and fear building up on a daily basis. I tried to convince myself that I was under no threat and that my fears were unjustified, but I quickly began to be afraid of everyone and feared that my life was in danger. I did not know what to do. I had no idea that I could have paranoid schizophrenia; I did not even know what schizophrenia was.
Stress and paranoia began to take their toll. I quickly became confused in my thinking and obsessed that I was being followed. Often, when I got back to my bedsit after work I would huddle in the corner of the room in fear.

As the weeks passed and pressure took its toll, I had to take time off work. Anxiety and paranoia were now quickly and devastatingly beginning to run my life, and a deep-rooted illness was setting in.

During this time I had my first and worst psychotic experience. It was an extremely frightening time and still scares me now as I think of it. As I lay on my bed trying to relax, I suddenly found myself in complete darkness. I had the experience of being physically vortexed into my own dark mind. I cannot truly explain what went on, but the feeling of it still terrifies me. I screamed to be let out, and as I screamed I found myself back on my bed with a strange sensation around my head. It was as though I was sucked into my own dark mind away from any life or reality.


On reading and re-reading these stories, we find ourselves reflecting on each individual’s experiences, wanting to know more and wondering what happened next. We both feel a range of emotions as we read and reflect on the stories, which may resonate with or be initiated by the vivid descriptions within each account. While each of us responds to different details within the stories, feeling different emotions in different ways, we both find the stories difficult to read or hear – they are troubling and challenging, perhaps because of the degree of suffering they portray. There are some recurring themes which strike us in the stories: a strong sense of fear, how the experiences recounted were experienced as frightening or even terrifying; a sense of isolation, that the teller recounts feeling somehow separated or removed from other people and/or life; a sense of joylessness, a loss of fun, humour, enthusiasm; hopelessness, a loss of optimism or interest in the future; a loss of agency or autonomy, a feeling of being out of control; a sense of inactivity, inertia, feelings of nothingness or emptiness; and, finally, a sense that the experience of distress is total, complete and permeates across many aspects of the individual’s life in profound ways.

For us, perhaps the most striking theme across the stories is their diversity. Although each story describes the experience of mental health difficulties, the stories are varied and individual both in terms of the particular events and actions recounted as well as the individual’s emotional response to those occurrences. The themes we identify above arise from our perspective on the stories – we see the stories through the lens of our own experience. In recognition of this, and because the stories are so diverse and complex, we encourage you to reflect on the stories from your perspective in order to form your own interpretations and conclusions. What do you feel having read the stories? How would you respond to the experiences recounted in the stories? Our reason for presenting this selection of stories here and now is to allow for this openness, because we understand that mental health and illness can be experienced in many different ways which relate to individual circumstances, biographies, experiences and contexts. We hope that these brief passages provide some insights and provoke some reflection on what is clearly a very personal yet highly distressing and extremely difficult set of experiences.
Attendant to each story – either before or after the events recounted – is likely involvement with mental health services and, therefore, the medical processes of diagnosis and treatment. We would now like to briefly consider this aspect of experience by presenting a further story of one individual’s contact with mental health services which is taken from the writings of Baker-Brown (2007), who was diagnosed with, and treated for, schizophrenia. A further and comparable example may be found in Deegan (1996):

I was unprepared for the weeks after my diagnosis, during which my psychiatric nurse told me that it was very likely that ‘I would never work again in my life’ and that the rest of my life would probably be about ‘fighting to keep my schizophrenia under control’. I had never contemplated not working again and had always assumed that I would gain control over my illness and one day, sooner rather than later, be able to return to work.

These statements from my nurse threw me completely. More was to follow from the trust. My nurse told me that I had ‘to prove’ that I could function as a normal member of society and that I would not be ‘a threat’ to anyone. I was shocked by these words and this very poor attitude towards me and my illness. The demoralisation caused by my illness was complete, and soon after receiving my diagnosis I became a broken man. The trust’s lack of proper care and understanding of my needs as a person with schizophrenia, and being treated more as a ‘condition’ that needed controlling than a person who needed ‘understanding’, made sure of that.

(Baker-Brown, 2006, p. 637)

This account raises the important issue of how the processes of being diagnosed with and treated for a mental health problem can interact in powerful ways with a person’s understanding of themselves and their goals and aspirations for life. While the previous stories of the experience of mental distress are diverse, varying widely in terms of both their form and content, accounts of what it is like to ‘be a mental health patient’ often exhibit a worryingly high level of agreement and consistency concerning the ways in which diagnosis and treatment can in themselves be a damaging experience. It seems to us that a two-level impact is described by many people who have written about mental illness: First, the experience of a mental health problem is in itself traumatic and potentially damaging. Second, the experiences accompanying diagnosis and treatment can – for some people – lead to a second level of trauma and suffering. One result of this can be the loss or denial of the day-to-day freedom and opportunities that many of us take for granted. In this regard, as Chadwick (1997b, p. 580) puts it, ‘there is no doubt that a psychotic episode leads to severe marginalization, pejorative categorization and disempowerment’.

A conceptualisation of mental health

In light of these and many other diverse accounts of mental health and illness, what position might we take in terms of conceptualising or defining mental health and illness? While we are reluctant to prescribe a specific definition, a working conceptualisation seems necessary. We are drawn to the broad and humanistic definition of mental health
provided by the Department of Health (2003) which states that mental health is ‘the emotional and spiritual resilience which enables us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own and others’ dignity and worth’ (p. 8). In the United States, a similarly broad definition of mental health is provided in the Surgeon General’s Report which sees mental health as ‘a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity’ (US Department of Health and Human Services, 1999, p. 4).

Although we are cautious of using the terms ‘illness’ or ‘ill-health’ in the context of mental health on the basis of the adverse effects such labelling can have on individuals (see, for example, Rogers & Pilgrim, 2005), we find it difficult to talk about our research or describe our research participants’ backgrounds and experiences without using these terms. This particularly applies to the terms serious mental illness and severe and enduring mental illness because they are routinely used to cover the variety of diagnoses which apply to the individuals with whom we have worked. So while we try to minimise our use of these potentially pejorative terms, when we do employ them we follow the definition of serious mental illness as ‘a diagnosable mental disorder found in persons aged 18 years and older that is so long lasting and severe that it seriously interferes with a person’s ability to take part in major life activities’ (US Department of Health and Human Services, n.d.).

Another way of defining mental health and illness might be on the basis of its aetiology; however, this in itself is a highly contested area. Rogers and Pilgrim (2005) and Chadwick (2009) provide thorough discussions of recent and current debates concerning the causation of mental health and illness. As these authors make clear, arguments have raged over decades – and continue in some quarters – regarding the extent to which mental health is seen as biologically determined (through genetic makeup, for example) or shaped by socio-cultural, environmental, economic and psychological factors. With regard to this question, Rogers and Pilgrim (2005, p. 3) write:

It may be argued that biological treatments that bring about symptom relief themselves point to biological aetiology ... However, this may not follow: thieving can be prevented quite effectively by chopping off the hands of perpetrators, but hands do not cause theft. Likewise, a person shocked following a car crash may feel better by taking a minor tranquillizer, but their state is clearly environmentally induced. The thief’s hands and the car crash victim’s brain are merely biological mediators in a wider set of personal, economic and social relationships.

We consider that, for a variety of reasons which recur throughout the book, mental health and illness are heavily shaped by a host of social, cultural, psychological, biographical and contextual factors. On this basis, we share the perspective that mental health is not determined by biological or biochemical factors, but that these factors act as mediators or vehicles for psychological changes. Although all psychological processes are, at the most fundamental level, carried out by biochemical or biological processes this does not imply that chemical or biological factors actually caused a particular disorder (Bedi, 1999). While some will beg to differ, either as proponents of biological and genetic determinism or supporters of a wholly socio-cultural explanation,
our work has led us to accept Chadwick’s assessment of current opinion regarding the causes of mental health problems. In his words:

In light of the fact that the pendulum in research internationally has swung first from environmentalism (‘mind with no brain’) to biochemical reductionism (‘brain with no mind’), it now rests pretty well between these misguided earlier extremes and both genetic and constitutional vulnerability as well as environmental and cognitive, emotional and motivational factors are recognised as important in explanation and recovery. (2009, p. x)

From this perspective, Chadwick identifies and expresses well a stance in relation to recent debates concerning the genetic determination of mental illness (in this case, schizophrenia) which aligns with our own perspective on mental health and illness. This conception seems to us to offer a constructive, ethical and humanistic way forward. As he explains, to understand the extent to which ‘genetic vulnerability’ influences the occurrence of mental health problems it is necessary to consider the role of many genes which each have, at best, only a small to moderate effect on mental health. These genes, he points out, are widely distributed in the population and are also likely to be associated with valuable qualities and abilities such as perceptual sensitivity, creative and linguistic imaginativeness and meaning-seeking. Hence, in Chadwick’s words, ‘we are all “a little schizophrenic”, it is part and parcel of the human condition and may indeed be why we are such an imaginative and creative, inventive species’ (2009, p. xi). Importantly, he points out:

This conceptualisation of schizophrenia sees sufferers as kith and kin with the rest of humanity, sees madness as not essentially an alien state experientially but something that everybody, because of their humanity, has at least a slight inkling of at some time in their lives. Schizophrenia, in my view, and as a sufferer who has known it from the inside, is essentially an exaggeration of normal processes that interweave with toxic results for one’s well-being and, on many occasions, for one’s very willingness to stay alive at all. (p. xi)

This conception, we think, emphasises the core concept of humanity which we all share, and resists casting as ‘Other’ those who experience mental health problems by suggesting people who experience mental health problems are in some way ‘different’ from those who do not. By taking this perspective, we hope that our work contributes to an increased awareness of similarity and reduced perceptions of difference which help fracture damaging distinctions between ‘them’ and ‘us’. This philosophy is critical to the work we describe in this book and central to the task of offering or supporting sport and physical activity opportunities which are likely to be experienced as helpful.

The concept of recovery

A notable shift has taken place in recent years within the mental health field in terms of what recovery is taken to entail. Julie Repper and Rachel Perkins (2003) note that the traditional focus of treatments and services for people with mental health problems has been on symptom alleviation – often through medication regimes – and suggest this
has led to a culture within mental health services which is preoccupied with deficits and dysfunctions. Within this culture, these authors suggest, need is assessed in terms of symptoms to be alleviated, interventions are focused upon difficulties, and effectiveness is evaluated in terms of symptom removal or ‘cure’. While modern treatments, very often medication, may be effective in symptom alleviation terms, those who have experienced mental illness often assert that elimination of symptoms is only one part of the recovery picture – that something more than the remission of symptoms is necessary for recovery to occur. Chadwick (1997a, p. 48), for example, recalls how ‘despite the quite incredible power of the medication to wipe out symptoms (for which I will always be grateful) the inner feelings of downheartedness and guilt were still there’.

With a similar attention to a broader and more humanistic set of recovery-related factors, Repper and Perkins (2003, p. ix) write:

The challenge facing people with mental health problems is to retain, or rebuild, a meaningful and valued life, and, like everyone else, to grow and develop within and beyond the limits imposed by their cognitive and emotional difficulties. Recovery is not about ‘getting rid’ of problems. It is about seeing people beyond their problems – their abilities, possibilities, interests and dreams – and recovering the social roles and relationships that give life value and meaning. This requires hope and opportunity. Building for a future necessitates a belief in the possibility of that future. Hope is the motivating force that gives life purpose and direction, but, without the opportunity to do the things you want to do, such hope is easily snuffed out.

In a similar vein, William Anthony (1993) describes recovery as a unique and personal process which involves a transformation of values, feelings, attitudes, goals, skills or life roles. In his words, it is ‘a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life, as one grows beyond the catastrophic effects of mental illness’ (1993, p. 19). From this perspective, the recovery process can be appreciated as far-reaching, complex and closely related to each individual’s particular life experiences.

A very similar viewpoint has been reiterated more recently by Davidson and colleagues (2005) who, in attempting to establish a conceptual framework for recovery, argue that remission of symptoms or other deficits is not necessary for recovery. Rather, they suggest, ‘recovery involves incorporation of one’s illness within the context of a sense of hopefulness about one’s future, particularly about one’s ability to rebuild a positive sense of self and social identity’ (2005, pp. 484–5). Rebuilding this sense of self and a social identity is also an important aspect of Davidson and Roe’s (2007, p. 462) concept of recovery in serious mental illness (as opposed to recovery from mental illness) which they suggest is needed to overcome the ‘loss of valued social roles and identity, isolation, loss of sense of self and purpose in life’ which frequently accompanies severe mental health problems.

From the perspective of those who have experienced mental health problems, alleviation of symptoms is only one part of a more complex recovery picture. The recovery process, it seems, is likely to be unique to each individual and closely tied to situational and contextual factors as well as personal life experiences. It is on this basis that Coleman (1999) argues against defining recovery in terms of standardised outcome measures such as symptom rating scales and quality of life scales on the basis that they
may hold little meaning for particular individuals and fail to allow for the personal and subjective nature of recovery. For us the priority is meaning over measurement. Instead of a set of tightly defined criteria through which recovery may be defined and measured, it seems more useful to conceptualise an open and loosely defined ‘menu’ of themes which hold meaning for the individual and are present across diverse conceptions of recovery. Core themes of recovery as identified by those who have themselves experienced mental illness (based on Anthony, 1993; Repper & Perkins, 2003; Davidson et al., 2005) focus on the need to:

- rebuild social roles and relationships
- develop meaning and purpose in one’s life
- recreate a positive sense of self and identity
- change one’s attitudes, values and goals
- enact, acquire and demonstrate ability
- pursue personal interests, hopes and aspirations
- develop and maintain a sense of hopefulness about one’s future.

Physical activity and mental health research

Over the past decade or so a handful of books have been published which have explicitly explored the relationships between physical activity and mental health through reviewing the existing research in the field. These include Morgan (1997), Biddle et al. (2000), Leith (2002) and Faulkner and Taylor (2005). In addition, several review articles have been published in academic journals and books during this time, some of which have focused on physical activity within the context of severe forms of mental illness. These include Faulkner and Biddle (1999), Fox (1999, 2000), Grant (2000), Carless and Faulkner (2003), Callaghan (2004), Richardson et al. (2005), Saxena et al. (2005), Faulkner and Carless (2006), Stathopolou et al. (2006), Ellis et al. (2007) and Teychenne et al. (2008a). Numerous research papers have been published from the diverse perspectives of sport and exercise science, health promotion, mental health, nursing, psychology, public health and sociology. Published research studies over the past decade or so which have focused specifically on physical activity and sport within the context of severe and enduring forms of mental illness include Faulkner and Sparkes (1999), Raine et al. (2002), Carter-Morris and Faulkner (2003), Crone et al. (2004), Jones and O’Beney (2004), Beebe et al. (2005), Fogarty and Happell (2005), Skrinar et al. (2005), McDevitt et al. (2006), Crone (2007) and Soundy et al. (2007). Finally, several studies drawn from our own ongoing research (which forms the basis of this book) have been published: Carless and Douglas (2004, 2008a, 2008b, 2008c, 2008d, 2009c), Carless (2007, 2008) and Carless and Sparkes (2008).

A large volume of physical activity and mental health research has focused on exploring the relationship between participation and the occurrence of depression. Several reviews of this research have been published and authors of these papers report an inverse relationship between physical activity participation and the occurrence of depressive symptoms (e.g. Mutrie, 2000; O’Neal et al., 2000; Lawlor & Hopker, 2001; Saxena et al., 2005; Stathopolou et al., 2006; Teychenne et al., 2008a). At the
population level, there is evidence that people who are physically active are less likely to experience depression (e.g. Teychenne et al., 2008b) while among groups of people who are experiencing clinical depression, physical activity leads to statistically significant reductions in scores on symptom rating scales (e.g. Stathopolou et al., 2006). The positive effects of various forms of physical activity on depression are now widely recognised and acknowledged in the Chief Medical Officer’s Report (Department of Health, 2004) which recommends exercise as a treatment and preventive measure against depression.

It is evident that the majority of research conducted to date – and reviews of that research – have tended to focus primarily or exclusively on the extent to which physical activity alleviates the symptoms of mental health problems. For example, in reviewing the research which has explored the therapeutic potential of exercise for people with schizophrenia, Faulkner (2005) considers the potential psychological effects of exercise exclusively in terms of the alleviation of positive and negative symptoms. A similar symptom-focused orientation is evident in the review by Ellis and colleagues (2007) concerning the therapeutic effects of exercise among people with psychosis. In this regard Crone and colleagues (2005, p. 601) observe that ‘researchers have concentrated on establishing a relationship, rather than asking why a particular incident, experience or situation is important’. By focusing on measurement (i.e. measuring what activity ‘takes away’ in terms of symptoms, impairments or problems) as opposed to meaning (i.e. understanding what activity contributes or brings to a person’s life), the ways in which physical activity and sport may help individuals recover from mental health problems have mostly been sidelined. These include the possibility of changing attitudes, values, feelings, goals, skills and/or roles or providing a way to live a satisfying, hopeful and contributing life. Focusing on what activity removes as opposed to what it contributes is, we think, an important and significant oversight because, as Anthony (1993, p. 20) suggests:

‘efforts to positively affect the impact of severe mental illness can do more than leave the person less impaired, less dysfunctional, less disabled, and less disadvantaged. These interventions can leave a person with not only ‘less’, but ‘more’ – more meaning, more purpose, more success and satisfaction with one’s life.

To date, it is evident that the literature on physical activity and mental health has largely failed to address the potential for exercise and sport to contribute to recovery in this kind of broad, humanistic and positive sense.

It is notable that recent qualitative research which has focused on service-user perspectives on physical activity has tended to identify ‘non-medical’ kinds of benefits which are not necessarily related to mental health diagnosis or symptom occurrence. For example, Crone and Guy (2008) report a range of benefits as perceived by service users who participate in sports therapy activities. These included feelings of accomplishment and well-being, enhanced self-esteem, a more positive mentality, greater mental alertness, increased energy and improved mood. Similarly, Crone (2007) identifies several perceived benefits among members of a walking project which included enjoyment, opportunity to meet and be with people, knowledge and appreciation of plants, purposeful activity and help with sleeping.

Raine and colleagues (2002) note that not all therapeutic interventions aimed at relieving mental distress are equally valued by recipients and suggest that a critical
factor in their value is the degree to which the intervention is seen as meaningful and relevant to a person’s life. Clearly, meaning and relevance are highly subjective; what is meaningful and relevant to one person may be meaningless or irrelevant to another. From the perspective of researching the recovery process, developing an understanding of what is essentially a subjective process would seem to require a focus of attention on how individual persons experience recovery with reference to their own preferences, values and life circumstances.

According to Richardson and colleagues (2005), exercise is generally well accepted by people with serious mental illness and is often considered one of the most valued components of treatment among those who participate. On the basis of the Crone (2007) and Crone and Guy (2008) studies, it would seem that what users value most as outcomes from their physical activity and sport experiences has less to do with ‘being a person with a mental illness’ and more to do with ‘being a human being’. In other words, research which takes as its starting point the voices of service users seems to us to point towards a need to consider the role of sport and exercise in a holistic and person-centred manner rather than in terms of symptom alleviation.

A final point which we would like to mention is that existing research in this field currently provides little theoretical insight into how mental health changes come about through involvement in physical activity. At present, there seems to be little understanding of possible processes of change. While this understanding need not be definitive, fixed, infallible or final, we do need some kind of lens through which to understand or ‘make sense’ of what happens when a person engages in sport or exercise. While some researchers strive for a biochemical explanation (for reviews of this work see Morgan, 1997), these approaches have so far failed to identify a single causative mechanism, perhaps because no single biochemical mechanism is responsible for the diverse range of effects which are possible through physical activity. What is needed, therefore, in order to complement existing knowledge in this area, is an alternative tack that can combine social, cultural and psychological approaches in order to provide insights into processes which, while perhaps involving biochemical change, cannot be reduced to biology or chemistry.

Key points

- Stories of the experience of mental health problems are highly diverse and individual. However, we see several themes (which may be experienced in different ways) across personal accounts of mental illness. These include fear, isolation, joylessness, hopelessness, a loss of agency, a sense of inactivity or emptiness, and distress that is total, permeating a person’s life in profound ways.
- The experience of a mental health problem – alongside the processes of diagnosis and treatment – can interact in powerful ways with a person’s understanding of themselves and their goals and aspirations for life. Often, people who have experienced severe mental health difficulties describe a loss of identity and sense of self alongside a loss of meaning and purpose in their lives. Marginalisation and disempowerment are common themes in individuals’ accounts of being users of mental health services.
Recovery necessitates more than the alleviation of symptoms. It is widely recognised as a deeply personal and individual-specific process which is likely to include several tasks: rebuilding social roles and relationships; developing meaning and purpose in one’s life; recreating a positive sense of self and identity; changing one’s attitudes, values and goals; acquiring and enacting ability; pursuing personal interests, hopes and aspirations; developing and maintaining a sense of hopefulness about one’s future.

Most existing research reports broadly positive conclusions regarding the mental health benefits of physical activity. However, the majority of studies have focused primarily on the potential of physical activity to alleviate symptoms as opposed to contributing to recovery in a broad and holistic manner.

The potential contribution of physical activity and sport in mental health may have more to do with what participation contributes to a person’s life, rather than what it takes away.