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Running head: PHYSICAL ACTIVITY AND SERIOUS MENTAL ILLNESS

The Physical Activity Experiences of Men with Serious Mental Illness:

Three Short Stories

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Abstract

Objectives: Although a considerable amount of research has explored the effects of physical activity on mental health, the voices of people with mental illness have been largely excluded from published reports. Through this study we aim to foreground service users' voices in order to shed light on the personal and subjective nature of the relationship between physical activity and serious mental illness (SMI).

Method: An interpretive case study approach was used to explore in depth the physical activity experiences of three men with SMI. Creative analytic practice was used to write three creative non-fictions which, as first-person narratives, foreground the participants' voices.

Findings: We present three short stories in an effort to communicate participants' personal and subjective experiences of physical activity in an accessible, engaging, and evocative manner. We hope to: (i) provide potentially motivating physical activity success stories for others who live with SMI; (ii) increase awareness among mental health professionals of the possibilities of physical activity; and (iii) provide an empathetic understanding of possibilities and problems of living with SMI which may help challenge the stigma surrounding mental illness.

Conclusions: For us, the stories communicate the diversity and difference inherent in the ways men with SMI experience physical activity. We reflect on how the short story form allows these differences to be preserved and respected. We resist making further interpretations of the stories preferring instead to encourage the reader to form her or his own conclusions.

Keywords: sport, mental health, schizophrenia, exercise, creative non-fiction, stories

The Physical Activity Experiences of Men with Serious Mental Illness:

Three Short Stories

Research into the links between physical activity participation and mental health has increased in recent years and several substantial reviews report a range of benefits for diverse populations (Biddle, Fox, & Boutcher, 2000; Faulkner & Taylor, 2005; Morgan, 1997). Most research has explored the therapeutic potential of physical activity for people with mild to moderate depression and a number of studies have shown positive effects (e.g., Blumenthal, Babyak, Moore, et al., 1999; Brosse, Sheets, Lett, & Blumenthal, 2002; Craft, 2005; Faulkner & Biddle, 2004). Existing reviews generally report similarly positive conclusions concerning the effects of physical activity on depression (e.g., Craft & Landers, 1998; Mutrie, 2000; O'Neal, Dunn, & Martinsen, 2000) although Burbach (1997) and Lawlor and Hopker (2001) express reservations concerning the suitability of exercise as a clinical intervention.

Although much less research has explored the benefits of physical activity for people with serious mental illness such as schizophrenia, several studies suggest that, for some people at least, benefits occur through regular participation (Beebe, Tian, Morris, Goodwin, Allen, & Kuldau, 2005; Carless & Douglas, 2004; Faulkner & Biddle, 1999; Faulkner & Sparkes, 1999; Fogarty & Happell, 2005). Serious mental illness (SMI) is defined 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” (United States Department of Health and Human Services, n.d.). Given the high levels of disability experienced by people with SMI, it is perhaps unreasonable to expect participation in physical activity to lead to remission. However, as part of a more holistic care package physical activity participation may have something to offer. Existing research suggests that physical activity offers psychosocial benefits for people with SMI such as opportunities for

social interaction, achievement, and relaxation which can contribute to quality of life (Carless & Douglas, 2004; Faulkner & Sparkes, 1999; Fogarty & Happell, 2005). Faulkner and Biddle (1999) suggest that physical activity can also be an effective way of tackling the negative symptoms (such as low motivation and social difficulties) and assist in managing of the positive symptoms (such as delusions and hearing voices) of schizophrenia. From the perspective of physical health, Faulkner, Soundy, and Lloyd (2003) suggest that physical activity has a potential role in helping reduce the weight gain which is a common side effect of antipsychotic medication (Green, Patel, Goisman, Allison, & Blackburn, 2000). There is no reason to believe that the health and fitness benefits of physical activity reported for the general population will not occur for people with SMI and preliminary research suggests that this is indeed the case (Beebe et al., 2005). In light of the poor physical health of some people with SMI (Brown, Birtwistle, Roe, & Thompson, 1999), participation in regular physical activity may be particularly valuable.

Understanding the Experience of Physical Activity in Serious Mental Illness

While existing research provides information on the effects of physical activity, it is questionable whether it provides much insight into the personal experience of physical activity for people with SMI. The majority of research to date has been conducted from a positivistic perspective and findings have been represented as scientific or realist tales (see Sparkes, 2002). This approach has tended to exclude the perspectives of people with SMI themselves by silencing the subjective voice of personal experience. Faulkner and Sparkes' (1999) ethnographic study of exercise as a therapy for people with schizophrenia is one notable exception which, through an interpretive approach and the presentation of extended excerpts from interviews with service users and mental health professionals, provides insights into the personalised and subjective nature of the benefits and problems of physical activity. Because the

physical activity-mental health relationship is likely to be complex, varied, and individual-specific (Carless & Faulkner, 2003; Faulkner & Biddle 2004; Faulkner & Carless, 2006; Fox, 1999, 2000), developing an understanding of the subjective nature of the benefits of physical activity is, we suggest, essential if we are to appreciate its potential. Communicating this understanding in an accessible, humanised, idiographic form is important for three further reasons.

Firstly, although the disablement experienced as a direct result of SMI can be severe, it is the indirect social effects of mental illness that are often the most debilitating at the individual level (United States Department of Health and Human Services, 1999). Negative social attitudes towards mental illness, in the form of stigmatisation, are widespread and make the experience of a mental disorder much more damaging, difficult, and disabling for many people (Repper & Perkins, 2003; US DHHS, 1999). To a large extent, stigmatisation results from misunderstanding over what mental illness is and what it means at a personal level (US DHHS, 1999). Improving understanding of the experiences of people with SMI is therefore an important task if the stigmatisation and, subsequently, social exclusion of those with mental health problems is to be tackled. Making this understanding socially available in an accessible form is one way to challenge stigma and social exclusion at the personal level.

Secondly, despite the existing evidence base for the mental health benefits of physical activity, few mental health professionals include physical activity as a treatment option (Faulkner & Biddle, 2001). Further, there is evidence that some mental health professionals have low expectations and negative assumptions concerning the abilities of people with mental illness which can limit progress (Social Exclusion Unit, 2004). Repper and Perkins (2003) have argued that this tendency has a powerful effect on the opportunities offered to people with SMI and that, to counteract this, it is

necessary to move our focus away from the *problems* experienced through SMI towards what is *possible* for people with SMI. In the context of physical activity, we suggest that a fuller understanding of the possibilities offered through physical activity may encourage mental health professionals to make physical activity opportunities more widely available to service users.

Thirdly, mental health service users themselves may benefit from awareness of the physical activity experiences of other people with a mental illness. Social isolation, low motivation, and loss of hope are recognised as threats faced by people with SMI (Chadwick, 1997a, Repper & Perkins, 2003). Awareness of the success experiences of others, perhaps in similar situations, through physical activity has the potential to encourage the consideration and initiation of physical activity participation. The opportunity to relate to the positive experiences of others with SMI who have participated in physical activity may also help reduce perceptions of isolation and hopelessness through promoting a sense of affiliation and connectedness to others who are living through similar experiences.

Gaining insight into the place of physical activity within the personal context of people with mental illness is, however, unlikely to be an easy task given the nature of the experiences which often accompany SMI. During the acute psychotic stages of illness, these experiences can be extreme and unusual. According to Peter Chadwick, a person who has himself experienced SMI, the experiences associated with the acute stages of illness can make understanding people with SMI a difficult and challenging task:

The interfacing of a psychotic person with the normal and sane is a jarring and disturbing one for both parties. Once delusions are in place and systematised, no two sets of people have a bigger gulf between them. Be they black and white, male and female, heterosexual and homosexual, the gulf separating them pales

literally into insignificance when compared to that between the sane and the floridly insane. (Chadwick, 1997a, p. 39)

A lack of understanding and awareness of the personal experience of SMI may be particularly critical when it comes to recovery. Despite the effectiveness of modern medications in tackling mental illness, it seems that recovery is a personal process which requires something more than symptom removal (Chadwick, 1997b; Repper & Perkins, 2003). In Chadwick's (1997a) words, "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" (p. 48). Likewise, Chadwick's accounts of other patients' comments on treatment suggest that being understood is an important component of recovery: "the people who help us don't know what it's like' and 'he doesn't listen to my *experiences*, everything's a symptom to be *removed*' and so on" (Chadwick, 1997b, p. 581). In relation to this issue Repper and Perkins (2003) note, "Recovery is not about 'getting rid' of problems. It is about seeing people beyond their problems – their abilities, possibilities, interests and dreams" (p. ix). In order to become aware of the abilities and possibilities of life with SMI, Repper and Perkins argue that it is necessary to value the voice of those who have "been there." That is, people who live with SMI:

In moving beyond symptoms and deficits, it is vital that we start in a different place, i.e. with the voice of first hand experience. We need to begin by listening to people who have mental health problems. We must gain insight into the possibilities of life with mental health problems (Repper & Perkins, 2003, p. 14).

A Story Approach

In recent years, set against the backdrop of the 'crisis of representation' within the social sciences as described by Denzin and Lincoln (2000), qualitative researchers

have experimented with novel ways to represent their data and articulate the voices and first hand experiences of the participants in their studies. These include confessional tales, autoethnography, poetic representations, ethnodrama, and fictional representations in the form of storytelling (see Sparkes, 2002 for a review and examples of each). With regard to the latter a number of scholars have begun to mark out the ground on which this more evidently aesthetic research form might be constructed (Barone, 2000; Ellis & Bochner, 1996; Goodley, Lawthom, Clough & Moore, 2004; Sandelowski, 1994; Tierney, 1998). For example, Clough (2002) stated:

As a means of educational report, stories can provide a means by which those truths, which cannot otherwise be told, are uncovered. The fictionalization of educational experience offers researchers the opportunity to import fragments of data from various real events in order to speak to the heart of social consciousness – thus providing the protection of anonymity to the research participants without stripping away the rawness of real happenings (Clough, 2002, p. 8).

Clough's (2002) acknowledgement of 'data' in relation to the production of educational stories signals an allegiance to the tradition of literary non-fiction that draws on real people and real events as opposed to people who do not exist, and events that did not happen. This approach stands in contrast to creative fiction (e.g., Angrosino, 1998) where stories need not be based on real events or real people other than through suggesting "things *like these* happened to people *like these*" (Angrosino, 1998, p. 101).

In contrast, with regards creative non-fiction Barone (2000) commented:

The basic materials of the inquirer into the experienced curriculum are pieces of evidence, particular facts collected during observations in a classroom or a school. Inquirers may select, interpret, and shape this factual evidence in order

to provide a forceful, coherent, rendering of classroom life ... for an educational portrait to have real value, it is essential that authors use as their material the actual, particular, specific phenomena confronted in the research setting (Barone, 2000, p. 24).

For Barone, therefore, there is a concern with accuracy as the characters and setting must be actual, not virtual. For the qualitative researcher this means that their work is grounded in everyday, concrete, specific events and research protocols that generate data. Fictional strategies and techniques are then utilized to make the findings of the study available to the reader. That is, as Agar (1995) notes, the stories are fictional in form but factual in content.

With a view to generating insights into the individual experience and meanings of physical activity in the lives of men with SMI, along with the possibilities of physical activity within the context of life with mental illness, we now draw on data from a wider study on physical activity and mental health (Carless, 2003). While conducting this study as part of my doctoral research, I (David Carless) created three short stories in an effort to further explore and communicate the physical activity experiences of three participants who were living with SMI. The published work of the second author (Andrew Sparkes) provided a theoretical framework and academic rationale for the use of the story form (e.g. see Sparkes & Silvennoinen, 1999; Sparkes 2002, 2003a, 2003b, 2003c). During the preparation of this article Andrew, as a professor of social theory with extensive experience of qualitative research and the use of alternative genres to represent lived experience in physical activity contexts, was ideally placed to act as a 'critical friend'. As part of a symbiotic relationship with the first author, this involved providing a theoretical sounding board to encourage reflection and critique regarding not only the choice of the story form to represent the experiences of the participants, but also the development of the stories in relation to the data, and

their final composition for publication (see Holt & Sparkes, 2001; Sparkes & Partington, 2003).

Method

Following ethical clearance from the local research ethics committee, the first author (David Carless) began an 18 month period of immersion in the daily life of a vocational rehabilitation centre for people with SMI. During this time, David took part in sport and exercise groups as well as social and day-to-day activities which helped build trust and rapport with potential participants. Through close liaison with mental health professionals three men were identified who: (i) had personal experience of SMI and physical activity participation; (ii) were willing to take part in the research; and (iii) were considered by health professionals to be sufficiently mentally well to participate in interviews. Ben, Mark, and Colin (all pseudonyms) might be considered “successful exercisers” as they had been involved in regular physical activity for at least six months. Given the low levels of physical activity common among people with SMI (Brown et al., 1999), regular physical activity was conceptualised as more than one exercise session per week. Ben, Mark, and Colin were receiving antipsychotic medication and had long histories of mental illness (between eight and twenty years) the severity of which had precluded independent living and paid employment. All participants had begun their current physical activity participation at the rehabilitation day centre under the guidance of a physiotherapist and the activity sessions formed part of each individual’s weekly schedule and were considered an important and integral component of their rehabilitation programme.

A semi-structured interview was conducted with each participant at a location of their choosing which lasted between 45 and 90 minutes. The interview schedule began with four basic questions about the individual’s current physical activity participation. This topic was selected as a relatively “safe” starting point that would allow the

participant to talk freely about their own experience and help build rapport while minimising possible perceived threat by raising sensitive issues. A second section focussed on previous physical activity participation prior to the onset of mental health problems. A third section probed psychological effects of physical activity beginning with a general question seeking unprompted ideas from the participant followed by questions which sought clarification, details, and possible alternatives. The fourth section of the schedule investigated specific explanations for the individual's psychological responses beginning with a general question before probing specific theoretical issues such as social support and relations, autonomy, competence and achievement, and identity. Finally, questions were posed concerning the perceived place of physical activity in the participant's future and personal problems with physical activity. Descriptive questions (to learn about the participant's activities and experiences), structured questions (to investigate specific details of these activities and experiences), and contrast questions (to clarify and check meaning and interpretation) were used throughout the interviews in an effort to generate a comprehensive and complex understanding of individual experience (Biddle, Markland, Gilbourne, Chatzisarantis, & Sparkes, 2001).

Two open-ended follow-up interviews lasting approximately 45 minutes each were conducted with the first participant (Ben) in an effort to develop issues that had previously emerged. While these interviews provided further insights, Ben later reflected that the additional interviews were, in his view, excessive. While he reiterated his consent that existing data be included in the study, he declined to take part in further interviews. This event caused David to reconsider the wisdom of conducting follow-up interviews with the other participants given the severity of their illness and his desire to avoid causing distress through revisiting potentially traumatic moments in their lives. For the same reasons, in consultation with mental health professionals, David made the

decision to seek feedback on the stories from other service users, family members, and mental health professionals rather than the participants themselves. The considerable ethical dilemmas within these events will be explored in a subsequent publication.

Analysis: Type 1. Interviews were transcribed verbatim before a process of repeated close reading was conducted in order to become immersed in the data (Maykut & Morehouse, 1994). A content analysis was conducted to identify and code themes arising from the data and quotations were used as the unit of analysis (Sparkes, 2005). A second stage of analysis involved compiling the obtained codes, relating to the specific theme and the location of the quotation within the transcript, on a single, large-scale mental map (Ryan & Bernard, 2000). The mental map allowed the co-ordination and linking the historical data from the participant's medical records with contact summary sheets and interview data. A third stage of analysis involved the development of a series of charts and matrices for each participant. These one-page displays "show reduced, organised, and focused data on a single page" (Miles & Huberman, 1994, p.93) that provided a manageable visual representation of the life experiences of each participant.

Analysis: Type 2. According to Richardson (2000), "Writing is also a way of knowing – a method of discovery and analysis. By writing in different ways, we discover new aspects of our topic and our relationship to it. Form and content are inseparable." (p. 923). In support of this position, Sparkes (2002) comments:

Modes of writing along with other forms of representation are fundamental to the work of qualitative data analysis. As a consequence, we can no longer relegate the production of our scholarly works to an apparently mechanical and minor aspect of the research, that is, the 'writing up' stage. Quite simply, writing and representation cannot be divorced from analysis, and each should be thought of as analytic in its own right" (p. 15).

Accordingly, a second type of analysis was conducted in order to value the voices of Ben, Mark, and Colin, and to gain different insights into the experiences and possibilities for them as they lived with their mental health problems. This analysis involved selecting data from the previous Type 1 analysis and presenting it in the form of a creative non-fiction short story which draws upon the participant's own words with the intention of communicating his personal experience of physical activity in the context of mental illness. One fictional technique, authorial presence, was particularly important in writing these stories. According to Agar (1995) authorial presence is when the creative non-fiction writer is the voice behind – or perhaps in – the story. In this sense the writer is the organising consciousness, “the force that makes coherent meaning through skilful rendering of the details” (p. 118). Given the severity of the participants' mental illness, the data produced through interviewing Colin, Ben, and Mark was at times disorganised and fragmentary. A degree of authorial presence was therefore needed if a coherent rendering of each participant's telling was to be constructed. Specifically, although the three stories comprise between 81% and 97% of the participants' own words taken verbatim from the interview transcripts, additional words were added to provide a clear, smooth, and comprehensible account that retains the original context of the remarks. For example, the primary investigator (David Carless) expanded Colin's response to his question of when he last swam from, “I would say about a month ago” to, “I would say the last time I swam was about a month ago” to clarify context. Additionally, although the specific episodes in each story were drawn directly from the interview transcripts, it was sometimes necessary to change the chronological sequence of events in an effort to construct a coherent story.

Criteria for Judgment. According to Sparkes (2002, p. 199), “any kind of research can be dismissed, trashed, and trivialized if inappropriate criteria are imposed on it.” Given that short stories are at present an unusual form of representation in sport

and exercise psychology, we would like to suggest some appropriate criteria by which these stories may be judged, drawn from a review provided by Sparkes (2002). In light of the constructive process as described that involved orchestrating extracts of interviews into a coherent whole, one particularly relevant criterion that might be used in judging the stories relates to the notion of coherence. That is, have the sometimes disorganized and fragmentary accounts of the participants been brought together in such a way as to create a readable and meaningful picture of the individual's experience? Do the parts fit, and do the stories hold together in an intelligible and articulate manner? In this regard we might also ask of these stories, are they plausible? Do they seem credible in pulling together a believable combination of the parts? Given that the voices of people with SMI are often absent from more traditional research articles, readers might also consider whether the stories create spaces for silenced voices to be heard, whether they display empathy and respect for the participants, and whether participants are portrayed in an ethically informed manner. Finally, given our purposes as previously described, readers might also consider the following questions as they evaluate the stories: Do they make a substantive contribution to our understanding of SMI and physical activity? Is there something to be learned from the stories about the experiences of 'others' living with SMI? Do they provide an embodied sense of the lived experience with regard to SMI and physical activity? Do they invite dialogue and/or interpretive response? Do they affect the reader emotionally and/or intellectually? With these issues in mind, we now present the stories.

The Future's Looking Bright

I think I was talented. I think that's what it was. I played for the school when I was young – eleven, twelve or thirteen. I played for the juniors, made two appearances, but scored one goal and I always remember that. I remember going down the wing, 'cause I played left half, and this ball came over from one of the players and I just

looked up and hit it and it went behind the goalkeeper's head! I just took it as normal, just hit the ball and it just went in. It was great! I felt really, you know, just felt great. Thought I'd achieved something. We were at home against our local rivals, Bridgeside, who used to play at Borough Park. I knew the goalkeeper you see, he played for City in the end, Peter Reeves. I can't remember what the score was but that was our local rivalry. That was when I first started really. But I used to play football, outside, in the house gardens on my own, just kicking a ball. So really I started when I was about seven or eight I suppose. I used to play football over the park, Sunday mornings with my friends and then Sunday afternoons again, another match. I just got addicted to it. It just went from there really.

When I was about twenty I started playing in the local league for Wanderers. That was my first football team, I played for other teams, but I think that was my favourite one cause I was there the longest – about four or five years. I used to play left-back. We had an injury to one of our players, Terry Stone, he played left-back and I took his place. And then what happened, the manager, Steve Corr, was in goal and he had a knee injury and I took over in goal. I made about one hundred appearances in goal for the team.

I used to train over the park on my own. There's one of my favourite photos, one of the earlier ones before I had my breakdown. That's the house in the background and Woodland park where I used to train on my own – skills, like. I used to kick the ball in the air, let it bounce, catch it, do shooting practice with two footballs. I used to ride a bike at the time, and I did a bit of swimming then, so I was quite fit really. And football just gave me a kick, you know, enthusiasm! I just thought it was a great game, it really gave me a lift. I've always loved the game.

I stopped football when I was unwell 'cause I was pretty low. That was my first breakdown then. I was twenty-eight, I can remember that very well. I think it was anxiety, stress, work, everything, like. I'd just done too much and it hit me for six. I just had a breakdown and that was it really. I was over at my mother's house, I used to go to sleep a lot, I switched off. I used to go into my own little synchronisation sort of thing, I used to sleep for hours and hours. The head doctor of the mental side of the hospital came round to the house and saw me a couple of times; come to my room, just say "we're checking you out", ask me a few questions. She knew I was very low and she said you've gotta go to Brentree – we're taking you in.

So I was at Brentree hospital for a bit, about two or three months I think it was. I was so bored in there - nothing to do. I just stayed in the ward and just went to bed and that was it. I'd just get up, have something to eat, a cup of tea, sit in the television room, talk to somebody and then just hang about for a couple of hours unless a doctor wanted to see me. I think that's what made me go to sleep 'cause I was bored, depressed. I thought, well, I've got nothing else to do. I just want to go to sleep. The doctors knew that as well, my morale was still quite low, that's why they asked me to do some activities. They tried to get me to do exercise just to get me out of that system.

It was the group, starting to talk to people, and the medication I think. I started taking medication and saw a few doctors and I started getting better. The medication helped me to stabilise myself. I started talking and got out of my shell. It was important to talk to people, communicate with people and once I started talking to people it gave me more confidence. So all that was on my own part really, I did it myself, started to talk to people myself.

I started with some activities like going somewhere in the van for a couple of hours. Chaps would come round and take us out, so that was like a walking group

really, just to get out of the hospital. And then I started going to gym and went to OT and then I started going swimming – that was it then. It wasn't so bad then. My confidence came back. I was actually on the road to recovery. Once I got in the gym I used to go and do those exercises on the bars, the weightlifting, and the bike and what have you. I was doing it every day, five days I think, about nine o'clock in the morning. It was an early session! It was hard work 'cause I wasn't so strong then but I was there about forty-five minutes. 'Cause I was doing exercises I felt a bit better like, felt more, a bit of energy, felt a bit stronger. Rather than feeling low, when I was doing some activity - the exercises - I felt better. I gained something out of it. 'Cause when I was low I had different mood levels - the medication I was on that'd alternate the moods I was in. When I took that it gave me a lift. But when I was doing exercises it was similar to that, it gave me a lift similar to the medication 'cause I'd done something, I'd participated in something. It was something out of the blue that came to me and I just had a go. I just attacked it in a normal way and, you know, I appreciated what I'd done in the end. I got something out of it.

It was only a couple of weeks. After that I knew I'd had enough of it - that was enough of the gym for me I think. It did enough to boost my morale. I was a little bit better then and I could do other things like routine work, therapy work, go to OT, play table tennis, do quizzes and I used to do a bit of cooking there as well. I used to make my own way down to the OT, whereas sometimes when I was low they used to come over and meet me to make sure I would turn up. That's the time they knew I was low - depressed.

It could have been a year, or, I think it was, yeah. It took quite a long time to get back to normal, the person as I was. 'Cause I made a recovery and then I started playing football again, just kind of natural really. I've just always been mad on sports! The sort

of games that I played in the past, when I was younger, I sort of started back playing them again. It's just the enthusiasm really, that's what has changed my life. Well, apart from the music I would say. If I didn't play football or have any music I don't think I'd be here today. I think it's kept me going. Well, it brings all your talent out, your ability in other words. It brings the, say, the cleverness out of you. Cause we've all got talents, everybody's got some talents, doesn't matter if its art or its football, engineering, cars, anything, I think we've all got a talent. Mine is activity - sports. Keeps me going, keeps the adrenalin going.

I like to play other games – it's just, like, *doing*. When you do all these other sports it's not so boring. I think it's better for a person to do a different sport, see how you get on, rather than just sticking to the one game. Skittles, I played that for must be sixteen years now I think I've been with the team! I've been with the team so long it's like a family really. Pool, I play pool sometimes - that's the other sport. But it's mostly the football and walking really. It's basically football, swimming – a bit of swimming – walking with the walking group and badminton sometimes.

I feel more relaxed after I've been swimming - something about the water makes you feel good. When I was young I was afraid of the water. My mum used to encourage me to jump into the water and I was just terrified of water! But I met a chap that used to live over near Oakside baths where I used to go that taught me how to swim - breaststroke and front crawl - and gave me a lot of confidence in the water. I still get the same confidence 'cause I know that I can swim. It's like when I go on holiday, I know that I can swim in the sea, I'm quite a strong swimmer, I know that I can do it – it gives me a buzz.

I would say the last time I swam was about a month ago with Simon. I was looking forward to it 'cause I know it'll just come natural, see. Switch off and

concentrate on swimming a few lengths, just taking it steady. Think about other things as well, what's happening and that. It could be what you saw the other day, or what you're gonna do an hour after you've finished swimming, or your mother and father. Depends what mood you're in. If you're in a sad mood you might think of your dad, I would anyway, always think of my dad now and again. Get flashes with him like, but I think it's a good thing in a way. 'Cause I was so close with him - when I went to our dad's funeral I was in hell of a state. I cried my eyes out. Terrible. Nobody likes going to funerals do they? But I always think of him, I always remember him.

I think it was the doctors - the doctors wanted me to keep being active. I used to go to the gym to do a little exercise with Sarah and Catherine, the physios. They made a programme for me and I started all different activities. They asked me what I wanted to do, told me what was available and what I could fit in, like a school programme. That was five years ago when I was here - I only come here for sports now. So I've got a big connection with Redview Lane really. When I'm not actually working, doing jobs here, I still communicate with the people here. Keep close with the people, the same people. I'm sort of supported. I feel supported with other people here, especially with the football team. It's people that I never knew before, but I got friendly with, made good friends, and we all just participated in sport. Family as well, they supported me since I was ill really. They used to come round, make sure I was up, when I went out with them they asked how I was. You know, just good friends really - just care.

I used to be so quiet, see, and shy. Now that I've got better I'm just talking and more relaxed - I feel better. And I focus better as well. Like when I used to answer the phone I used to stutter, get embarrassed. I was stuck for words. But now I'm just a different person. My mum's seen it as well, the change in me. I feel more confident when I'm speaking to somebody.

Since I was in Brentree I really feel on top of the world. Until I get an injury or something I don't want to stop really. I'm an active person, sports and interests - that's about it I suppose. It'll have to come to a halt when I get older, football-wise, I'll have to keep playing cricket and walking and just slow it down, don't do so much. But there's always cricket or something you can play when you get older.

The future? Well, I think it's looking quite bright. I'm optimistic. 'Cause you don't know what's gonna happen the day after do you? I could have a heart attack or something, anybody can, can't predict the day after can you? It's why you gotta make the most of the day you're doing now. You know, it's never tomorrow - you just gotta start today.

The Long Run

It's a fear of a fear really. You're just frightened and you don't know why. Everything becomes out of touch. You're just frightened to death for some reason and you don't know why. The fear is so intense it just gets a grip of you. That's what a panic attack's like. And it lasts for about an hour, something like that. Then it's gone again. And then you think, well you know, what was I worried about? Then all of a sudden, you'll be alright for a few days or a few weeks, and all of a sudden you'll go out running and it'll come back again. I had it in the last half marathon I ran. Not only was I thinking of keeping going, I had to deal with a panic attack as well. So I went 13 miles and I was in the panic attack all the way round. I got out of it as I finished and had a shower and as I was in the shower it just disappeared. I was alright.

I can sometimes bring it on. 'Cause I get so tensed up about the race, nervous, that I actually bring an attack on. So really I've got to try and concentrate on focusing on not having the attack - just getting round all the race. Sometimes if I can divert my thought I'll be OK. All I've got to do is divert my thought. But it's hard to do. You've

got to try and take your mind off it for a few seconds and then ... it's gone. So I can get through it sometimes. Other times I need to lay down – I can't beat it.

I used to do half marathons before I was unwell. When I was 21 I saw marathons on the TV and thought, "I'll have a go at them!" I started with a friend and we gradually built up, sort of went through the pain barrier together. We ran to Dilsley Common and shook hands afterwards, it was a real feat to actually do it, we'd conquered it – we *actually* got there. I got the running bug then. Later that year I did a six miler, then a few half marathons and eventually a few 20 milers. Then when I was 29 I became unwell. For four years I didn't do anything; I went up to 21 stones.

When I first started getting unwell I had a paranoia illness. Psychosis. Thinking people were following me and stuff like that. I had a lot of things go wrong – a marriage break up, a lot of failures, too much stress – and I was running and I think that was stressing me out as well. I was overdoing it, at everything I was overdoing it, and it sort of spiralled out of control. When I became unwell I stopped exercise – I became so unwell that I couldn't do it. The medication was making me worse, it made me put on a lot of weight and I couldn't do any exercise anyway I was so overweight. Then I had a change in the medication. When I got the right medication I felt better and I thought to myself, well, I'll get back into running and keeping fit again. The medication made me well enough to think about my appearance 'cause before I was neglecting myself. But then I started shaving and bathing, and I got to that stage and I had the confidence to come to the day centre every day and then eventually I wanted to do exercise again.

I started exercising gradually with Catherine, one of the physios. I'd go to the gym, and I'd go on the bike and all the cardiovascular stuff, very gentle. I sort of gradually built up to it. I lost a sufficient amount of weight to be able to run again. I started off on the treadmill for about five minutes, built it up, then I went out for a run, about quarter of a mile, a few hundred yards, and I sort of built up. I started getting fitter

and fitter and eventually I was back to – apart from being overweight – I was back to normal again. The first time I was out running again I felt on top of the world – I was actually back to what I used to be like. It took me nearly two years. To get where I am now it's taken about three. I was so out of condition. Three years ago I was walking up Winbridge fields with Rob and I had to keep laying down I was so unfit – incredible. I was so overweight and out of condition I had to lay down a few times! But now I can run up there. Where I had trouble getting up, I can run up it now.

If it wasn't for Sarah and Catherine I don't think I'd have got back into it; well, I *would* have got back into it but not so soon. I think it was important for them to be there first of all – it gave me a bit of confidence. Because I was so unwell I wouldn't have had the confidence on my own – thinking I was going to have a panic attack. Somebody was there I could chat to and take my mind off it. I suppose in a way exercise is a bit of a drug – I want to do it to get that good feeling back again. But I think it's better than drinking; when you drink you're living in a dream world 'cause at the end of the day after you stop drinking you've got to come back to reality. But if you're keeping fit you're not living in a dream world – you're *actually* feeling better, making *yourself* feel better.

You think more when you're running, you can work things out – things that are bad don't seem that bad anyway. I suppose it makes you face the problem head on. It makes you feel as though it's not that bad in the first place, there's nothing really to worry about. Things become brighter, you sort of see things more clear and everything around looks brighter. When I'm actually exercising, no matter what I feel like, I don't feel depressed or anything. I'm ready to tackle the day, you know.

I'm nearly 100% now. It's just the odd attack every now and again but other than that I'm fine. It just proves one thing: if I can do it, and realise that exercise does help, there's a lot of other people can do it. It's just having the right medication and the

right frame of mind and exercising – you can totally get cured of a mental illness I reckon. I think the exercise and the illness has made me value life more. In a way the illness has made me more conscious of life and feel better about life – and how much life means. Having a mental illness wakens you up. You realise that things you worried about in the past, you think “hang on a minute, I’m not worrying about that again ‘cause it makes me ill”. I either stop worrying about it or I make myself ill again. So I don’t worry about it. I’m not letting the stresses and strains worry me anymore.

I’ll do a long run tonight at about half-three, when I finish here. Down the A34, sort of run from Winbridge down through Milton, along the B540 and back into Dilsley.

Starting Afresh

I suppose I took a twenty-five year holiday from exercise. I wasn’t into exercise during that period – when I was unwell – just wasn’t. But I’ve always enjoyed football. When I was a kid, I used to play for Fleetway Falcons on the beach. On the beach! I did football at school too. We had a choice of rugby or football – I chose football. I used to play defence and I used to play pretty well I thought. So nowadays I’m better at football than anything else ‘cause I used to play a lot when I was a kid.

It all started because I had a chat with Sarah the physio a few months back when I was in woodwork and she suggested that I take up a bit of exercise to get a bit fitter. She said I wasn’t very fit. So that’s what I decided to do. I decided to take up a bit of exercise, to start afresh. I started on the exercise bike and, well, just progressed – one thing led to another – progressed to football, badminton and the walking group. I started off at about two or three minutes ‘cause at first I just felt a bit lethargic, a bit slowed up. But Sarah said you will improve as you go along, and it was true. I stepped up to about five minutes, gradually getting better and now on the exercise bike I do ten minutes. I know that I can comfortably do that. Say twenty minutes on the bike, I wouldn’t do that

‘cause that’s beyond my limits, but I’m OK with ten minutes. I don’t want to start overdoing it. I just do what I feel comfortable with.

I always used to be a bit slowed up, just not really concentrating on what I was doing. But the exercise improved that. It’s helped me to concentrate on what I’m doing at a specific time like talking to someone and listening to them as well, listening to what they are actually saying. I feel a bit more with it and a bit more alert than I was. It improves your will power ‘cause you’re using your legs and you can feel your heart pumping and you know that you’re doing something good. That’s what I reckon anyway. I’m a bit fitter than I used to be. Like doing the wood work, I used to have trouble sawing through thick wood but now I can do it quite, well, not easily but I can do it easier now than I did before. I feel stronger in myself, it’s got me a bit fitter. That’s what I think anyway. Whenever I exercise I feel a bit more refreshed and that usually lasts until I do some more exercise.

The next thing I started was badminton. I didn’t know what to expect but I had a go at it, gave it a try. Simon told me I used to be “static” – kind of rooted to the spot – so if the shuttle came through I’d only hit it if it was close. Maybe take a few steps to it but nothing major! But yesterday when he told me that my badminton had really improved – well, I’d noticed that myself – that I was moving about the court a bit more and reaching for shots, I was well chuffed! I played in a badminton tournament last week. I didn’t know what to expect. I never played in a tournament before. Sarah ran it with another woman and gave warm-up exercises to start with. Sarah drew up a table of who’s playing who and gave us all numbers. I was number five. Then I had to play someone who was number one. I remember I played six games all together and won three and lost two, drawn one. I come third – that ain’t bad is it? The same happened with football. When I first started I was a bit conscious that I was making mistakes and didn’t score or anything like that. But then I started being the top scorer – just stood

down the other end and kept hammering them in! I scored six goals last week so that ain't bad is it? One week I got fourteen goals – that's a lot ain't it? Once I got into play and started scoring a few goals I got a bit more of a smile on my face. I get satisfaction from playing football – if I score a goal I'm pleased with myself and it gives satisfaction that way. But I get satisfaction from it even if I don't score a goal – some weeks when I haven't scored I get pleasure from playing good defensively or passing or helping out my fellow players. I used to be a bit selfish and just go for goal all the time but I've realised there's more to football than just scoring goals.

I feel happy when I'm exercising and afterwards I have a sense of satisfaction that I actually played because I was doing something with my time. That's important I think, to actually be able to use your time properly. With sport I know that I haven't wasted my time, that I've used my time constructively, doing something that'll do me good. That's what I think anyway. And, at the moment, I've got the time to exercise so I use it. Every morning when I get up I know I've got exercise on my daily agenda, so I just wait until it comes round. I don't dwell on it. Once I've done it I just move on to something else – the next thing on the agenda. Busy – I like it like that. I suppose I like the social side to it too 'cause you're meeting other people that are sharing a common thing aren't you? Common exercises, sharing that experience, all doing the same thing, so we've all got something to talk about. That's what I reckon. Sometimes we get a couple of new people along and I get to know them and sometimes, you know, they finish the football – just don't turn up anymore. That's just the way of things.

But I think the biggest thing is enthusiasm – I've still got the enthusiasm for it – and you've got to have the will power to do the exercise, to actually carry through with it. That's what I reckon anyway. You've got to want to do it, that's important. I always loved my sport in the past but now I'm starting afresh. Starting afresh, that's what I reckon anyway. I'd like to continue the exercise 'cause it's doing me some good and

hopefully the future will be rosy. I've been through some bad times so hopefully things will be better for me. So no, exercise hasn't made me into a different person. I'm still Mark. But I feel a bit more energised, a bit more with it than I did before I started.

Reflections on the Stories

So, you may ask, what do my stories mean? Listen, if you like, I will tell them to you again. Perhaps they resonated with you; if they did, take them and look after them. When it is needed, share them with others. If they did not speak to you, maybe you have your own stories and can share them with me, and others (Lewis, 2006, p. 848).

At the end of a paper in a more traditional form of presentation it is expected that the authors offer some conclusions about their findings as a means of narrowing and closing down the possible interpretations of the 'findings'. Given our use of short stories to represent our data, we resist this impulse. In the first instance, this is because we have chosen to show rather than tell stories. Accordingly, our aim is not to prompt a single, closed, convergent reading but to invite the reader to contribute their own questions-answers-experiences to the stories as they read them. Rather, we seek to operate as what Barone (2000) calls 'artful writer-persuaders' who understand the necessity of relinquishing control over the interpretations placed on a story and allowing readers to interpret the text from their own unique vantage points.

Operating in this mode, we seek a different relationship between author, text and reader where the reader, instead of being a passive 'receiver' of knowledge, becomes a co-participant in the creation of meaning. As Lewis (2006) noted: "Stories are brought to life though the storyteller; however, the story itself has a life that is given to the teller and the listener though the telling" (p. 831). Of course, given this situation, just what meanings the stories have for the reader will depend on their vantage points, how this locates them in relation to each of the stories, and how they choose to use the stories in

specific contexts. For example, the meanings of the stories and what is learned from them is likely to vary depending on whether one is a person living with SMI, a family member or friend of a person living with SMI, a psychiatric nurse, a consultant psychiatrist, a health professional, or an exercise and sport psychologist. In this regard, Frank (2006) argued that stories are actors that do things that can make a difference. He stated:

Yet like all actors, stories make a difference in relation to other actors, and exactly what difference they make will never be predicted ... Stories make themselves available to consciousness because they support many view points; the same story makes a different point to different listeners. As actors in relation to other actors, stories are always a bit out of control (Frank, 2006, p. 423).

Thus, one of the reviewers of a previous draft of this paper stated, “The stories are great.” In contrast, another reviewer stated:

Story one was interesting in the patterns of exercise that were reported and the phases of inactivity and activity. The vital role of the practitioners was a moving issue (for me) ... I found myself thinking, running may have become a stressor that contributed to the breakdown. Could a new running routine go the same way? ... Story two just did nothing for me as a reader ... Story three was moving and really allowed me to get an insight into the illness.

In contrast again, following one public reading of *The Future's Looking Bright*, the mother of a young man with schizophrenia spoke emotionally about how the story provided her with a sense of relief that her and her son's experiences were not unique. For this woman, the story accurately reflected her son's experiences of mental illness and physical activity; she told the primary investigator, “Thank you for the story. I was listening to it with tears in my eyes and thinking of my son. You could have just swapped my son's name in there. It was so him.” In noting these different responses to

the stories we do not intend to suggest that one response is more legitimate than another. Rather, these varied responses are given as an example of how, as Frank (2006) suggests, stories affect people in different ways that cannot be controlled or predicted by their authors.

A characteristic of a good story, therefore, is a degree of openness that allows different readers to make use of the story in varied ways. Paradoxically, some may consider this very openness, in terms of how a story is both interpreted and used by readers, to be a weakness or limitation of stories in specific research contexts. For example, the conventions of the scientific tale lead readers to expect a degree of closure in terms of clearly stated conclusions or practical recommendations. For such readers, the openness of stories might be deemed problematic. Similarly, the conventions of the realist tale that dominates qualitative inquiry lead the reader to expect, among other things, that the authors provide explicit interpretations that are made compelling by the use of abstract definitions, axioms, and theorems that work logically to provide an explanation of events. Here, each element of the theory used is carefully illustrated by empirical data. Once again, for readers of this tale, the openness of stories might be deemed problematic.

That the openness of storied forms is problematic in relation to the scientific and realist tale is only to be expected because both of these tales have different conventions that serve different purposes, with openness not being one of them. Therefore, as Sparkes (2002) reminds us, given the varied purposes of qualitative research, authors need to make strategic, principled, and informed choices regarding the genre they use to represent their research data depending upon the purpose and intended audience of their work. In choosing to use a story form for this particular representation, we are not advocating that the dominant forms of telling be totally replaced. Rather, as Sparkes (2002) notes, the intention is to “*displace* them so that other tales can make their own

valuable and legitimate contributions to how we understand the world around us” (p. 37). At other times, and for different purposes and audiences, we might choose to represent our data in the form of a realist tale, or an ethnodrama, or a poetic representation. However, as we have explained, for our current purposes we have chosen to represent our data in the form of three stories. With regard to these purposes it is appropriate that we offer some reflections on what we hope might be learned from the stories of Ben, Mark, and Colin as part of an ongoing invitation to dialogue and interpretive response.

First, as mentioned earlier, existing mental health literature is characterised by a focus on deficiencies, deficits and problems of mental illness. One implication of this imbalance is that positive perspectives on people with mental illness are rarely (if ever) heard. Some scholars have argued that people who experience serious mental illnesses such as schizophrenia also have something positive or unique to offer to society, perhaps in terms of insights or understandings about life, but that this positive perspective is sidelined or ignored (see Chadwick, 1997a). Certainly, positive perspectives are wholly missing from the literature on physical activity and mental health and, to date, there has been no discussion of what a person with SMI might offer to others with whom he or she shares physical activity or sport experiences.

In some ways Ben, Mark, and Colin are “success stories” with “happy endings.” For example, they all described positive childhood experiences of physical activity, valued physical activity, enjoyed considerable social support, and were no longer experiencing psychotic symptoms. Clearly, these positive stories do not match everybody’s experience of SMI, but neither do the dominant negative stories match everyone’s experience. By presenting “success stories” we do not intend to suggest that every person with SMI will experience such positive experiences through physical activity. Instead, we wish to provide a vision of possibilities as an alternative to the

more common problem-focussed stories. In this sense, making success stories available may be seen as an attempt to redress the existing imbalance towards negative outcomes and expectations (Chadwick, 1997a). It is increasingly recognised that this negative focus in itself can adversely affect the lives of people with SMI (Repper & Perkins, 2003). According to Chadwick (1997a):

One can indeed be too portentous about schizophrenic illness. It is true that this group of conditions can kill people – but of course so do mountains kill climbers. However if, as a climber, one is forever thinking of this fact (e.g. ‘this peak has claimed three lives this year’ or ‘there’s been a death on this mountain every year for the last four years’), one’s capacities and confidence are greatly undermined. One has to have an attitude and ‘Self talk’ that breeds realistic resolve and strengthens will. Forever harping on about disasters, dangers, deficits and dysfunctions does not encourage the strength needed to overcome the problems that present themselves (p. 23).

We suggest that in the context of SMI more positive stories such as these are urgently needed in order to help change attitudes among mental health professionals and practitioners as well as sport and exercise psychologists regarding what can be achieved despite the difficulties of SMI.

Second, the use of stories provides a direct focus on the voices of those who personally live the experience. Historically, people with SMI have been excluded from professional dialogue; their voices are not heard, they are a marginalised and silenced population. In this sense, the stories provide one avenue for service users’ voices to be heard by academics, health professionals, and lay audiences. If the stories are to be effective in this regard they need to recreate authentically the voice and experience of individuals with SMI. Preliminary feedback on the stories suggests they have been successful in this regard. For example, following a reading of *The Long Run* to an

audience of mental health professionals, one audience member told how he felt that the story communicated Ben's experiences in a powerful and direct manner. In his words: "When you read the story it felt like Ben was right here in the room."

In this regard, as Richardson (1990) suggests, individual stories that give voice to those who are marginalized or silenced, can become part of a collective story. This displays an individual's story by narrativizing the experiences of a social category to which the individual belongs. Even though this collective story is about a category of people, the individual response to it (if it is well told) is, 'That's my story. I am not alone.' (p. 26). For Richardson, this can have transformative possibilities for the individual since collective stories can deviate from standard cultural plots and provide new narratives that legitimate the re-plotting of one's own life. She also recognizes that transformative possibilities can also exist at the socio-cultural level:

People who belong to a particular category can develop a consciousness of kind and can galvanise other category members through the telling of a collective story. People do not even have to know each other for the social identification to take hold. By emotionally binding together people who have had the same experiences, whether in touch with each other or not, the collective story overcomes some of the isolation and alienation of contemporary life. It provides a sociological community, the linking of individuals into a shared consciousness. Once linked, the possibility for social action on behalf of the collective is present, and, therewith, the possibility of societal transformation. (p. 26)

Given the challenges that SMI presents for service users, family members, and carers, the availability of stories of others' (similar) experiences through stories can offer a potential source of comfort and a sense that they are not alone. In this way the story provides 'someone to walk with' through the illness experience (Frank, 1995). A sense

of solidarity can thus be generated that connects people with SMI together in ways that challenge the feelings of isolation that can often prevail.

Third, as previously mentioned, people with SMI are one of the most stigmatised sections of society. The stigma surrounding mental illness results primarily from a lack of understanding of what it's like to be a person with SMI (US DHHS, 1999) which is best challenged by providing accessible alternative perspectives. Short stories are certainly more accessible to lay audiences than scientific tales and they also offer the possibility of a more "human", emotive, and evocative representation of a person's experiences. These kinds of understandings – which allow the reader to appreciate what they have in common with the narrator – have the potential to affect the reader's attitude towards the narrator and, subsequently, other people with SMI. This process relies on the development of empathy; an awareness that people with SMI have much in common with others in society. The reaction of one student to the stories suggests, for him at least, they were successful in this regard: "Why should it be surprising that physical activity should be beneficial for those who have a mental illness? If it works for the 'normal' population, why not for those who are suffering 'imbalances'?"

Finally, the stories provide accessible insights into complexity. For Sparkes (2002), creative forms of writing, in breaking with the conventions of traditional genres, allow for the inclusion of the irregularities of personal experience. Complexity, ambiguity, unpredictability, and individuality are evident in these stories just as they are evident in the experiences and accounts of the participants. These themes are important components of participants' physical activity experiences in the context of SMI. But often, as a result of the need to provide a coherent and ordered account, these issues are excluded from scientific and realist tales. Creative analytic and representational practices allow these somewhat disconnected and illogical themes to be included

without the need to make smooth connections or concrete interpretations (Richardson, 2000). It is particularly important that this complexity is appreciated by academics as well as exercise and health professionals who might influence or dictate the kinds of physical activity and sport opportunities made available to people with SMI.

With these points in mind we hope the stories presented in this article have served their purpose and generated insights into the personal experience of physical activity for individuals like Ben, Mark, and Colin who live with SMI.

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