NURSING CONCEPT ANALYSIS
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NURSING CONCEPT ANALYSIS
APPLICATIONS TO RESEARCH
AND PRACTICE

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Nursing science, theory, and research are in the early stages of development. As the number of nurse scientists increases, there is a concomitant advancement in the scientific basis that guides professional nursing practice.

As the science develops, there is a need to name the core concepts that define the disciplinary perspective. Many of those concepts have been named here, by authors who are expert clinicians and researchers. Because the discipline of nursing includes both the content and the process of nursing, the concepts chosen are grouped into categories that reflect the core of nursing, the nurse–patient relationship. These categories are patient/client-focused concepts, caregiver (nurse)-focused concepts, and organizational concepts. The organizational category reflects the reality that the majority of nursing practice takes place within health systems.

Each concept analysis chapter in the book follows the same structured format. This allows for comparison across concepts, particularly those that are closely related within a category. Each chapter also includes a diagrammatic representation of the concept attributes, antecedents, and consequences. This visual representation of characteristics across concepts allows the reader to make comparisons and, ultimately, to build on the knowledge base available in this book.

It is expected that the concepts included in this book will lead nurse scholars to further develop and critique existing nursing knowledge. While a number of concept analyses have been published in nursing journals in the past decade, this book includes the largest collection of concept analyses that are presented together, thus facilitating further disciplinary development.

We encourage the reader to expand the concept analyses and build on this work, both in theory development and research. We believe that, together with the chapter authors, we have set an important direction for the future. We are indebted to all of the chapter authors for their contributions to this seminal work and look forward to their future contributions.

Joyce J. Fitzpatrick
Geraldine McCarthy
Self-neglect is a complex multidimensional concept that was first identified in the 1950s. Historically, terminologies used to describe self-neglect have included: Senile Squalor Syndrome (Clark, Mankikar, & Gray, 1975), Diogenes syndrome (Reyes-Ortiz, Burnett, Flores, Halphen, & Dyer, 2014), and “domestic squalor” (Snowdon, Halliday, & Banerjee, 2012). There are many definitions of self-neglect, yet no consensus has emerged. Self-neglect is described as a behavioral condition, whereby an individual is unable or unwilling to provide care for himself or herself and consequently the individual’s health and safety are threatened; this can extend to the wider community (National Center on Elder Abuse, 2005). A multiplicity of factors are associated with self-neglect, such as old age, living alone, poor social networks, alcohol and substance abuse, impaired physical and cognitive function, depression, dementia, executive dysfunction (ED), economic decline, poor coping, hoarding, and animal hoarding (Braye, Orr, & Preston-Shoot, 2011; Day, Leahy-Warren, & McCarthy, 2013; Pickens et al., 2013).

Growth in aging populations, associated burden of chronic diseases, declining economic resources, and migration all have the potential to increase substantially the risk for self-neglect (Dong, Simon, & Evans, 2010). Adult protective services (APSs) in the United States investigate approximately 1.2 million self-neglect cases annually (Dong et al., 2010; National Center on Elder Abuse, 2005). Self-neglect reports to APS varied from 37.2% (Teaster et al., 2006) to 87% of all alleged neglect reports (Pavlik, Hyman, Festa, & Bitondo Dyer, 2001). A population-based U.S. study reported prevalence of self-neglect at 9%, and noted higher prevalence for men (10.1%) compared to women (7.5%) in people aged over 85 years (Dong, Simon, & Evans, 2012a). Self-neglect accounts for 18% to 21% of referrals to senior case workers (SCWs) in Ireland (Health Service Executive, 2013). In 2013 (Health Service Executive, 2014), there were 463 absolute self-neglect referrals and in addition 87 self-neglect cases that involved elements of elder abuse. At year-end 2013, 191 cases were still open, highlighting the ongoing nature of self-neglect (Health Service Executive, 2014). Some countries have no data on self-neglect.
Multiple factors make it very difficult to precisely ascertain the incidence and prevalence of self-neglect. There is consensus within the literature that, globally, self-neglect is a serious and understudied issue. A growing number of research teams (Chicago Health and Aging Project [CHAP], the Consortium for Research of Elder Self-Neglect in Texas and Schanfield Research Institute, Chicago), nurses (Day, 2014; Gibbons, 2009; Lauder, Roxburg, Harris, & Law, 2009), and social workers (Braye, Orr, & Preston-Shoot, 2013; McDermott, 2008) are making important contributions to the understanding of self-neglect. Self-neglect cases present many ethical challenges in practice for health and social care professionals (Braye et al., 2013; Day et al., 2012, 2013; Gunstone, 2003). Self-neglect is conceptualized in many different ways by health and social care professionals and by individuals across communities and populations. Gibbons, Lauder, and Ludwick (2006) developed a nursing diagnosis and definition of self-neglect which is included in the North American Nursing Diagnosis Association (NANDA) lexicon. According to nurse researchers, self-neglect is socially constructed and is the product of a series of social judgments that are influenced by social, cultural, and professional values (Day et al., 2013; Lauder, Anne Scott, & Whyte, 2001). Assessment of self-neglect, professional judgments, and decisions can be influenced by professional philosophy (Day et al., 2012), organizational background (McDermott, 2010), and knowledge (Day & McCarthy, 2015; Doron, Band-Winterstein, & Naim, 2013; Dulick, 2010). A concept analysis of self-neglect can establish essential components and provide guidance to both research and clinical practice.

DEFINING ATTRIBUTES

The defining attributes of self-neglect are environmental neglect and cumulative behaviors and deficits (intentional or unintentional).

Environmental neglect is a significant and defining factor in self-neglect. Environmental neglect can include lack of equipment; unmaintained or non-functioning appliances; unsafe environment; observed home/physical living environment that is very unclean, unsafe, and unhygienic; presence of vermin; animal hoarding; accumulation of items; and failure to pay bills or replace equipment despite having adequate income—any or all of these raise serious health, and safety concerns (Day, 2014; Day et al., 2013; Dong & Simon, 2015; Dong, Simon, & Evans, 2012b; Gibbons et al., 2006; Hurley, Scallan, Johnson, & De La Harpe, 2000; Iris, Ridings, & Conrad, 2010; Kutame, 2008). The living environments are described as hazardous; they may contain volumes of newspapers, used food containers, and human or animal excrement (Pavlou & Lachs, 2006). The poor environmental conditions can extend outdoors to yard or garden and affect other lives and areas the community. The terms domestic squalor (Snowdon et al., 2012) and Diogenes syndrome are often used to define and diagnose extreme self-neglect (Pavlou & Lachs, 2006). Diogenes syndrome has been defined as extreme self-neglect, domestic squalor, social disengagement, affinity for hoarding (syllogomania), apathy, and
sometimes lack of awareness of home living circumstances (Pavlou & Lachs, 2006). These behaviors and attributes are at the extreme end of the trajectory of squalor, and this definition would not be representative of all self-neglect cases (Pavlou & Lachs, 2006). Available evidence that self-neglect is a syndrome is sparse and has been questioned (Braye, Orr, & Preston-Shoot, 2011b; Halliday, Banerjee, Philpot, & Macdonald, 2000; Lauder et al., 2009). In Australia, self-neglect is viewed as neglect of self; domestic squalor is used to contextualize and describe extreme neglect of the environment; collecting is the accumulation of certain objects, and hoarding is the inability to throw objects away (McDermott, 2008). In severe cases of self-neglect, living environments are often described as hazardous; they may contain large volumes of newspapers, used food containers, and human or animal excrement (Choi, Kim, & Asseff, 2009; Pavlou & Lachs, 2006). Severe environmental neglect was a key factor used by nurses in the classification and judgments of self-neglect (Day, 2014; Lauder et al., 2001).

Cumulative behaviors and deficits are the second defining attribute. These can include malnourishment, poor hygiene, poor grooming, failure to pay bills, noncompliance with medication, nonadherence to self-care regimes, poor health management, withdrawal/poor engagement, fear, aggressive behaviors, misplaced trust, and noncooperativeness or unwillingness to accept assistance (Dong et al., 2010; Dyer et al., 2006; Iris et al., 2010; Turner, Hochschild, Burnett, Zulfiqar, & Dyer, 2012). Dimensions used in judgment and classification of self-neglect by nurses were self-care status and poor personal hygiene (Lauder et al., 2001), which identified characteristics as “combination of lack of food in the home, low body weight, difficult with meal preparation and shopping, potential nutritional frailty with potential to exacerbate medical problems” (p. 300). Poor compliance and nonadherence to medication regimes are very prevalent among older adults who self-neglect (Leibbrandt, 2007; Turner et al., 2012), as is nonadherence to treatment regimes (Kutame, 2008). Malnutrition (Adams & Johnson, 1998; Ernst & Smith, 2011; Smith et al., 2006), obesity (Ernst & Smith, 2011), and incontinence (Alexa, Ilie, Morosanu, Emmanouil-Stamos, & Raiha, 2012; Lauder, 1999) are associated with self-neglect. Cumulative behaviors and deficits can be attributed to multiple losses, homelessness (Lauder et al., 2009), alcohol/substance abuse (Choi et al., 2009; Gibbons, 2009; Halliday et al., 2000; Lauder et al., 2009; Tierney et al., 2004), defiant behavior (Lauder, 1999), life history (Band-Winterstein et al., 2012), and discordant and fractured lifestyles (Day, Mulcahy, Leahy-Warren, & Downey, 2015; Day et al., 2013; Lauder et al., 2009).

DEFINITION

Elder self-neglect (ESN) encompasses environmental neglect and cumulative behaviors and deficits, with potential for serious adverse outcomes that impact on health, safety, and well-being of the person and may extend beyond to the community.
MODEL CASE

Mr. M is a 68-year-old single man, a diabetic, who has poor mobility, appears frail, and lives alone. The Public Health Nurses (PHNs) undertook a home visit and had difficulty in gaining access to the house. They observed severe environmental neglect. There was barely room to walk in; clutter, dirty beer bottles, and empty food cartons were everywhere, and it was extremely cold. An offensive odor of animal excrement pervaded the house. Assessment identified cumulative behaviors and deficits. Mr. M’s face, hands, nails, and clothes were deeply ingrained with dirt and he was malnourished. Mr. M had not obtained medical treatment and had not kept hospital appointments; he had a leg ulcer that was very infected and toes that were gangrenous. Mr. M reported that he was fighting with his neighbors; he had no social supports, was socially isolated, and appeared to be indifferent to his situation; he was refusing services. Initial assessment suggested that Mr. M had capacity.

In this case, Mr. M’s home environment was described as portraying severe environmental neglect and accumulation of animal excrement added a very offensive odor to the home environment. There were cumulative behaviors and deficits relating to personal care, nutrition, nonattendance at hospital appointments, and poor attention to health care regimens that posed serious threats to Mr. M’s well-being and safety. Social isolation, absent social support, personality, behaviors, and indifference of Mr. M compounded his vulnerability. In essence, this case is complex and presents an array of health and safety challenges. In protecting and safeguarding Mr. M, the PHN and primary care team members need to work through a number of ethical issues: for example, self-determination, choice, capacity, and best interest.

RELATED CASE

Related cases have some of the defining attributes. An example is that of Mr. T, who lives in a very unclean home that has numerous health and safety hazards (environmental neglect). Mr. T agreed to host a charity golf classic as a fundraiser for cancer services. He was disorganized, not a team player, and disregarded the amount of detailed planning required. He was late advertising the event in local papers, so only a few tickets were sold. Tom’s self-neglect of the details had far-reaching consequences that meant the event had to be cancelled, to his dismay and embarrassment.

This case reveals environmental neglect that is hidden from sight of Mr. T’s friends and neighbors, as he does not invite people into his home. He is a very private man and presents well to others. However, Mr. T had no insight into the effort necessary to take on a project like hosting a golf classic. An accumulation of poor behavior by Mr. T, including neglect of and indifference to project planning and late advertising, led to huge disappointment and resulted in the cancellation of the golf event (failed cumulative behaviors and deficits).
BORDERLINE CASE

Mr. B is a diabetic, partially blind, and has been experiencing pain due to a chronic infected leg ulcer in recent weeks. He was prescribed antibiotics, but he has not been taking them. Mr. B’s mobility has deteriorated; he is having physical difficulty caring for himself, his home, and his four cats. He appears to have lost weight recently. He has poor contact with neighbors, his family do not live close by, and he is refusing home help (cumulative behaviors and deficits). However, his home environment is clean.

In the case of Mr. B, there is one defining attribute: cumulative behaviors and deficits. For example, the infected leg ulcer, not taking prescribed antibiotics, refusing services, poor mobility, reduced self-care, weight loss, social isolation, and poor social support are creating vulnerabilities for his health, safety, and well-being. Mr. B needs support and he is not coping; however, he is not self-neglecting (failed environmental neglect). Self-neglect occurs on a continuum of severity, and he is vulnerable.

CONTRARY CASE

Mrs. H, a 75-year-old widow, is an insulin-dependent diabetic with coronary heart disease. She lives on her own and has good support from family and neighbors, and she is involved with community groups. She monitors and records her blood glucose levels daily, using a glucometer, and diet is taken as advised by nutritionist. Home environment is very welcoming. In this case, there is no vulnerability, and there is failed environmental neglect or cumulative behaviors and deficits. Mrs. H is engaged with her community and all critical attributes of self-neglect are absent.

ANTECEDENTS

The antecedents of self-neglect (SN) are multiple comorbidities, mental health issues, and absence of social networks. There is a close relationship between alcohol/substance abuse, mental health issues, and self-neglect (Halliday et al., 2000; Leibbrandt, 2007; Spensley, 2008). Dyer, Goodwin, Pickens-Pace, Burnett, and Kelly (2007) suggest that the presence of one or more comorbidities (depression, dementia, diabetes, psychiatric illness, cerebrovascular disease, functional decline, and nutritional deficiency) can lead to ED. ED can affect capacity and cause inability for self-care and protection (Dyer et al., 2007); it also can inhibit appropriate decision making and problem solving (Hildebrand, Taylor, & Bradway, 2013). Tierney et al. (2004) found that individuals with increased cognitive deficits and ED were more likely to self-neglect and experience harm. This signals that individuals who self-neglect may refuse services because they lack the necessary skills, capacity, and insight or problem-solving ability for safe independent living. ED was associated with greater risk and greater severity for reported and confirmed self-neglect (Dong et al., 2010), and is likely to be an important factor in older adults who self-neglect (Pickens et al., 2013).
Certain client characteristics may contribute to the risk of self-neglect; these antecedents include older age, living alone, marital status, absence of social networks, childhood abuse, drug/alcohol abuse, poor self-related health (Hurley et al., 2000), traumatic life history (Band-Winterstein et al., 2012; Lauder et al., 2009), poverty, and frugality (Day et al., 2013). Self-neglect is associated with absent and reduced social engagement and poorer social networks (Ernst & Smith, 2011), and these were associated with increased reporting of self-neglect (Dong, Simon, Beck, & Evans, 2010; Spensley, 2008) and greater self-neglect severity (Dong et al., 2010). Leibbrandt (2007) reported that self-neglect clients engaged in fewer activities, had a preference for staying at home, and often refused services (Hurley et al., 2000). Self-neglect can be intentional or nonintentional, and Gibbons (2009) concluded that personal beliefs and coping abilities were factors in intentional self-neglect. Therefore, self-neglecting behaviors should be seen in the context of people’s life experiences and life stories (Band-Winterstein et al., 2012; Bozinovski, 2000; Day et al., 2013, Gibbons, 2009; Kutame, 2008). Resistance by individuals who self-neglect may be a way of coping, trying to take control over their death and destiny (Braye et al., 2011; Gibbons, 2009).

CONSEQUENCES

Consequences of Self-neglect are lower health status (Dong et al., 2010), increased mortality (Reyes-Ortiz et al., 2014), and increased use of health services (Dong & Simon, 2013; Dong, Simon, & Evans, 2012c). People who self-neglect are at increased risk for nursing home placement (Lachs, Williams, O’Brien, & Pillemer, 2002), hospitalization (Dong, Simon, Mosqueda, & Evans, 2012), and hospice admission (Dong & Simon, 2013); their rate of annual visits to the emergency department are three times higher than those who did not self-neglect. A CHAP cohort study found that the annual rate of hospitalization for reported self-neglect participants was significantly higher when compared to participants without self-neglect. Elder self-neglect was linked to increased risk for subsequent caregiver neglect, financial exploitation, and multiple forms of elder abuse (Dong, Simon, Evans, 2013; Mardan et al., 2014).

EMPIRICAL REFERENTS

Empirical referents demonstrate current perspective on measureable ways to demonstrate the occurrence and recognition of self-neglect. A small number of researchers have developed and operationalized measures for self-neglect (Day, 2014; Dyer et al., 2006; Iris, Conrad, & Ridings, 2014). These include the Self-Neglect Severity Scale (SNSS) (Kelly, Dyer, Pavlik, Doody, & Jogerst, 2008), Assessment of Self-Neglect Severity (Dong, de Leon, & Evans, 2009); Elder Self-Neglect Assessment (ESNA-25; Iris et al., 2013), and the Self-Neglect (SN-37) Measurement Instrument (Day, 2014). However, self-neglect assessment tools are not being used widely by health and social care professionals (Braye et al., 2011; Day et al., 2012). Globally, lack of clarity in relation to a standardized definition of self-neglect and the absence of an instrument
for identifying self-neglect have led to conceptual, assessment, and intervention problems for health and social care professionals (Fulmer, 2008; Iris et al., 2010; Kelly et al., 2008; Lauder, Anderson, & Barclay, 2005; McDermott, 2008; Pavlou & Lachs, 2006; Skelton, Kunik, Regev, & Naik, 2010).

The SNSS (personal hygiene, impaired function, and status of environment) was developed by the Consortium for Research in Elder Self-Neglect (CREST) at Baylor College of Medicine, Texas (Dyer et al., 2006). Field-testing with older adults (n = 23) enabled identification of self-neglect, but acceptable validity was not attained (Kelly et al., 2008). The Assessment of Self-Neglect Severity (15 items; Dong et al., 2009; Dong et al., 2012a) relates to assessment of health and safety risks. A trial in Chicago yielded an interrater reliability coefficient greater than 0.70, and face and content validity and predictive validity were established (Illinois Department of Aging, 1989). Iris et al. (2013) developed the Elder Self-Neglect Assessment (ESNA-25) tool, which has two subscales: Environmental Conditions and Behavioral Characteristics. This tool, also tested in Chicago, had an explained variance of 39.1%, person reliability of 0.83, Cronbach’s alpha of 0.87, and a residual variance of 15.3% (no substantial rival dimension).

Day (2014) developed the Self-Neglect (SN-37) Measurement Instrument, and exploratory factor analysis identified a five-factor solution that explained 55.6% of the cumulative variance. Factors were labelled “Environment,” “Social Networks,” “Emotional and Behavioral Liability,” “Health Avoidance,” and “Self-Determinism.” Preliminary construct validity was supported by findings in relation to the content validity and factor analysis results.

Halliday et al. (2000) used the 13-item Living Conditions Rating Scale (Samios, 1996) to describe and rate 76 living environments. In Australia, Snowdon et al. (2013) used the Environmental Cleanliness and Clutter Scale (ECCS) to rate home environments of 203 people referred to the Domestic Squalor Project. Principal component analysis conducted on 186 cases identified two factors: Factor 1 (7 squalor items) explained 33.7% of the variance, and Factor 2 (3 items on reduced accessibility and accumulation of items) explained 17.6% of the variance. Findings reported that 105 cases (56%) scored high in both squalor and accumulation; 38% had high squalor and 15% were high for squalor and accumulation. Cronbach’s alpha for scale was 0.72, demonstrating good internal consistency. Further research is necessary to establish the construct- and criterion-related validity of instruments across different populations (Figure 2.1).

**SUMMARY**

Globally, self-neglect is a public health issue that has very serious adverse outcomes yet is largely hidden. The concept of self-neglect remains elusive, and the absence of a common definition has hampered research. The goal of this concept analysis of self-neglect for theory development was to clearly establish the critical attributes that will enable self-neglect to be readily identified. This will make explicit the meaning of self-neglect and promote consistency in using the concept in nursing dialogue and research. This concept
I Patient/Client-Focused Concepts

Analysis has identified the antecedents, defining attributes, and consequences of self-neglect. A synthesis of the literature concluded that self-neglect can manifest both externally and internally (e.g., hoarding of rubbish, poor self-care, gross domestic squalor, refusal of medical treatment or lack of attention to medical regimens).

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EXERCISE ADHERENCE

Health benefits related to exercise are well established, and those benefits increase with adherence to a program with regular duration and frequency (Powell, Paluch, & Blair, 2011; U.S. Department of Health and Human Services [USDHHS], 2008). Overall, exercise adherence has many desired benefits that include physical and mental health, longevity, and reduction in weight, cardiovascular disease risk, and cancer risk (Bertram et al., 2011; Blanchard, Courneya, & Stein, 2008; Irwin et al., 2009; McCullough et al., 2011; Shay, 2008). However, studies that have examined exercise adherence often use different terms, leading to confusion in the literature and in practice. Therefore, clarification of exercise adherence is necessary to help understand how best to promote exercise adherence in the clinical setting in order to improve health-related outcomes.

Research relating exercise adherence to health has blossomed over the past two decades, and shows consistent benefits to nearly all individuals (USDHHS, 1996, 2008). Exercise plays a critical role in preventing or reducing the sequelae of chronic illness (Nunan, Mahtami, Roberts, & Heneghan, 2013; USDHHS, 2008). The American College of Sports Medicine (ACSM) and American Heart Association (AHA) recommend at least 30 minutes of moderate- to vigorous-intensity exercise on most days of the week (McArdle, Katch, & Katch, 2014). Yet, despite these recommendations, the Centers for Disease Control and Prevention (CDC) determined that less than 50% of Americans are adhering to these recommendations (CDC, 2014). The ACSM additionally recommends flexibility and muscular strength training 2 to 3 days per week. Unfortunately, less than half of the individuals who initiate an exercise program are still exercising 6 months later, and almost one-quarter of our population reports no exercise within the last month (CDC, 2014). Exercise adherence throughout life is essential in health prediction. In fact, nonadherence predicts negative health consequences more than such risk factors as high blood pressure, high cholesterol, obesity, and family history (McArdle et al., 2014).
In literature, there is often overlapping of similar terms, which can make disease management confusing to individuals. The terms *adherence*, *compliance*, *concordance*, *maintenance*, and *sustenance* are often used interchangeably. However, there are significant differences between these words. *Adherence* is nonjudgmental and describes a mutual desire to achieve behaviors. Adherence to exercise is foundational in a healthy lifestyle.

In 2002, the Department of Health and Human Services described adherence as an antonym of noncompliance. Van Dulmen et al. (2007) describe adherence to be much more comprehensive in that it describes a shared nonjudgmental decision-making process to continue with a medical plan.

Exercise as a concept is generally clearer, but is still dynamic in nature and our understanding continues to improve. The terms *exercise* and *physical activity* are frequently used as overlapping terms. However, exercise is much clearer in its scope; being planned, structured, and purposeful.

Shepard and Balady (1999) defined *exercise* as being planned, structured, repetitive, and purposeful and paramount in cardiovascular therapy. Catenacci and Wyatt (2007) additionally looked at exercise and a similar term, *physical activity*. They noted that exercise was a type of physical activity and recommended that future research be done to determine the intensity, type, and frequency of activity required for health.

When paired, the terms *exercise* and *adherence* present a concept of a faithfully continued, structured physical activity for the benefit of health promotion and disease prevention and treatment. For the purposes of this chapter, the concept will be further refined to include exercise for disease prevention and treatment.

The Transtheoretical (stages of change) Theory has been used as a framework to study adherence in physical exercise (Prochaska & Velicer, 1997). This theory, developed in the 1990s, acknowledges that individuals go through five stages to change their behaviors: precontemplation, contemplation, preparation, action, and maintenance. Key concepts in this theory are based in other models of human behavior and how people change, with the main focus being on decision making. Hellman (1997) attempted to predict exercise adherence in the cardiac rehab patient, by studying perceived self-efficacy over the different stages of change. During the precontemplation stage, individuals are not exercising and they have no intention of initiating an exercise program. In the next stage, contemplation, although the person is still not exercising he or she is now thinking about starting a program. The preparation stage allows the individual to actually start a program, though the actual exercise is inconsistent and/or limited in nature. Action, the next stage on the continuum, is when exercise becomes regular (for instance, 3 times per week for 30 minutes per session). Still, in the action phase, the behavior is performed for less than a 6-month period. In the final phase, maintenance, the individual’s behavior has continued for a period of more than 6 months’ duration.
DEFINING ATTRIBUTES

The defining attributes of exercise adherence are self-efficacy promotion, active voluntary involvement, and relapse prevention.

Self-efficacy promotion is the first defining attribute of exercise adherence. By examining a variety of strategies to improve adherence in diabetes self-management, Schechter and Walker’s (2002) meta-analysis concluded that even a combination of interventions yielded only small improvements. They did find that the most successful approaches included improving self-efficacy and coping skills. Young, Friedberg, Ulmer, Cho, and Natarajan (2009) also determined that improved self-efficacy along with social support were key in exercise adherence for diabetic patients. A 4-week study on a home exercise program for individuals with chronic low back pain yielded positive predictions for adherence with improved self-efficacy and social support, along with duration of the exercise session.

Positive strategies to address adherence included education, professional support, and improving self-efficacy. Self-efficacy interventions, such as mindfulness-based stress reduction to enhance mood, social support, and reinforcement, aided the seniors with adherence. Self-efficacy is a promoter of exercise and exercise adherence promotes self-efficacy (Schnoll & Zimmerman, 2001). Mastery of exercise is one of the strongest sources of self-efficacy and can be facilitated with identifying past successes both mentally and physically and using goal setting to continuously promote exercise (Jackson, 2010).

Active voluntary involvement is the second defining attribute for exercise adherence. Treatment adherence is challenging in chronic illness management, and health outcomes can be directly tied to patients taking a voluntary active role in their care. An active role versus a passive role in one’s care in diabetes and in obesity have been correlated with better engagement in all aspects of self-care (Delamater, 2006). Patients with low back pain were shown to improve faster when they took an active role in physical therapy, both during their visits and at home (Fritz, Cleland, & Brennan, 2007).

Relapse prevention is the third attribute for exercise adherence. Choosing to exercise is a daily choice, and there are many reasons why people do not exercise: “I am too tired” and “I do not have enough time” are reasons commonly given not to exercise. Understanding this is critical in exercise adherence. Jones and Rose (2005) described relapse prevention as necessary for older patients to continue with their exercise plan, because lapses are certain to occur at some point. They identified cognitive and behavioral plans that could prevent individuals from succumbing to high-risk situations that would make a brief lapse in exercise into a permanent condition.

DEFINITION

Exercise adherence is defined as active voluntary involvement in exercise characterized by self-efficacy promotion and relapse prevention.
MODEL CASE

Mr. W, recently diagnosed with noninsulin-dependent diabetes, is 75 pounds overweight (BMI 30.9%) and leads a sedentary lifestyle. His physician encouraged Mr. W to start exercising and stressed the importance of adherence to the program. Mr. W received a packet of information from his doctor and joined a local fitness center. A personal trainer taught him how to use the equipment and provided instruction for the first 2 weeks. This initial support provided by his personal trainer, along with continuous encouragement by his wife, facilitated Mr. W’s going to the gym for his workouts at least 4 days per week. Mr. W also developed logs of his workouts, monitoring his physical activity and incorporating what he learned from the trainer. After a month, he was sleeping better, he had lost 5 pounds, and his hemoglobin A1-C was in the normal range. To prevent relapsing, he found a workout buddy and also started to track his diet and exercise on his smartphone (active voluntary involvement and self-efficacy promotion). At his 6- and 12-month doctor’s appointments, Mr. W reviewed his log during his doctor’s appointment and discussed the improved lab values. His improved health keeps Mr. W motivated to exercise on a daily basis (relapse prevention).

RELATED CASE

Ms. V is 25 and she decided to run a half marathon with her best friend to raise money for breast cancer research. Ms. V is a couch potato and really prefers curling up with a good book and a bowl of popcorn. Although she felt better than she had in years after training for the marathon and completing the race (active voluntary involvement), she did not make any plans to prevent relapse (failed self-efficacy promotion and relapse prevention), and she returned to her previous lifestyle, spending most of her free time on the couch.

BORDERLINE CASE

Mrs. T is a 53-year-old, obese female who has a strong family history of hypertension and dyslipidemia. She lives a mostly sedentary lifestyle, eats a typical American diet high in simple carbohydrates, and is a nonsmoker. She started seeing a personal trainer after having two elevated readings on her home blood pressure monitor. She believed she could make some health lifestyle changes that could help prevent chronic health problems, but knew there was no one that would support her efforts. Mrs. T started going to the gym every other day and would ride the bike for 30 minutes (active voluntary involvement). She lost 45 pounds and her blood pressure returned to normal, but she is thinking of discontinuing her gym membership due to cost and has no plans for sustaining her current exercise routine (failed relapse prevention and failed self-efficacy promotion).
CONTRARY CASE

Mrs. A is a 57-year-old with heart disease and arthritis, who is moderately obese and enjoys a sedentary life. She was told by her physician that she needed to exercise 5 days a week for at least 60 minutes to manage her weight and blood pressure. Mrs. A’s physician said that if she did not start and adhere to an exercise program, she would need to be on more medication. Mrs. A is scheduled for a follow-up visit in 6 weeks. Upon getting home, Mrs. A told her husband what the doctor said and his reply was, “You’ll never do that. You have tried exercise a dozen times before and you just quit and I am not paying for another gym membership.” A few minutes later, Mr. A went to go pick up Pizza Hut’s Meat Lovers pizza for dinner. In this example, Mrs. A did not have any of the defining attributes reflecting the concept of adhering to exercise (failed active voluntary involvement, self-efficacy promotion, and relapse prevention).

ANTECEDENTS

The antecedents of exercise adherence are the biomedical status of the individual, the self-efficacy, and the motivation. Boyette et al.’s (2002) literature review identified barriers to exercise in older adults. They found that adherence was limited by biomedical status, education, socioeconomic status, and past participation in exercise. Furthermore, they identified factors that did not impact exercise adherence, which included age, ethnicity, gender, occupation, and smoking status (Figure 3.1).

Cuaderes, Parker, and Burgin (2004) addressed leisure time and exercise issues with Native Americans. They identified gender, self-motivation, physical self-efficacy, support, and addressing barriers as keys to adherence, whereas body mass index and age were not. Schutzer and Graves (2004) thought that adherence to exercise was best in those with high self-efficacy. They additionally thought that physical environment and physician influence played a role. Speck and Harrell (2003) found that history of relapse from exercise predicted long-term nonadherence and also that spousal support increased adherence.

Resnick (2002) reported on high self-efficacy expectations: Older adults would adhere to an exercise program if they had positive outcome expectations (if they believed that the exercise would improve their strength, function, or overall health). Resnick, Luisi, and Vogel (2008) again studied elderly adults and noted that negative outcome expectations, along with fear of falling, age, and pain, impacted adherence. A systematic review of exercise adherence in the elderly by Picorelli, Pereira, Pereira, Felicio, and Sherrington (2014) identified that low socioeconomic status and living alone negatively influenced exercise adherence.

McArthur, Dumas, Woodend, Beach, and Stacey (2014) identified factors influencing adherence to regular exercise in middle-aged women. They determined that routines, intrinsic motivation, biophysical issues, psychosocial commitments, environmental factors, and resources all contribute to a
woman’s exercise adherence. They did not find that lack of time or meno-
pause symptoms affected adherence.

CONSEQUENCES

The consequences that result from exercise adherence are decreased mortal-
ity; higher self-efficacy; and improved outcomes, including improved men-
tal, physical, and social health. Improved health outcomes can be manifested
mentally, physically, and socially. Miller et al. (2014) evaluated the health ben-
efits of adhering to an exercise program in adults and found that exercise
adherence health indicators were improvement in anthropometric measures
and cardiovascular risk factors. Exercise improves sleep, provides more
energy, and can make one more toned, which often allows clothes to fit better
(Anshel, 2007). The endorphins that are released with regular aerobic exercise
can improve mood and concentration, which allows individuals to focus on
the exercise activity itself with an increased desire to adhere to doing the exer-
cise. Higher self-efficacy can further support adherence to exercise and the
positive effects of physical exercise.

EMPIRICAL REFERENTS

A multidimensional literature review identified instruments for the defining
attributes; no single tool measures exercise adherence. Price et al. (2008)
compared self-report tools of physical activity in adults to five direct report
instruments. Existing self-report scales lacked quality measures. Tools like the Sports Injury Rehabilitation Scale (SIRAS), an observational scale measuring adherence to exercise for rehabilitation, was limited by the need for direct observation. Furthermore, none of the direct report instruments in Price and colleagues’ (2008) study had content validity. The Self-Efficacy for Exercise Instrument, developed by Wilcox, Sharpe, Hutto, and Grammer (2005) can be used to measure one’s motivation (i.e., self-efficacy) with a higher scores of self-efficacy paralleling greater exercise. Motivation to exercise, an essential part of exercise adherence, can also be measured with the Behavioral Regulation in Exercise Questionnaire (BREQ), which was developed by Mullan, Markland, and Ingeldew (1997) and tested for validity by Wilson, Rodgers, and Fraser (2002), and is a widely used tool in exercise psychology. Refinements to this scale continue with attempts to fully capture the concept of motivation in exercise. The BREQ 2 was developed by Markland et al. (2004) to measure motivation in exercise, while the third version of the BREQ 3 (Wilson et al, 2006), is designed to capture an individual’s initial motivation to engage in exercise.

SUMMARY

Exercise adherence is a phenomenon that is necessary to help nurses create a foundation for knowledge and develop interventions to improve health outcomes. Identification of antecedents, attributes, and consequences helps nurses understand how the concept is used within the discipline. Furthermore, identifying what is essential and providing cases to describe how different scenarios meet the whole or parts of the definition will help standardize the meaning. This will enhance the understanding among health care professionals in both practice and research. Clarity and consistency may be the first step in implementing interventions and therefore improving measurable health outcomes.

REFERENCES


