PHYSICALLY ACTIVE LEISURE CONSTRAINTS AND FACILITATORS IN A RACIALLY DIVERSE RURAL SETTING

BY

KEREN VALIN OSGOOD

THESIS

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Master’s Committee:

Professor Kimberly J. Shinew, Chair
Assistant Professor Julie Stafford Son, Director of Research, University of Idaho
Abstract

Background

This qualitative study investigates physically active leisure and health in a population of racially diverse rural adults, aiming to describe physically active leisure in the town of Carington, IL, as well as to identify key constraints and facilitators to physically active leisure participation among community members. The ultimate purpose is to inform physically active leisure interventions to promote overall health and well-being in Carington and similar communities.

Methods

Twenty-four community leaders (5 African American, 7 male) took part in semi-structured qualitative interviews in October – December, 2007. Forty-four residents (average age 52 years, range 18 to 85 years, 8 male) took part in 4 focus groups during the same time period. Leaders represented such community organizations as schools, churches, recreation groups, social service organizations, the local hospital, and area businesses. Focus groups targeted specific subpopulations within the community: African Americans, low income residents, older adults, and healthcare workers. Data was coded according to prominent themes and analyzed by both manifest content and latent content analysis.

Results

Participants described opportunities for physically active leisure as widely available, though community members were seen as insufficiently active. Structural constraints came up more often than either intrapersonal or interpersonal constraints. Key facilitators participants cited included organizational support, negotiation strategies, and enjoyment. Leaders spoke
about partnerships more than residents. African American participants tended to indicate more constraints than other participants.

**Discussion**

The key to increasing participation in physically active leisure in Carington may be through increasing motivation for negotiation resulting in participation despite constraints. Ultimately, there is potential for the factors identified in this study to inform health-promoting physically active leisure interventions in this setting.
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Introduction

The United States (and, increasingly, the rest of the world) is facing nothing less than a public health crisis (World Health Organization, 2004). Roughly two-thirds of American adults are overweight or obese (Flegal, Carroll, Ogden, & Johnson, 2002; Hedley et al., 2004; United States Department of Health and Human Services, 2001), conditions which are associated with increased risk for numerous health problems, including hypertension, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, and some cancers (National Heart, Lung and Blood Institute, 1998). The overall health and well-being of Americans is at stake in determining whether any effective solutions to the obesity epidemic can be developed and implemented.

Along with poor diet, lack of physical activity has greatly contributed to a dramatic increase in obesity in the U.S. since the 1970s (Flegal et al., 2002; Mokdad et al., 2003; Ogden, Flegal, Carroll, & Johnson, 2002). Sufficient levels of physical activity can aid in weight control (Jakicic, Otto, Polzien, & Davis, 2007). Accordingly, increasing levels of physical activity should be part of the answer to the obesity epidemic in America.

The increasing trend in obesity rates has been disparately observed in different segments of society, with both rural and racial/ethnic minority populations consistently showing poorer health indicators when compared nationally (Parks, Housemann, & Brownson, 2003; National Center for Health Statistics, 2009). These two factors – rurality and race/ethnicity – compound health and health care access problems for rural racial/ethnic minorities (Probst, Moore, Glover, & Samuels, 2004).

Physically active leisure affords a fun, enjoyable way to participate in physical activity. Such leisure provides a potential means through which this public health crisis might be
alleviated (Godbey, Caldwell, Floyd, & Payne, 2005). Participation in physically active leisure may be one way for rural adults to improve their health and well-being, particularly through recreation and park-based physical activity (Son, Kerstetter, & Mowen, 2009).

Statement of Purpose

This study looked at a mostly White rural town with a substantial (11.8%) African American minority population (U.S. Census Bureau, 2011): Carington, Illinois, a pseudonym intended to protect the true identity of the town and participants. The purpose of this study is to identify and describe Carington residents’ and community leaders’ views on physically active leisure and health in the area. Of particular interest are factors identified by participants as facilitating or constraining engagement in physically active leisure, and the extent to which these factors fit (or do not fit) with social cognitive theory in order to better inform potential theory-based health promotion programs that could be applied in this setting. Health behavior interventions based on social cognitive models have been shown to be more effective than those developed without a theoretical framework (Abraham & Sheeran, 2000). In focusing on a racially diverse rural population, the current study aims to further elucidate the unique pattern of leisure-time physical activity determinants in a racially diverse rural setting where little research has focused thus far (Wilcox, Castro, King, Housemann, & Brownson, 2000). In short, the purpose of the current study is to: (a) describe the current state of physically active leisure in the racially diverse, rural town of Carington, Illinois and (b) begin identifying the unique patterns of constraints and facilitators to active leisure in this setting.
Literature Review

Health Disparities in Rural and Racial/Ethnic Minority Populations

Evidence of health disparities among rural and racial/ethnic minority populations presents itself in several ways. Eberhardt et al. (2001) found rural area residents have generally poorer health statuses than their suburban and urban counterparts, as indicated by mortality, rates of chronic disease, limited access to health care, poor diet, and sedentary lifestyles, including leisure-time physical inactivity. Other research has suggested that rural residency itself may entail immersion in a culture and/or environment that negatively influences health, in part through a prevalence of physical inactivity. Hartley (2004) went as far as to state that “a pattern of risky health behaviors among rural populations [suggests] a ‘rural culture’ health determinant” (p. 1675) that poorly affects health. In addition, Lutfiyya, Lipsky, Wisdom-Behounek, and Inpanbutr-Martinkus (2007) investigated and found support for rural residency as a risk factor for overweight and obesity in U.S. children, citing factors that included restricted access to health care and preventive care, as well as elevated time spent in sedentary activities like watching TV and non-schoolwork computer use. Likewise, in a study of rural communities in three western U.S. states, Liebman et al. (2003) found that “the vast majority of overweight and obese respondents believed that they do not get as much exercise as needed,” (p. 684) highlighting how cognizant rural residents are of their physical inactivity. This evidence of the health disparities faced by rural populations calls those interested in rural health promotion to consider the special context of rural areas, rather than transplant a one-size-fits-all program from other contexts to rural communities. As Phillips and McLeroy (2004) indicated, “Progress in facing health problems in rural areas requires a clear recognition that rurality is a contextual
issue that demands special attention from public health researchers as well as practitioners” (p. 1663).

In Carington, race may compound this issue of poor rural health. Often times, rural African Americans face higher rates of diabetes than both rural White residents and urban African American residents, and are at increased risk for lack of control of diabetes and high blood pressure (Mainous III, King, Garr, & Pearson, 2004). In a study on minority women, those living in rural areas were found to be more likely than urban-dwelling study participants to be completely inactive during leisure time (Brownson et al., 2000). Adding to the problem, rural racial and ethnic minorities are among the least studied and most underserved groups in the country (Mueller, Ortega, Parker, Patil, & Askenazi, 1999).

**Physically Active Leisure and Health Promotion**

One promising way to address poor rural health is through physically active leisure. Studies have shown time and again the potential for physically active leisure to promote health and well-being. Both the fields of public health and leisure studies “have progressed toward an appreciation of the role of active leisure in enhancing a population’s health and well-being” (Ainsworth, Mannell, Behrens, & Caldwell, 2007, p. S24). Sufficient amounts of physical activity (60 to 90 minutes daily) can aid in weight loss and weight loss maintenance (Jakicic & Otto, 2006). Chia-Yih et al.’s (2010) examination of U.S. adults’ cardiorespiratory fitness using data from the 1999-2004 National Health and Nutrition Examination Survey revealed a strong positive association between leisure-time physical activity and fitness in both men and women.

Similarly, Iwasaki, Zuzanek, and Mannell (2001) found evidence supporting the positive influence of physically active leisure on health in a population of 9,568 women and 8,058 men in Canada. They used structural equation modeling and found a direct positive relationship between
physically active leisure and physical health and well-being, as well as a direct negative relationship between physically active leisure and mental ill-health. In addition, Iwasaki, Zuzanek, and Mannell’s (2001) study supported an indirect relationship between physically active leisure and stress reduction, with physically active leisure reducing stress and enhancing health and wellbeing through its positive effects on social support, self-esteem, and sense of mastery (Iwasaki, Zuzanek, & Mannell, 2001).

Buccholz et al. (2009) conducted a study on leisure-time physical activity and individuals with spinal cord injury. They found that greater daily physically active leisure was associated with lower levels of cardiovascular disease and type 2 diabetes risk factors. Valtonen et al. (2009) looked at middle-aged men, physically active leisure, cardiorespiratory fitness, and feelings of hopelessness. They found that physically active leisure (which affects cardiorespiratory fitness) and cardiorespiratory fitness both had a negative relationship with feelings of hopelessness. In other words, the authors found physically active leisure to have mental health benefits. A further study on older adults in Canada with chronic disease conducted by Ashe, Miller, Eng, and Noreau (2009) stressed the importance of community-based programs to facilitate physically active leisure, since physically active leisure has known health benefits.

These studies demonstrate that physically active leisure is associated with health benefits, and can successfully be used to promote health. Many of these studies even point to the importance of community-based physically active leisure opportunities to promote health.

**Leisure Constraints Research**

Despite the many studies that stress the importance of physically active leisure for health, many people still do not participate in physical activity at sufficient levels. Factors that may hinder people from participating have been captured in the concept of constraints. Much leisure
research has been conducted on constraints. Of the constraints models theorized in leisure research, one of the longest standing and most useful has been Crawford and Godbey’s (1987) conceptualization of three distinct categories of constraints: *intrapersonal*, *interpersonal*, and structural. *Intrapersonal* constraints consist of psychological states, beliefs, attitudes, internalized norms, and things of that nature, all of which influence leisure preferences (Crawford & Godbey, 1987). Examples of intrapersonal constraints might be a lack of interest, failure to see an activity as fun or worthwhile, or viewing a leisure activity as inappropriate for oneself. *Interpersonal* constraints on the other hand involve social interaction of some sort (Crawford & Godbey, 1987); for example, a person might want to play baseball but needs others to form a team. Interpersonal constraints arise in this way between people, whether it be between friends with differing interests or spouses with conflicting schedules. The third category, structural constraints, involves constraints from the environment, specifically that intervene between leisure preferences and participation (Crawford & Godbey, 1987). These are often constraints over which an individual has little control and include things like lack of resources: if there are no snorkels there will be no snorkeling; similarly, there may be no body of water to snorkel in, or people cannot afford to travel to a place where snorkeling is available. Crawford, Jackson, and Godbey (1991) further defined this constraints model to be hierarchical, with intrapersonal constraints as the most influential in terms of leisure participation, followed by interpersonal, and finally structural constraints. Important to note is that the presence of constraints does not always equate to a lack of participation, but rather constraints may be *negotiated* so that participation is still possible (Jackson, Crawford, & Godbey, 1993; Hubbard & Mannell, 2001; Jackson, 1999, 2000). For example, perhaps someone does not want to go to a kickboxing class unless a friend will go with them. This would be an interpersonal constraint, and an individual might negotiate it
by inviting friends to go until at least one agreed or by going to the class anyway and making a friend there.

Leisure researchers have set up this way of conceptualizing constraints that many studies have since employed. Brown, Brown, Miller, and Hansen (2001) looked at active leisure constraints in mothers with young children and found a series of structural, intrapersonal, and social-support-related (interpersonal) constraints. Loucks-Atkinson and Mannell (2007) examined the negotiation of physically active leisure constraints among women with fibromyalgia. They found that the presence of constraints decreased participation but also sparked women to use negotiation strategies that then increased participation. Higher levels of motivation increased the women’s efforts to negotiate constraints and participate in physically active leisure (Loucks-Atkinson & Mannell, 2007). In a study focusing on physically active leisure constraint negotiation in middle-aged and older adults, Son, Mowen, and Kerstetter (2008) found that negotiation could entirely offset constraints (conceptualized as intrapersonal, interpersonal, and structural) to leisure participation, and that motivation affected participation solely through its influence on negotiation. These studies have furthered leisure constraints and constraints negotiation research, and point to the important role of motivation in negotiating constraints.

Though a good deal of research has investigated leisure constraints, few studies seem to have been conducted specifically on rural leisure constraints, much less rural physically active leisure constraints in particular. Rural areas have a pattern of physical activity determinants (including constraints) distinct from that of their urban counterparts (Wilcox, Castro, King, Housemann, & Brownson, 2000). Therefore, findings from studies conducted in urban or suburban settings may not be applicable in rural communities. In addition, Carington represents a
racially diverse rural population, a setting which has seldom been studied in terms of physically active leisure constraints. Even the most preliminary descriptive information seems to be lacking in the literature.

**Health Behavior Change Theories and Past Research**

It is important to understand the unique constraints to and facilitators of physically active leisure experienced by a racially diverse rural population like Carington. Aiding this understanding are several theories which have been developed to help explain health behavior like physically active leisure participation (or nonparticipation). Existing health behavior theories may provide a foundation on which to translate what participants say about physically active leisure in Carington into effective interventions.

Quite a few theories have been developed to explain health behavior change. Among them are self-determination theory (Deci & Ryan, 1987, 1991), the health belief model (Becker, 1974; Rosenstock, 1974), the theory of reasoned action (Ajzen & Fishbein, 1980), the theory of planned behavior (Ajzen, 1991), and social cognitive theory (Bandura, 1986, 1997, 2000, 2004). A brief description of each these theories will be given, though social cognitive theory will be the prominent framework for this study.

Deci and Ryan initially developed self-determination theory to describe how external events influenced intrinsic motivation, but later included intrapersonal and interpersonal events (Deci & Ryan, 1985). “The theory analyzes the effects of events relevant to the initiation and regulation of behavior in terms of their meaning for a person’s self-determination and competence” (Deci & Ryan, 1985, p. 9). Self-determination essentially refers to the extent to which behavior is determined by the self, as in self-directed, or freely chosen and acted upon. Self-determination theory looks at the process through which extrinsic motivators are
internalized (Deci & Ryan, 1985). There have been a few studies that have examined leisure and health using self-determination theory (e.g., Coleman & Iso-Ahola, 1993; Gillison, Standage, & Skevington, 2006). These studies have found support for the importance of being intrinsically motivated for sustained participation in healthy leisure.

While self-determination theory focuses on intrinsic motivation, the health belief model examines the value someone places on a given goal as well as the perceived likelihood that a certain action will achieve that goal (Janz & Becker, 1984). The theory’s major constructs are as follows: perceived susceptibility—beliefs on how vulnerable to a certain condition one is; perceived severity—beliefs about how severe that condition is; perceived benefits—beliefs about what the benefits would be of acting to prevent the condition; and perceived barriers—beliefs about what barriers are in the way of acting to prevent the condition (Janz & Becker, 1984). In their comprehensive review of studies using the health belief model, Janz and Becker (1984) found that perceived barriers had the strongest association with health behavior, thus underscoring the significance of constraints (e.g., Crawford & Godbey, 1987; Crawford, Jackson, & Godbey, 1991; Jackson et al., 1993; Hubbard & Mannell, 2001).

In the theory of reasoned action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975), behavioral determinants are conceptualized as follows: beliefs and evaluations feed into attitudes; “what others think” and the motivation to comply feed into subjective norms; and then attitudes and subjective norms feed into behavioral intentions, which (theoretically) predict behavior.

Ajzen (1991) went on to develop his theory of planned behavior from this model. The theory of planned behavior holds that (a) behavioral beliefs influence attitude toward a particular behavior; (b) normative beliefs determine subjective norms; and (c) control beliefs predict
perceived behavioral control. According to the theory of planned behavior, attitude toward the behavior, subjective norms, and perceived behavioral control all contribute to behavioral intentions, which thereby predict behavior. In other words, the theory of planned behavior is the same theory as that of reasoned action, with the addition of perceived behavioral control.

To illustrate the theories of reasoned action and planned behavior, imagine someone with a particular set of beliefs and evaluations about a given behavior, say playing basketball. Perhaps this person thinks playing basketball is inherently both fun and good for health. His/her attitude would reflect those beliefs and evaluations—(s)he would have a positive attitude toward playing basketball and view it as a worthwhile activity, and this would contribute to an intention to actually play basketball. Similarly, this person might think that other people would find it cool if (s)he played basketball, that basketball players themselves are cool, and (according to these theories) this subjective norm would also contribute to an intention to play basketball. Finally, this person might believe that playing basketball is not too difficult to achieve and that it is completely within his/her power to choose freely to play basketball. This idea of free agency or being able to control whether or not to engage in a behavior, according to the theory of planned behavior, also plays an important role in predicting this person’s intentions to play basketball, with the more perceived behavioral control, the higher the intention to engage in that behavior. In the end, these theories posit that it is behavioral intentions that then predict behavior.

Fishbein (2000) went on to develop an integrative model of behavioral determinants. Fishbein (2000) based this model on social cognitive theory (Bandura, 1986), the theory of reasoned action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975), and the theory of planned behavior (Ajzen, 1991), among others. The integrative model proposes that distal variables (like past behavior and demographics, to name a few) influence behavioral beliefs and outcome
evaluations, normative beliefs and motivation to comply, and control beliefs. These influence attitudes, norms, and self-efficacy, respectively. All of these feed into intentions, which the theory still assumes will predict behavior, but mediated by environmental constraints and skills/abilities (Fishbein, Hennessy, Yzer, & Douglas, 2003).

Fishbein et al. (2003) found support for the integrative model’s ability to predict behavioral intentions, but demonstrated that intentions do not always translate into action. The authors went as far as to conclude that “it seems reasonable to ask at this point whether a ‘new’ theory is needed to explain why some people do, and some people do not, act on their intentions” (Fishbein et al., 2003, p. 3).

Perhaps the model’s shortcomings in predicting behavior from intentions are due to some of the factors predicting only behavior, some predicting only intentions, and others predicting both. For example, perceived behavioral control—which was conceptualized at first in the theory of planned behavior as only predicting intentions—has been found also to predict behavior directly (Ajzen, & Driver, 1992), despite findings that behavioral intentions do not always predict behavior (Fishbein, Hennessy, et al., 2003). It could also be that existing studies differ in the way they measure perceived behavioral control due to some ambiguity in the theory’s conceptualization of this construct. The conceptualization of these determinants may thus need additional formulation to better predict behavior.

Although the theories of reasoned action and planned behavior have had mixed results in predicting behavior from intentions, previous research has found good support for the concepts used in social cognitive theory as behavioral determinants (e.g., Motl et al., 2000; Ryan, 2005; Petosa, Suminski, & Hortz, 2003). The authors of one study asserted that “the social cognitive theory constructs were better predictors of physical activity than those from the theories of
reasoned action and planned behavior” (Dzewaltowski, Noble, & Shaw, 1990, p. 388). The current paper will conceptualize behavioral determinants using social cognitive theory as the primary framework.

Social Cognitive Theory Constructs as They Relate to Health Behavior

Social cognitive theory (see Figure 1) utilizes four main constructs to account for health behavior: self-efficacy, outcome expectations (physical, social, and self-evaluative), goals (proximal and distal), and impediments (personal, situational, and health system) (Bandura, 2000).

![Social Cognitive Theory Diagram](image)

*Figure 1. Social Cognitive Theory, adapted from Bandura (2004).*

First, self-efficacy “is conceptualized as [an individual’s] perceived operative capability” (Bandura, 2007, p. 646). Essentially, self-efficacy shows how confident a person is in his or her ability to do something. As follows, “self-efficacy appraisals reflect the level of difficulty individuals believe they can surmount” (Bandura, 2007, p. 646). As an example, suppose a girl
has successfully scored goals while playing soccer many times and feels that she is good at scoring goals in soccer. She is confident that she can score goals while playing soccer, which is the same thing as having high self-efficacy for scoring goals while playing soccer. It is a situation-specific confidence. The same girl may not feel at all confident about her ability to score while playing hockey, for instance. Self-efficacy for physical activity has been shown to predict levels of engagement in physical activity in the general adult population (Sallis & Owen, 1999), and in many more specific populations, for example, college students (Von Ah, Ebert, Ngamvitroj, Park, & Kang, 2004; Wallace, Buckworth, Kirby, & Sherman, 2000), in older adults (Orsega-Smith, Payne, Mowen, Ching-Hua, & Godbey, 2007; Wilcox, Tudor-Locke, & Ainsworth, 2002), rural populations (Beets, Pitetti, & Forlaw, 2007; Zizzi et al., 2006), and minorities (Martin et al., 2008; Sharma, Sargent, & Stacy, 2005).

Also playing a role in predicting levels of participation in physical activity are outcome expectations. Outcome expectations have been found to predict levels of physical activity in some populations, as illustrated by Wilcox, Castro, and King’s (2006) study on older women. In developing social cognitive theory, Bandura (1997) proposed that outcome expectations include three domains of anticipated consequences of engaging in a particular behavior. These domains are physical, social, and self-evaluative.

The physical domain encompasses beliefs about what physical consequences will result from participation in a given behavior; the social category of outcome expectations consists of the anticipated social consequences of engaging in a certain behavior; and finally, self-evaluative outcome expectations refer to the anticipated self-praise or self-censure that will result from participating in a behavior. To illustrate, a person might think that engaging in physically active leisure will result in weight loss, may believe that physically active leisure will provide
opportunities for social interaction that result in increased social acceptance, or believe that physically active leisure will result in an increased sense of personal accomplishment. These represent physical, social, and self-evaluative outcome expectations in social cognitive theory, respectively.

The latter two categories of social cognitive determinants of health behavior proposed by Bandura (1997) consist of goals and impediments. Goal-setting is a way of regulating physical activity behavior by envisioning specific goals and structuring behavior in order to achieve them. Goals can be short-term (proximal) or long term (distal). For example, an individual might decide to set a goal of walking for twenty minutes twice a week in the short-term, with a long-term goal of walking for an hour five days of the week.

Impediments in social cognitive theory line up nicely with leisure constraints research, in that Bandura specifically categorized impediments as personal, situational, and health system (Bandura, 2000). Personal impediments in social cognitive theory refer to the same concept as intrapersonal constraints in leisure research; the same goes for situational impediments and interpersonal constraints, and—to a lesser extent—health system impediments and structural constraints. Bandura’s construct of health system impediments failed to cast its net as wide as that of the structural constraints concept in leisure research. Many more constraining factors influence people’s health behaviors beyond what a particular societal institution or health system might entail. For example, residents in a community might view themselves as constrained by a lack of affordable transportation or facilities close to where they might be physically active in their free time. Physical activity is certainly a health behavior; however, issues of lacking parks/recreation facilities or affordable public transportation fall beyond the scope of a health system.
Self-efficacy, outcome expectations, goals, and constraints (i.e. impediments) all influence motivation for a given health behavior. Social cognitive theory posits that higher levels of self-efficacy, more positive outcome expectations, the setting of proximal and distal goals, and fewer constraints will all positively influence motivation for participation in healthy behavior, like physically active leisure. Leisure research has added that constraints can be negotiated (Jackson, Crawford, & Godbey, 1993), and that high self-efficacy for one’s ability to negotiate constraints results in increased motivation for constraint negotiation and thus increased participation despite constraints (Loucks-Atkinson & Mannell, 2007). As Loucks-Atkinson and Mannell (2007) put it, “the greater people’s confidence in the successful use of negotiation resources to cope with constraints, the greater the motivation and effort to negotiate and the higher the level of participation” (p. 19). Here we see how important efficacy beliefs are for motivation, specifically in the context of constraining factors. “Efficacy beliefs,” Bandura (2000) explained, “operate as one of many determinants that regulate motivation, affect, behaviour” (p. 305). Likewise, social cognitive theory’s other constructs play important roles in motivation, and thus in understanding why people may or may not participate in physically active leisure.

Negotiation plays well into social cognitive theory’s construct of impediments, insofar as leisure studies expands this construct through constraints research. These impediments themselves can be motivating, the prerequisite being that some motivation is already there. It seems that for some, the process of negotiating through constraints in order to still participate in some way in a given behavior (like physically active leisure) in turn strengthens motivation for participating, and this strengthens efficacy beliefs around their ability to negotiate these constraints, providing motivation to continue the negotiation process (Loucks-Atkinson & Mannell, 2007; Son, Mowen, & Kerstetter, 2008). This cycle of affirming success begins with
motivation, but in turn strengthens and perpetuates that motivation. Perhaps the process of
overcoming challenge in the form of constraints to participation is in itself rewarding for many
people, above and beyond continued participation in physically active leisure or other health
behavior. Of course, it is important to note that where there is no initial motivation to participate,
there is also no motivation to negotiate any constraints to participation. If the goal is for people’s
health behavior to include regular physical activity in order to promote health, then constraints
will need to be negotiated, as everyone will experience constraints to maintaining regular
physically active leisure in some way or another. The questions that remain are how to get
people started who are not already motivated, and how to help people negotiate constraints.

In many cases, people also identify with the behaviors they engage in on a regular basis.
Thus, someone who practices Kung Fu may think of him or herself as a martial artist; it is part of
his/her identity. As Son, Kerstetter, and Mowen (2009) found in their study on older adults,
“physical activity identity positively influenced [leisure time physical activity] directly as well as
indirectly through negotiation” (p. 96). Feeling that an activity is part of oneself again
contributes to a person’s motivation for that activity and to motivation for negotiating constraints
to that activity. Certainly someone who self-identifies as a runner will be more motivated to run
and overcome obstacles to running than someone who does not think of him or herself as a
runner. Core constructs in leisure research such as self-actualization (Csikszentmihalyi, 1990;
Csikszentmihalyi & Kleiber, 1991; Mannell & Kleiber, 1997) describe how it is that engaging in
something like physically active leisure provides an outlet for self expression and an opportunity
to overcome obstacles, grow the self and further define one’s identity (e.g. as a martial artist, or a
runner). All of this in turn strengthens a person’s motivation for that activity. But again, the
questions are how to get people started and how to help them negotiate any constraints they perceive.

Social Cognitive Theory, Past Research

Through social cognitive theory’s ability to explain motivation for health behavior, the theory’s applicability to explaining participation (or lack thereof) in physically active leisure is apparent. However, few researchers have applied this theory to studies on leisure and health in a racially diverse, rural setting. One of the few studies looking at rural minorities and physically active leisure is Wilcox, Castro, King, Housemann, and Brownson’s (2000) paper on older and ethnically diverse women in the United States. The authors looked at 1,242 rural women compared to 1,096 urban women aged 40 years and older. They found that:

Rural women, especially Southern and less educated women, were more sedentary than urban women. Rural women reported more personal barriers to leisure time physical activity, cited caregiving duties as their top barrier (compared with lack of time for urban women), and had greater body mass indices. Rural women were less likely to report sidewalks, streetlights, high crime, access to facilities, and frequently seeing others exercise in their neighbourhood. Multivariate correlates of sedentary behaviour in rural women were American Indian/Alaskan Native and African American race, older age, less education, lack of enjoyable scenery, not frequently seeing others exercise, greater barriers, and less social support (p<0.05); and in urban women, older age, greater barriers, less social support (p<0.05), and less education (p<0.09). (Wilcox, Castro, King, Housemann, & Brownson, 2000, p. 667)

The authors summarized several key differences between urban and rural ethnically diverse women in the U.S. They pinpointed differences in current health status and constraints, and demonstrated the potential compounding effects of race and rurality on health. Wilcox et al. (2000) went on to say that “rural and urban women seem to face different barriers and enablers to LTPA [leisure time physical activity], and have a different pattern of determinants” (p. 667).

Though this study highlighted the importance of tailoring interventions to the unique needs of rural and racially diverse populations, it did not directly base its recommendations in theory.
Health behavior interventions based in social cognitive models have been shown to be more effective than those developed without a theoretical framework (Abraham & Sheeran, 2000).

Along these lines, many studies have investigated physical activity participation using social cognitive theory constructs. Wilcox, Castro, and King (2006) studied outcome expectations and older women’s participation in physical activity in the San Francisco Bay area (the authors make no mention of participants’ race). They found a relationship between outcome expectations, attainment of these expectations after six months in an exercise program, and the motivation to continue participating. Women with high attainment, regardless of initial expectations, were more likely to continue participating. These authors’ conceptualization of outcome expectations and their “attainment” was more akin to the goal setting construct of social cognitive theory than to outcome expectations as Bandura conceptualizes them. Having participants recount what outcomes they expected to see equated to having participants set goals, and then the researchers measured attainment of these goals at 6 months and whether or not there was participation in subsequent physical activity at 7 to 12 months. Nonetheless, the study showed support for the affirming and motivating power of setting and then reaching goals in physical activity. Most likely the concept of self-efficacy came into play in the study, in that women with high attainment became more confident in their ability to participate in physical activity which increased their motivation for continuing, though the authors did not measure self-efficacy.

Dishman et al. (2002) looked at social cognitive physical activity determinants in African American and White adolescent girls. They found that overall, White girls had higher self-efficacy scores than did African American girls, indicating the important role race might play in social cognitive determinants of physical activity. Doerksen, Umstattd, and McAuley (2009)
examined social cognitive determinants of physical activity in college freshman, finding support for self-efficacy and goal setting as predictors of vigorous physical activity. Rogers et al. (2005) found that breast cancer patients had higher levels of participation in physical activity when they also had the following: higher constraint negotiation self-efficacy, higher task self-efficacy, an exercise partner, an exercise role model, and higher physical activity enjoyment. These findings taken together lend credence to the ability of the constructs used in social cognitive theory (such as outcome expectations, self-efficacy, proximal and distal goals, constraints and constraint negotiation, and social modeling) to predict health behavior and motivation to engage in healthy behavior like physically active leisure.

As follows, social cognitive theory provides a solid theoretical foundation on which researchers and programmers might effectively base physical activity interventions. This study will utilize social cognitive theory in its recommendations in part for this reason, but also because its constructs have been shown to be potentially important determinants of health behavior in rural and minority populations (e.g., Martin et al., 2008; Sharma, Sargent, & Stacy, 2005; Wilcox et al., 2000).

Still, relatively few studies currently have addressed rural needs. This study aims to help leisure and health professionals better address rural needs for physically active leisure in a racially diverse community. The purpose of the current study is to: (a) describe the current state of physically active leisure in the racially diverse, rural town of Carington, Illinois and (b) begin identifying the unique patterns of constraints and facilitators to active leisure in this setting.

**Research Questions**

Corresponding to these aims, two main research questions guide the current study:
1. How do Carington residents and community leaders describe the current state of physically active leisure in the area?

2. What factors do participants see as facilitating and/or constraining regular participation in physically active leisure?
Methods

Setting and Population

“Carington” is a rural Illinois town comprised of 14,136 residents at the time of data collection. The broader community spans three counties. While 11.8% of the population is African American in Carington itself, that percentage drops slightly to 10.3% when including surrounding communities. The rest of the population is largely non-Hispanic White, making up 86.5% of the broader Carington community (Illinois Department of Public Health, 2007; U.S. Census Bureau, 2007). This relative racial diversity affords a unique opportunity to examine physically active leisure and health across two different racial groups (White and African American).

Aside from its unique racial makeup, Carington is characteristic of many rural communities. Almost 15% of Carington residents live below the poverty line, compared to 11.4% statewide. About 20% of residents do not have health insurance, and 25% have not completed high school. The median household income is well below the state median, at $31,905 compared to $47,367 (Illinois Department of Public Health, 2007; U.S. Census Bureau, 2007). Industry in Carington has been in decline, leeching vital jobs from the area. Substance abuse and teen pregnancy plague the community. Many residents feel forced to work more than one job in order to earn a living wage, while others face long-term unemployment with few prospects. In other words, many of Carington’s issues echo broader trends in postindustrial rural communities across America.
Procedures: Sample and Data Collection

This study is drawn from a larger project involving four phases of data collection: semi-structured one-to-one interviews, focus groups, a survey, and finally, town hall meetings. This paper will examine the qualitative data from the interviews and focus groups. Data collection occurred from October 2007 through December 2007.

There were 24 participants in the semi-structured, one-to-one interviews with community leaders who were identified through meet and greet sessions with organizational leaders. Upon communicating with leaders in the community, researchers requested additional contacts. This process of purposive snowball sampling yielded a diverse list of community leaders representing a range of voices on physically active leisure and health in the community. A leader from each organization represented on the list was contacted for an interview, yielding the final 24 participants, 5 of which were African American (or just over 20% of the sample). The research team sought this overrepresentation of African American leadership to ensure that their perspectives would be heard. Participants represented such organizations as the local nonprofit hospital, school system, churches, recreation facilities, and social service organizations. Only a handful of contacts from the intended sample remained unreachable throughout the three-month span in which data collection took place. Interviews were conducted over the phone, audio recorded, and later transcribed.

To recruit participants for the four focus groups, researchers posted flyers on message boards or left available copies at area recreation facilities, a nonprofit computer center, a senior center, a nonprofit advocacy agency for low income residents, the area hospital, and others. Organizational representatives from the four focus group locations directly recruited participants for the focus groups, and co-moderated the session at their representative site. The four locations
of the focus groups were: a community agency located in the predominantly African American part of town, a continuing education and job skills training center, the local hospital, and an area agency on aging. The aim of this recruitment strategy was to recruit participants associated with each facility, respectively. Therefore, the majority of participants in each focus group were associated with the target organizations. As a result, the majority of participants at the focus group located at the community agency in the predominantly African American part of town were African American, most participants at the focus group located at the continuing education and job skills training center were low income or unemployed, most participants at the focus group located at the local hospital were healthcare workers, and most participants at the focus group located at the area agency on aging were older adults. Nevertheless, it must be noted that not all participants in each focus group fit into these categories due to multiple factors, including participants bringing friends, for example. Incentives included refreshments available during the focus group itself and a $10 grocery gift card for each participant. Focus groups were audio recorded and then transcribed.

In all, 44 residents participated in 4 focus groups. The focus groups ranged in size from 9 to 14 participants. The sessions were held at a local agency on aging, a community agency located in a predominantly African American neighborhood, a center for job training and skill building aimed at low income and unemployed residents, and the local nonprofit hospital. These locations provided access to older residents, African American residents, low income and unemployed residents, and healthcare workers, respectively. Results from a brief demographic questionnaire administered at the end of the focus group sessions characterized the sample as follows: 30 non-Hispanic Whites (68%), 12 African Americans (27%), and 2 (5%) listed as “other” (for race/ethnicity). Average age for focus group participants was 52 years-old (standard
deviation of 16 years), with a range from 18 to 85. Only 13 participants (30%) were married while 31 (70%) were not; 36 (82%) were female and 8 (18%) were male. In terms of work status, 21 participants (48%) worked full-time, while 3 participants (7%) worked part-time. Six (14%) self-identified as unemployed, 10 (23%) as retired, and 3 (7%) as a homemaker, with one participant’s employment status left blank. The income category containing the most participants (17 participants, or 39%) was the lowest income category, at less than $24,999 in annual income, followed by the second lowest, $25,000-$49,999 (with 14 participants, or 32%). Only 10 participants marked higher income categories, with 3 participants leaving the income category blank.

**Interview and Focus Group Scripts**

The purpose of the interviews was to gain an in-depth, qualitative understanding of community leaders’ views on leisure and health in the community, including needs, constraints, and opportunities connected to healthy leisure (including physical activity). Investigators placed special focus on the experiences of low income and African American leaders and residents due to assumptions (based in prior research, e.g., Probst, Moore, Glover, & Samuels, 2004; Mueller, Ortega, Parker, Patil, & Askenazi, 1999) that these residents would be most underserved, face the greatest constraints, and have the greatest needs. Another aim of the interviews was to get a sense of community leaders’ willingness to form partnerships both with the research team and across area organizations to promote healthy leisure. With these aims in mind, questions were asked in the areas of what resources leaders’ felt were currently available for healthy leisure in the community, what community needs and minority needs were in terms of leisure and health (including what barriers to healthy leisure existed), what healthy activities leaders’ saw residents not engage in *enough*, and what sort of health promotion program they would like to see (see
Appendix A). Although physical activity themes arose across participant responses to the interview questions, questions pertaining most to themes in this study were as follows:

- What resources does your community have to promote the health and well-being of its residents?
- What do you feel are your community’s needs in terms of improving residents’ health and well-being?
- Are there barriers that keep people from engaging in healthy leisure activities?

The first question above helped to elicit responses pertaining to community leaders’ views describing the current state of physically active leisure in Carington, as well as what resources might help facilitate physically active leisure, among other types of healthy leisure. In addressing the second question on needs, participants often touched upon physically active leisure constraints and facilitators to help address community needs in terms of physical activity. The last question above helped bring out important constraints to physically active leisure. In this way, interview questions elicited responses from participants that address the current study’s research questions.

For the focus groups, the research team wanted to get perspectives from area residents on healthy leisure like physical activity and health (not just the views of organizational leaders as in the interviews). Using Krueger and Casey’s (2000) guidelines, one trained facilitator from the research team lead all 4 focus groups, along with an organizational representative from each location as a co-moderator in order to establish rapport and to help make participants comfortable. Each session began with an “icebreaker” question asking participants to describe their favorite leisure time activities. Following this, the facilitator used a structured guide with follow-up prompts to address the following topics: what being healthy meant to residents, how
residents’ felt leisure activities contribute to health, what barriers residents face to engaging in healthy leisure such as physical activity, and what strategies might be used to overcome these barriers (see Appendix B). Although physical activity themes arose across participant responses to the focus group questions, questions pertaining most to themes in this study were as follows:

- What physical activities do you participate in regularly during your free time that you feel keep you healthy?
  - Can you tell me more about how they keep you healthy?
  - What challenges do you face in doing these physical activities?
  - What strategies do you use to overcome these obstacles?
- What are the community organizations that help you keep doing the healthy leisure activities you enjoy?

The first question above elicited descriptive responses about physically active leisure in Carington, while its follow-up probes helped identify key constraints to and facilitators of physically active leisure. The second question above served to describe how organizations in Carington act as facilitators for physically active leisure. In this way, focus group questions elicited responses from participants that address the current study’s research questions.

**Data Analysis**

Data analysis for the interview and focus group transcripts relied on Huberman and Miles’s (1998) guidelines for qualitative data analysis, including the identification of specific themes for use as codes in the codebook. Four interview transcripts emphasizing varying perspectives provided the basis for the interviewer’s initial thematic codebook (referential adequacy; Lincoln & Guba, 1985). A different member of the research team then coded the complete set of transcripts while adding, condensing, and reworking the codes (each of which
represented a theme) as they arose from the data (Huberman & Miles, 1998). A third member of
the research team verified these codes (verification check; Creswell, 2007). As another data
analysis step, the primary coder and verifier met, reaching agreement on all codes/themes, which
entailed a discussion about interconnecting themes and any negative or “disconfirming” cases
(Huberman & Miles, 1998).

For this paper, codes were further refined by a fourth investigator (the current
investigator) with an eye specifically for physically active leisure themes. The researcher used
the existing thematic codebook (for the semi-structured interviews) to recode all 24 of the
interviews, adding and refining codes for physically active leisure specifically in the process.
The previously coded interviews were not initially referenced during this process to ensure that
the old codes would not influence the fourth researcher’s coding decisions. The new codebook
was reviewed by one of the original coders for consistency and agreement. The newly coded
interviews were then compared to the previously coded interviews to ensure thoroughness and
consistency. A fifth investigator then verified all of the new codes (verification check; Creswell,
2007), meeting with the fourth coder to resolve the few coding differences that occurred.

Using this newly developed codebook with a focus on physically active leisure, the four
focus groups were then coded using an iterative process of coding and reworking the codebook
to incorporate any newly emerging themes unique to the focus groups. No new themes were
added, but clarification of existing codes helped incorporate new contexts.

**Steps Taken To Ensure Trustworthiness**

Lincoln and Guba (1985) described trustworthiness in qualitative research as comprising
credibility, transferability, dependability, and confirmability. Credibility refers to the degree to
which findings are “true” and believable. Transferability refers to how applicable findings are in
other contexts. Lincoln and Guba (1985) defined dependability as the degree to which findings can be repeated in a consistent manner. Finally, confirmability has to do with neutrality and the extent to which findings are grounded in the data and not shaped by researcher bias (Lincoln & Guba, 1985).

In this study, Institutional Review Board (IRB) approval was obtained for every step of the project. This contributes to dependability, in that standardized procedures for research must be followed. Participants in both the interviews and the focus groups completed documents of informed consent prior to their participation in order to inform them of any and all risks and benefits associated with their participation in the study, as well as who was conducting the study, what the study was about, and its purpose. During the data collection phase, researchers worked to achieve rapport with participants by arranging meet and greet sessions with community leaders, offering incentives for participation in focus groups, having organizational representatives co-moderate focus groups, and making it clear that the ultimate goal of the larger project was to promote healthy leisure in Carington. This helped to achieve good credibility, because without rapport, participants may have been less willing to open up about the real issues facing their community. Steps were taken by investigators to ask follow-up questions throughout the interviews and focus groups to clarify responses and ensure accurate interpretation. This process of checking with participants to ensure accurate recording and interpretation of data is called member checking (Lincoln & Guba, 1985), and it bolsters the study’s credibility and confirmability. The focus group script in particular entailed a segment near the end of the session in which the facilitator would sum up the important points raised by participants and ask for verification and elaboration (see Appendix B). Community leaders who participated in
interviews were each sent his or her transcript to ensure accuracy (participant verification; Creswell, 2007; member checking; Lincoln & Guba, 1985).

As mentioned above, during data analysis, all coders constantly verified codes and had other members of the research team confirm agreed-upon themes. The initial codebook was developed from 4 interviews, and then the complete set of interviews was coded using this codebook to ensure credibility in the findings. Lincoln and Guba (1985) called this process referential adequacy, and cited it as a way of establishing a study’s credibility. An iterative process of coding data, reworking the codebooks, and recoding the data allowed for themes to emerge naturally that were grounded in the data itself rather than researchers laying a thematic framework artificially on top of it, helping to establish confirmability. With at least 5 different researchers developing the codes, triangulation was achieved across multiple researchers in the development of the final codebooks (Patton, 2002). This study’s process of triangulation, involving multiple participants during data collection and multiple researchers during collection and analysis, as well as continual referral to the data itself, bolsters both credibility and confirmability (Lincoln & Guba, 1985).

Lastly, the thick description this paper aims to provide in the results section will add to the study’s transferability, and the many quotes from participants will bolster confirmability. Overall, the study takes adequate steps to ensure trustworthiness by considering techniques for establishing credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985).
Results

This study’s aims were to identify and describe the following: first, Carington residents’ and community leaders’ descriptions of physically active leisure and health in the area; second, constraints to physically active leisure; and third, facilitators to physically active leisure in the community.

The final codebooks for both the interview and focus group data contained the same major themes. Of particular interest for this paper are the themes for physically active leisure, particularly as these relate to leisure attitudes, constraints, and leisure motivations/facilitators.

Manifest Content Analysis

Overall, a manifest content analysis revealed that participants spoke about physically active leisure quite a bit: 259 times in the interviews, for an average of 10.79 times per interview, and 269 times in the focus groups, for an average of 67.25 times per focus group (see Table 1). In addition to this, participants also specifically spoke about sedentary or inactive leisure 52 times (average 2.17) in the interviews and 17 times (average 4.25) in the focus groups. Specific attitudes participants had toward leisure in general came up less than physically active leisure overall: 89 times (average 3.71) in the interviews and 105 times (average 26.25) in the focus groups (see Table 1).

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Table 1. Manifest Content Analysis Totals. Key themes across interviews and focus groups. Notes: The table shows the total number of occurrences of each code across the interviews and across the focus groups. The codes are as follows: 1a is physically active leisure; 1z is sedentary or insufficiently active; 1d is leisure attitudes; 1e is facilitators/motivators; 9a is intrapersonal constraints; 9b is interpersonal constraints; 9c is structural constraints; 9(x) is general or other constraints; 9y is no constraints; 9 is overall constraints (excluding the code for no constraints); and 12i is partnerships.
Constraints came up more prominently than any other theme. Instances where participants spoke about constraints totaled 299 times (average 12.46) in the interviews and 373 times (average 93.25) in the focus groups (not including the code for “no barriers”). Structural constraints by far outnumbered any other type of constraints, occurring 144 times (average 6.00) in the interviews and 217 times (average 54.25) in the focus groups. Intrapersonal constraints came up 82 times total in the interviews (average 3.42) and 71 times in the focus groups (average 17.75). Interpersonal constraints occurred the least, 37 times in the interviews (average 1.54) and 63 times in the focus groups (average 15.75).

Participants spoke about leisure facilitators to a lesser extent than constraints overall, though still often, for a total of 113 times (average 4.71) in the interviews and 164 times (average 41.00) in the focus groups. The theme for partnerships was examined because some participants spoke about community partnerships as potential facilitators. Partnerships came up a total of 69 times in the interviews (average 2.88) and 7 times in the focus groups (average 1.75). Table 1 displays this manifest content analysis information.

Within the interviews themselves, a few numbers stick out in terms of how often certain themes arose in specific interviews. For example, three leaders spoke about constraints much more than the other leaders interviewed: Nicole, who spoke about constraints 31 times in her interview, Annette at 36 times, and Pastor Carver, at 27 times. The next closest leaders were Jessica and Michael, each speaking about constraints 19 times in their respective interviews (see Table 2). Nicole, Annette, and Pastor Carver are all African American community leaders, 3 out of the total 5 interviewed (the other two are Dave and Phyllis). Nicole works with the Salvation Army, involved in social service to low-income community members and those in need of emergency assistance. Annette is president of the board for a community center and helps
operate a group home for developmentally disabled kids and young adults. Pastor Carver has long been the minister of one of Carington’s oldest African American churches. These three leaders brought up constraints more than other community leaders, perhaps indicating a perception of greater constraints. All three of these leaders, similar to most of the other leaders interviewed, stressed structural constraints more than both intrapersonal and interpersonal constraints.

While none of the other numbers from the manifest content analysis of the interviews stick out as much as constraints, a few others are worth mentioning. For instance, three leaders did not mention sedentary leisure or inactivity at all: Scott, Jessica, and Angela. Scott works for the city recreation department, Jessica operates a local retail shop, and Angela works for a local agency that addresses older adult needs. Additionally, two leaders, Marissa and Lilly, did not mention any leisure facilitators/motivators. Both Marissa and Lilly are healthcare workers at the local hospital. Marissa and Bill, an American Red Cross worker, also did not mention any intrapersonal constraints. Ten out of the 24 interviewed community leaders did not mention any interpersonal constraints, and those who did mention interpersonal constraints did not do so very often, indicating the lesser importance of these sorts of constraints for leaders. Interestingly, though structural constraints overall seemed to come up the most often, two leaders, Bill and Dolly, did not mention these at all. Dolly works for the local newspaper. Bill, in fact, did not mention any constraints at all, except to say, “I would tend to think that there are fewer barriers in [Carington] than there might be, let’s say, in a larger metropolitan area.” Plus, every leader spoke about partnerships at least once except for four: Jessica, the retail shop operator; Holly, executive director of a community resources center offering counseling on mental health and substance abuse issues; Dolly, who works at the local newspaper; and Rob, the chief of police,
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*Table 2.* Interview Manifest Content Analysis.
Notes: The table shows the number of times each code arose during interviews. 1a is physically active leisure; 1z is sedentary or insufficiently active; 1d is leisure attitudes; 1e is facilitators/motivators; 9a is intrapersonal constraints; 9b is interpersonal constraints; 9c is structural constraints; 9(x) is general or other constraints; 9y is no constraints; 9 is overall constraints (excluding the code for no constraints); and 12i is partnerships.
all of whom did not bring up partnerships at all. Table 2 details the manifest content analysis information of each interview with community leaders.

While the interviews represent the views of community leaders, Carington residents participated in the 4 focus groups. Manifest content analysis of the focus group data revealed a few interesting numbers. Overall, just as in the interviews with community leaders, residents in the focus groups spoke about structural constraints more than other types of constraints. Looking at constraints overall, however, residents in the focus groups held at the community agency in the mainly African American part of town and the local aging agency spoke about constraints more than residents in the focus groups held at the continuing education and job training center and the hospital. Constraints came up 114 times in the focus group located at the agency in the mostly African American neighborhood and 125 in the focus group held at the aging agency, compared to 65 times in the focus group at the job training center and 69 times in the focus group at the hospital. Interestingly, the theme of partnerships came up only in the focus groups held at the agency located in the predominantly African American part of town and the center for continuing education and job training, whereas the residents in the focus groups at the aging agency and the hospital did not bring up partnerships at all. Table 3 displays this manifest content analysis information from the 4 focus groups with residents.

Looking across interviews and focus groups, there were several key similarities and differences between leaders and residents that emerged from the manifest content analysis. Structural constraints emerged as the most frequently cited type of constraints in both interviews and focus groups, followed by intrapersonal constraints, and finally interpersonal constraints. Overall, both leaders and residents spoke about physically active leisure a great deal, as well as
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*Table 3. Focus Group Manifest Content Analysis.*

Notes: The table shows the number of times each code arose during focus groups. “African American” refers to the focus group located at the community agency in the mainly African American part of town; “older adults” refers to the focus group located at the area agency on aging; “low income residents” refers to the focus group held at the continuing education and job training center; and “healthcare workers” refers to the focus group held at the local hospital. The codes are as follows: 1a is physically active leisure; 1z is sedentary or insufficiently active; 1d is leisure attitudes; 1e is facilitators/motivators; 9a is intrapersonal constraints; 9b is interpersonal constraints; 9c is structural constraints; 9(x) is general or other constraints; 9y is no constraints; 9 is overall constraints (excluding the code for no constraints); and 12i is partnerships.
offering a good number of potential facilitators/motivators. The key difference that came out between leaders and residents, however, involved community partnerships. While almost every leader spoke about partnerships, this theme did not come up in half of the focus groups, and only came up three or four times in the two focus groups where residents did speak about partnerships. This gives the impression that leaders were already thinking about partnering across community organizations, whereas residents may not have had this issue in mind.

This manifest content analysis provides an overview on patterns in the data, but a latent content analysis of the deeper meanings in participant quotes in context adds richness to help understand themes in the data on another level.

**Latent Content Analysis**

**Views on physically active leisure.**

Participants described physically active leisure in the community in several key ways. Participants often emphasized the availability of opportunities for physically active leisure in Carington, and mentioned prominent organizations and facilities that offered such opportunities. Though participants largely described Carington as not physically active enough, including an underutilization of physical activity resources, of all physical activities residents engaged in, walking was by far the most common. Awareness of the health benefits of physically active leisure was another important aspect of participants’ views on physically active leisure in Carington, with most participants indicating that people were generally aware that they should be physically active to promote health and knew how to do so, though a few participants indicated that education along these lines was needed in the community.

First of all, participants mentioned time and again widely available opportunities for physically active leisure, especially those provided by prominent organizations and facilities in
Carington. Residents and leaders provided many quotes that represent what participants said about the area’s resources for physically active leisure. Lilly, a community leader who is a healthcare worker at the local nonprofit hospital as well as in the Illinois Department of Public Health, said of Carington, “There’s no lack of leisure activities.” This shows her confidence in the availability of physically active leisure opportunities in the area.

Scott, a community leader who works at the city parks and recreation department, said:

The city operates a very good rec program which is also supplemented by the private [Carington] Foundation rec complex. [...] Plus the Foundation also operates several other parks [...] that supplement the city rec parks program. [...] [There’s] a recreational center that tends to cater more towards the African American youth in the community. Primarily because it’s in that neighborhood.

Here, Scott gets at some of the different avenues available in Carington to pursue physically active leisure. He describes the dual system in Carington provided by both the city parks and recreation department and the Carington Foundation, which provides a recreation complex and operates several parks. Scott also points to the Carington Youth Center which caters mostly to African American youth.

In the focus group held at the continuing education and job training center, Mary noted, “My favorite places are always like out at [one of the parks] because there’s trails out there.” Mary highlights the availability of public spaces for physically active leisure in the parks’ walking trails. Greg, in the focus group held at the local agency on aging, said, “They put in that new golf disc in [a local park]. I go out there and play it. That's good exercise, but I love to fish too.” Greg refers to the park’s new disc golf course and the availability of fishing opportunities in town. Sarah added in the same focus group, “A lot of people walk in the park.” All of these quotes indicate the availability of the parks system to community members as places for physically active leisure.
Jessica, a community leader who operates a local retail shop, again highlighted the availability of the nonprofit recreation center, saying:

Well probably our greatest resource is the Rec Center. I mean it offers a place where people can go walk when the weather is bad, it offers climate control for exercising and walking. So that’s something here that not every place has. [...] I just started using the facility myself to walk every day.

Jessica not only describes the facility as providing opportunities for physically active leisure, but describes herself as taking advantage of the facility to walk every day.

Another of Carington’s community leaders, Rob, the chief of police, highlighted some of the area’s other opportunities for physically active leisure:

We have an active recreation department here that sponsors and hosts sporting events year-round as well as at least 4 different softball and baseball complexes. [...] We have a main rec center that’s downtown here in [Carington] and also up on the north side of town we have another off-site type [Carington] Youth Center is what it’s called. Utilized more by the minority part of our town is where it’s centralized at, try to give them more of a local ability to be involved in this kind of sports.

Rob describes sports opportunities available both through the city parks and recreation department and a prominent Carington nonprofit foundation. Like Scott, Rob mentions the Carington Youth Center that caters to youth in the African American community. All of these organizations and facilities offer opportunities for physically active leisure in Carington.

One of Carington High School’s administrators, Dana, a community leader, also expounded on the foundation’s recreation center:

We have such a great complex, like our Rec [Center] is a great facility, I think, and we do have opportunities. [...] We do also have a track, our old high school track is available for people who, adults who want to walk or jog. [...] It’s lighted and, you know, safe and things of that nature so, available as an outside resource. [...] When it’s bad weather, the Rec [Center] has a suspended track indoors that they can walk [on]. So walking facilities are available there year-round for people who want to do that.
Dana not only describes the opportunities available through the recreation center, but also an outdoor track available to the public at the old high school (a new one had been built on the edge of town).

These quotes illustrate some of Carington’s major resources for physically active leisure, including the city parks and recreation department, the Carington Recreation Center operated by a local foundation, schools (particularly the old high school track), area parks, baseball diamonds, and the Carington Youth Center located in a predominantly African American part of town.

In almost the same breath as participants indicated physically active leisure opportunities, they also indicated that many members of the Carington community do not take full advantage of these opportunities. In the focus group located at the community agency in the African American part of town, George said of one of the foundation’s parks, “it’s a massively under-utilized asset that we have.” Lilly, a community leader and healthcare worker, said, “I think people in [Carington] don’t realize how good they have it. […] [They] tend to overlook the fact that they have this beautiful park there and they overlook a lot of the good things that they could be taking advantage of.” Again, this gets at the underutilization of available opportunities in Carington for physically active leisure. Molly, a community leader who works at the foundation parks and also for a local cultural society, spoke about community members’ apathy, saying, “the apathy of getting involved, you know taking advantage of what is here.” What Molly is referring to amounts to the underutilization of leisure resources in Carington.

Jessica, the retail shop operator, added, “People have to take advantage of what’s there. And…I’m not always sure that it’s not there [as much as it is] that people just don’t use what they have. […] I think there’s a lot offered here. I don’t know that people take advantage of it.”
Here Jessica clearly spells out what many participants were getting at: there are a lot of opportunities for physically active leisure in Carington, but community members may not be taking advantage of those opportunities, resulting in an underutilization of available resources. Another community leader, Dana, one of Carington High School’s administrators, similarly said of physically active leisure opportunities, “I do think we have them available, I think that they’re just not utilized as much as they probably could be used.” Lastly, the American Red Cross worker and community leader, Bill, who did not mention any specific constraints in his interview, did refer to the underutilization of active leisure resources, saying:

Although the resources are available in [Carington] in terms of the Recreation Complex and a variety of recreational programs, we have a beautiful park with nature trails and all that and tracks for running and walking and so forth but I suspect that, like most communities, we probably underutilize those facilities.

All these quotes from leaders and residents show how participants viewed physically active leisure opportunities as available but underutilized in the community.

As indicated by this underutilization of resources, participants described Carington community members as largely inactive, or at least not active enough. Annette, an African American community leader, president of the community center board and active in running a group home for developmentally disabled kids and young adults, said of Carington adults, “You know I think that physical activity is the thing I don’t see them do enough of. […] To participate in regular physical activity, you know, I think a vast majority of our population is lacking in that area.” Annette clearly states that the Carington community is not physically active enough. Another African American community leader, Pastor Carver, minister of a local African American church, echoed this statement in saying of the community at large, “We do not exercise and we do not eat properly.”
In the focus group held at the community agency in the mainly African American part of town, Lynn said of community members, “Everybody is overweight, you know, not healthy.” This indicates that community members may not be getting enough physical activity. Lilly, a healthcare worker and community leader, added, “They’re like the rest of the United States, everybody’s overweight and everybody’s out of shape,” highlighting again an insufficient level of physical activity. Barbara, a county health department administrator said in her interview, “I think exercise is really a stress-reliever and I’m not sure that people do enough of that. Same kind of things you probably see everywhere.” This quote once more emphasizes that Carington community members do not get enough physical activity. These last two quotes from Lilly and Barbara additionally get at the idea that this problem is not unique to Carington, but common across the United States.

Along the same lines, Dolly, a community leader working at the local newspaper, stated, “I know I need to exercise more, I know I never want to exercise. (laughs) It’s not so easy doing it! (laughs).” Here Dolly admits that she, as a representative part of the Carington community, does not get enough physical activity herself. Rudy, the director of Carington’s parks and recreation department, also included himself in stating that community members do not get enough physically active leisure. “I think we make too many excuses,” he said, “and not do the things that we need to do to, to make ourselves better.” Dana, the high school administrator, agreed. “In general,” she said in her interview, “I think people are more sedentary than they ever have been and I think it’s a matter of getting out and doing what you need to do to be physically active or participate in a variety of different activities.” This quote again paints the picture of Carington as engaging in insufficient physically active leisure. Finally, Bill, the American Red Cross worker who did not mention any constraints in his interview, nonetheless claimed, “I’m
quite certain that there’s not nearly enough people that engage in physical activity as part of their leisure activities to stay in better health and better condition.”

Despite this general physical inactivity, some participants indicated that a good number of community members walk on a regular basis. As Annette put it in her interview, “Of course in every situation you have the walkers, people love to walk and run.” Annette is an African American community leader and president of a community center board, as well as a director at a group home for developmentally disabled children and young adults. Her quote refers to a common theme throughout the interviews and focus groups that many of Carington’s community members walk on a regular basis. In the focus group held at the local agency on aging, Sarah concurred, “A lot of people walk in the park.” Scott, a community leader working for the city parks and recreation department, said, “I think walking is one that they do quite a bit…. People do a lot of walking.” In the focus group at the job training and continuing education center, Gus said, “I'll walk a lot.” In the same focus group, Mary added, “I do an awful lot of walking. I walk every day.” Again, these quotes show how many participants viewed walking as a form of physically active leisure that Carington community members engaged in with some regularity.

In general, participants indicated that community members do largely attribute health benefits to physically active leisure. When asked in the focus group at the continuing education and job training center what leisure activities are more important in keeping people healthy compared to other activities, Fran said, “I think the physical ones, more physical and active ones probably keep people healthier.” Rudy, Carington’s city parks and recreation department director, said, “When it comes to my health […] I need to get my butt back in shape,” referring to a need to be physically active to promote health. Annette, the African American community leader operating a group home for developmentally disabled kids and young adults, said, “In
general, I don’t see a lot of activity, physical activity on the part of our adults. I’m guilty myself! (laughter) And of course we know that that shortens our lifespan and, you know, all kinds of problems happen with our health when we’re not taking good care of ourselves physically.”

These quotes shed some light on participants’ understanding of the role physically active leisure could play in health, showing that participants embrace the notion that physically active leisure is tied to health benefits.

However, some participants believed that community members needed education about physically active leisure benefits and about how to participate in physically active leisure in order to increase participation. These participants included Pastor Carver, a long-time pastor at a local African American church, who spoke about “exposure:”

And what I mean by exposure is becoming aware of your options. […] I think that the lack of knowledge is why people are destroyed. It’s not because people don’t want to be better. […] I’m thinking, ‘Well, why don’t they do this? Why don’t they do that?’ Sometimes you have to wonder, do they know how to? I just assume that you do, when you really don’t. […] But I think that the more you expose people to, it gives them another option. If I’m not exposed to things, then I don’t know my other options.

Here, this religious leader illustrates the view of some participants that Carington community members might engage in more physically active leisure if only they were better educated on how to do it and why it would be beneficial. This issue will be addressed in more detail in the results section on facilitators, because educating residents was largely seen as facilitating participation in physically active leisure.

**Constraints.**

Participants referred to constraints consistently throughout both the interviews and focus groups. Participants mentioned structural constraints more than all other constraints. Several
important intrapersonal constraints came out of the data. Interpersonal constraints also came up in the data, though far less than structural and intrapersonal constraints.

**Structural constraints.**

Of all types of constraints, structural constraints were discussed the most in both the focus groups and the interviews. Crucial structural constraints that participants cited included transportation, time, money, and—despite some participants’ description of Carington as generally having many physically active leisure opportunities available—a lack of available opportunities. The latter contradiction could potentially be explained by some participants perceiving higher or more insurmountable constraints to the leisure options that others see as available, resulting in the perception of a lack of opportunities.

One structural constraint that participants mentioned frequently was transportation. Talking about a potential program to promote healthy leisure, Nicole, who works for the Salvation Army, said, “It needs to be accessible as far as in different areas of town. Don’t just stick it on the north end or don’t just stick it on the south end because it’s a big town. It needs to be somewhere that people can get there or there’s some transportation to get there.” This gets at how the issue of transportation sometimes blocks community members from participating in healthy leisure.

Additionally, the following exchange taken from the focus group held at the local aging agency deals with transportation issues as structural constraints:

Researcher: Is there public transportation here?
Female 1: Not for [neighboring community].
Female 2: Not for [neighboring community].
Female 3 (Cindy or Meg): And what is here is as high as driving your car.
Female: Yeah.
Owen: And it's inconvenient, I mean that's what we get a lot, is it’s inconvenient. There aren't regular stops or anything like that. The public transportation we have here is by [appointment],
you have to call and make an appointment. [...] And they ask for 24 hours in advance. Well, you don't sometimes [know] that tomorrow you are going to have time to go. And if you call and make an appointment and then can't make it, they are going to charge you anyway.

Older female: And if you change your route, they charge extra.

This exchange shows how constraining transportation in the area might seem to community members, with limited availability, high cost, and inconvenience. Another brief exchange from the focus group held at the community agency in the mostly African American part of town brought out the same sorts of issues:

Nicole: Transportation in this area is terrible. [...] We have a transit system but it’s not free by any means; it’s extremely expensive.

African American female: And you gotta call days ahead to make reservations for it.

This exchange confirms participants’ perception of transportation issues as important structural constraining factors, by seeing transportation in the area as expensive and inconvenient. Holly, who is executive director of a community resource center providing counseling on mental health and substance abuse issues, also echoed these thoughts on transportation:

Transportation is problematic. There is public transportation available but it does have a small fee. Our individuals are mostly on very very limited income so then even paying a small fee a few times a week would add up for them and make it difficult for them even to maybe get to some of these resources that are available.

Holly emphasizes how constraining factors associated with transportation might contribute to an underutilization of seemingly “available” resources in the community.

Another important structural constraint participants cited often involved time. In the focus group held at the local aging agency, Cindy exclaimed, “I don't really have free time!” while Diana said, “I have [a] problem finding enough time.” As Frank put it in the focus group held at the job training and continuing education center, “What it is, is people are really busy just making a living and they can’t do that, you know.” He was responding to a conversation thread
about physically active leisure, suggesting that people in Carington are too busy working and lack the necessary time to participate in physically active leisure.

Also referring to physically active leisure opportunities in Carington, one woman in the focus group at the aging agency stated, “I think […] all those activities should not only be available 9-5.” This shows how a time constraint stops some community members from being active, because many leisure activities are offered only during the day. Louise in the focus group held at the local hospital also expressed this sentiment, saying of the Carington Recreation Center, “The hours are not convenient.” Anne, in the focus group held at the hospital as well, also spoke to the time constraints involved in scheduling physically active leisure. “It’s during the day, you got the working people, and it doesn’t fit in with the kids’ school things at night or whatever, so it’s going to have to be things that can be done at different times.” Anne speaks to the necessity of offering leisure programs on a flexible schedule, perhaps at odd hours, to accommodate people who work during the day and may have family obligations in the evening. All of this goes back to issues of time constraints.

The director of social services at the local hospital summed up two of the most prominent structural constraints found in the data, saying, “Everybody’s always strapped for funding and time.” Michael’s statement demonstrates how in addition to time, participants strongly emphasized money as an important constraint to physically active leisure. In the focus group held at the community agency in the mostly African American part of town, Vanessa stated, “Jobs are so hard to get anymore that are really paying anything and sometimes they have you working such crazy hours.” Vanessa’s quote gets at both the issues of time and money, and how the need of money can create a shortage of time, through working “crazy hours.”
In the focus group held at the aging agency, Cindy said, “You’re on such a fixed income, you can't do a lot of stuff. [...] You can't go into the Rec Center and afford to pay to go in.” Cindy gets at something that many participants expressed, namely that the foundation’s recreation center is too expensive for many community members to use.

Nicole, the Salvation Army worker, also addressed how many community members could not utilize leisure programs if they cost money. Speaking about what a program to promote healthy leisure would need to be like, Nicole mentioned, “Well I’d say the first thing [is], it needs to be something that doesn’t cost because that’s gonna eliminate the people that need it the worst if it’s going to be something that costs a lot.” This quote emphasizes how for many community members, cost can make some leisure activities completely inaccessible. As Lynn said in the focus group located in the predominantly African American section of Carington, “I used to work out but it's just the financial expense, [I] can't do it anymore.” In the same focus group, one exchange highlighted another issue with cost that may disproportionately affect some community members:

Nicole: We have a beautiful facility, but nobody can afford to go!
Alicia: And if you got a large family there is no way.

This emphasizes the pronounced burden placed on large families, who would have to pay a fee per family member to use the recreation center that might add up to quite a lot. Similarly, Dana, the retail shop operator, noted, “Sometimes I think that the cost of going to the Rec Center, participating in some of those [activities], may be cost prohibitive as far as some of our minorities are concerned.” Dana expressed the belief that the cost of using the foundation’s recreation center may have an impact in particular on minority community members.
Another woman, in the focus group held at the community organization in the mostly African American part of town, stated, “I did yoga but I had to quit because I couldn’t afford it anymore,” again emphasizing the cost constraint many participants expressed. Marissa, a community leader working at the local hospital, said, “When you don’t have a job and you don’t know how your bills are going to be paid, you’re not really worried about a gym membership. You know I think a lot of that comes [down] to the incomes and the high unemployment in [Carington].” Marissa expresses that money may act as such a powerful constraint due to the low incomes and high rates of unemployment among Carington community members. The primacy of these issues may shift the focus of many community members away from their health and the need to support it through physical activity.

Toni, of the Carington Cultural Society, concurred. “It’s hard here because people just don’t have money. They don’t have jobs.” These quotes on money as a constraint stress the underlying economic hardship faced by the community, including a lack of jobs and relatively low incomes.

In addition to money constraints, some participants cited a lack of opportunities as a structural constraint. For example, in the focus group held at the local hospital, Louise mentioned, “I would do aerobics and some other things if I could find any, but I can’t.” This quote gets at a perception of a lack of opportunities among some participants. Pastor Carver, a long-time minister of one of Carington’s oldest African American churches, also saw a lack of opportunity, but in a different light.

There’s not enough outlets or things for people to do for leisure, that’s what I want to get at. […] There’s just not anything here for them to do. […] As far as the Black community is concerned, which makes up 12 percent of this community, all the leisure time is, for those who can afford it, is spent outside of the area.
The latter quote points to a potential constraint faced in particular by the African American community in Carington, which is that opportunities for leisure may not cater to the tastes of African Americans. Nevertheless, White residents like Louise also claimed a lack of physically active leisure opportunities in Carington.

A handful of other structural constraints included issues of perceived safety (in terms of crime and risk of injury), weather, and community-wide issues like drugs and teen pregnancy. In the focus group held at the aging agency, Meg spoke about walking at night. “If you do it late at night, you’re back to walking [and] the safety of it. Because we are becoming an unsafe community.” Meg gets at the perception of some participants that Carington is an unsafe community. An exchange from the same focus group highlights safety concerns some participants had about the integrity of the walking surface:

Greg: See I won't walk at [one of the foundation’s parks] because there’s too many rocks […] If I lose my footing then I’m going down and I don't need to do that neither, so I go up to the football field.
Owen: And I just noticed recently that the track at the football field is getting bad.

These residents show safety concerns about falls while walking as a form of physically active leisure.

Additionally, some participants saw weather as a constraint to physically active leisure. For instance, in the focus group held at the hospital, Pam said, “I'd rather be outside. If it’s really really bad then I'll go in and use the walking track at the Rec Center (laughing).” In a community leader quote presented earlier (in the section detailing physically active leisure opportunities in Carington), Dana also indicated that weather can act as a constraint, saying, “When it’s bad weather the Rec Complex has a suspended track indoors.” Pam and Dana both express that while
weather may be a constraint to physically active leisure like walking, there is the option of walking indoors.

A final structural constraint that some participants spoke about involved community health issues like substance abuse among teens and young adults as well as teen pregnancy. In the focus group located at the hospital, Wilma suggested, “That’s why we have so many problems: the kids. The drug problem is tremendous in this area. […] There are lots of sports they could do but they wanna get into something else.” This quote shows how some participants may see young community members’ involvement in drugs as a constraint to physically active leisure.

These additional structural constraints of safety, weather, and drugs show that while some constraints are frequent issues across the community, some constraints may be more or less important depending on the individual. Issues of safety were brought up largely by older adults, for example, and though several participants spoke about issues of drugs or teen pregnancy, some never touched on these as possible constraints to leisure.

*Intrapersonal constraints.*

The overarching theme that came out of major intrapersonal constraints that participants spoke about was lack of motivation. Underlying this were such factors as hopelessness, lack of vision or inspiration, lack of self-esteem, lack of initiative, attitudes, lack of interest, and lack of knowledge or awareness. Also of note were a few participants’ comments about how African American community members might feel uncomfortable or unwelcome at some of Carington’s recreation facilities, or would prefer to seek resources within the African American community.

Lack of motivation was the major intrapersonal constraint cited by participants. In many cases, participants spoke about underlying factors that might contribute to a lack of motivation to
engage in physically active leisure. For example, Dave is an African American community leader who helps run an organization (headquartered in the mostly African American part of Carington) that assists mainly low income families across six counties in the region. Dave described Carington as “a low income population that sees no hope.” Toni, who works with the Carington Cultural Society, added in her interview, “People… have lost hope here. There’s not a lot of vision. […] Loss of hope is a big deal here.” These two community leaders speak to a sense of hopelessness in Carington that may sap motivation for things like physically active leisure among community members.

Molly also spoke about the lack of motivation for physically active leisure in Carington. Molly works with the foundation parks and the cultural society. “I think in today’s lifestyle,” she said, “it’s easier to sit and watch something than actually get up and participate in it.” This example of sitting and watching something because it is easier than participating demonstrates a lack of motivation when it comes to physically active leisure. Molly went on to say that the kind of program Carington needed was “like a motivational, I think people need to be inspired or a little bit more for their own self-esteem maybe.” Here Molly draws attention to the power of inspiration and boosting self-esteem to motivate people. These insights, along with Dave and Toni’s, draw attention to an overall lack of motivation, and underlying that, a lack of hope, vision, inspiration, and self-esteem.

“I think everybody has their own issue of why they don’t do something like they should. Some people just don’t have motivation,” said Jessica, the retail shop operator. She echoes the perception that Carington community members lack motivation for physically active leisure, but attributes this lack of motivation to factors that may vary by individual. Rudy, director of Carington’s parks and recreation department, suggested:
I think a lot of it might be just initiative, just getting up. Because I know I’m probably guilty about it, I keep saying I’m going to do this and this and that and never get around to doing it. Especially when it comes to my health. […] You think you can reach out to everybody or educate them and in some way or some kind, some aspect, but the initiative—I don’t know, that might be a million-dollar question.

Again, this quote about taking initiative points to a lack of motivation. It gets at the dilemma Carington residents face in intending to participate in physically active leisure but lacking motivation actually to follow through. Rudy suggests that even reaching out to community members and educating people is insufficient for bolstering motivation for physically active leisure. He would like to know what would be effective for motivating community members to be active, since they currently lack the necessary motivation.

Phyllis is a retired business administrator, now on the county board and volunteering at the hospital and at church. The following interchange from her interview further demonstrates the lack of motivation for physically active leisure among Carington community members:

Researcher: Do you think that adults in [Carington] also don’t do enough physical activity?
Phyllis: Yes. Yes I believe that.
Researcher: In what way?
Phyllis: They just don’t want to get involved.
Researcher: Okay.
Phyllis: You know, I just think they… I don’t know what it is. They’re not motivated, and why they’re not motivated I don’t know. But the motivation is not there.

This quote emphasizes participants’ perception that Carington community members are simply not motivated to participate in physically active leisure.

In the focus group located at the community agency in the mostly African American part of town, when the moderator asked participants about what physical activities they do that help keep them healthy, Lynn said, “I don't do what I want to truly anymore because, and you know the older you get the more it’s like ‘Well I’ll do it the next day’ and it never happens.” Here
Lynn describes procrastinating and putting off physical activities, indicating that motivation may in fact be lacking.

Perhaps contributing to this lack of motivation are various constraining attitudes that participants pointed to in the interviews and focus groups. Molly, who works with the foundation parks and the cultural society, said in her interview, “I think, you know, we’ve become a society where you want things automatic. You know it’s easy to run a DVD and sit in your home.”

Molly points to an attitude of wanting things to come easily and automatically, which is not conducive to participation in physically active leisure. Toni, also of the cultural society, hints at a similarly constraining attitude some community members may have:

You can only bounce a basketball until you hit a certain age, and you can only play football to a certain age, and those are important for the kids and building bodies, but once you’re in your 40’s and 50’s and 60’s and 70’s—what do you do? […] People don’t think about getting out and riding bicycles or just walking and doing things like that.

This quote illuminates a potential intrapersonal constraint around the attitude that physically active leisure is for kids but not adults.

Other community leaders offered examples of additional potentially constraining attitudes. A member of the research team asked Barbara, a county health department administrator, what barriers keep people from engaging in healthy leisure activities. “Sometimes I just think the culture in general?” Barbara said. “Sometimes we just tend to be couch potatoes instead of (laughs) wanting to get out and do things we need to do to promote good health.” This quote points to attitudes of a “couch potato culture” that may be hindering community members, even though they know physically active leisure promotes good health. When asked the same question about barriers, Dana, a high school administrator, explained. “I think attitude is one. […] ‘I don’t have time,’ ‘I don’t have the interest,’ ‘I can’t find anything I enjoy doing’, even
though there are a variety of different activities, I think it’s just a matter of attitude with people.”

These quotes demonstrate that participants view attitudes as preventing community members from engaging in physically active leisure, despite being aware of its health benefits and having a variety of activities available to them.

Dana’s quote also refers to a lack of interest among community members. Lack of interest—as an underlying factor in Carington community members’ lack of motivation for physically active leisure—came up relatively frequently in the data. In the focus group held at the job training and continuing education center, comprised mostly of low income residents, Gus spoke about workplaces forcing their employees to exercise. “I think, something you might have seen on the news recently, some companies are forcing their employees to exercise. You know, to do their exercise at work. […] People are feeling better. They rejected it, a lot of them did, and didn't like it, you know, but you gotta force people.” This quote shows that community members did not like being physically active and lacked the intrinsic motivation for doing it during leisure.

Referring back to a lack of inspiration, Jessica, the retail shop operator, also spoke about community members’ lack of interest. “I think more than anything everybody needs a little bit of inspiration. […] It’s to trigger that interest.” Jessica suggests that some sort of inspiration is needed in Carington to trigger community members’ interest in physically active leisure, ultimately in order to get them motivated. Rob, the chief of police, spoke about community members in two groups: those who are interested in physically active leisure and those who lack interest. “The people who are interested in sports are meeting that need and…you know the ones who aren’t interested in doing those things I guess aren’t and I don’t know that you can make them, you know, change that behavior.” Here Rob expressed some cynicism that for community
members who lack interest in physically active leisure, there may be no way of motivating them to participate.

Toni, of the cultural society, took a more optimistic approach. “I think it would help people to know that there’s things that they can go do that don’t cost a lot of money and they’ll have fun with it. I think fun is, for some people the concept (laughs) is kind of outside their reach.” This quote shows that the idea of having fun doing physically active leisure may not seem possible to some community members. It indicates a lack of interest in physically active leisure. Toni conveys the idea that if community members were made aware of low-cost options and convinced that physically active leisure could actually be fun, then some interest might be sparked and participation would increase.

Along these lines, some participants said that a lack of knowledge or awareness contributed to a lack of participation. For instance, Pastor Carver said in his interview, “I think that the lack of knowledge is why people are destroyed. It’s not because people don’t want to be better.” Molly, of the foundation parks and cultural society, agreed in saying, “People need to be made aware of healthy lifestyle choices.” These quotes point to a current lack of knowledge or awareness of healthy leisure options in Carington. Lilly, who works with the state department of public health and with the local hospital, said:

I think there’s a huge need for somebody to sit down with people in a small group and just explain what the options are and how to control their eating and how to get more exercise without getting on a treadmill for 3 hours a day, you know? They just honestly don’t know.

This quote highlights the importance of education in the community to increase knowledge and awareness of how to be healthy, including through physically active leisure. Lilly’s comment about exercise that does not require three hours every day hints at time constraints, which will be discussed in greater detail with other structural constraints. However, it is worth pointing out
here that Lilly is saying that these time constraints can be negotiated, that there are ways of exercising that do not take that much time. This would require educating community members to increase their knowledge and awareness of physically active leisure opportunities in Carington and how to take advantage of them.

In support of the idea that there is a need to increase awareness of physically active leisure options in Carington, one woman said during the focus group at the local hospital, “People don’t really know what’s available.” As evidenced by the above quotes, some participants believed that Carington community members simply do not know how incorporate physically active leisure in their lives or are unaware of the opportunities available to them. This is despite many participants’ views that Carington offers an abundance of physically active leisure opportunities.

While many of the themes surrounding intrapersonal constraints were universal to participants, some themes centered around minority issues. Participants brought up the notion that African Americans may not feel welcome at some of Carington’s recreation facilities, or would prefer to seek resources within the African American community. Annette, president of a community center board and director of a group home for developmentally disabled children and young adults, said, “I think that [Carington] wants to close its eyes as to the problem with minorities. They seem to be [in] touch with the problem once it becomes a general problem for all populations, but I don’t see them as eager to reach out to the minority community.” This quote illustrates how African Americans’ needs are not necessarily being met by the recreation resources for the community at large, creating a sense of exclusiveness in some cases.

Pastor Carver spoke about exclusivity among racial groups in Carington in a different way:
The minority community, it becomes a closed community in a way. [...] The minority community is more isolated in [a] sense. And therefore you’re lacking in exposure because if I’m living in a certain area, usually my leisure time and my knowledge and my exposure stay right within that community. [...] Minorities, it’s that independent thing, we take care of our own. [...] that’s the closed community I was talking about. That’s why I say exposure, exposure, exposure. And I’ve seen some, in my years of pastoring, I’ve been pastoring 37 years in different communities, and I’ve seen some good programs to help minorities but they wouldn’t take advantage of it, you know, because of that thinking.

Here Pastor Carver makes note that the African American community can be somewhat isolated from the community at large, not merely because Carington is not eager to reach out to minorities, but minorities may not be eager to reach out either, even if good programs were available to them. Phyllis, a retired business administrator, expounded on this idea:

It’s not because they are excluded because of their race. I don’t know whether we get to the point that we don’t feel like we belong or we’re uncomfortable or when I say ‘we’ I’m just talking about minorities. [...] I just think that the people are just uncomfortable around some of the other races. [...] There’s a lack of communication. We seem to think we’re different and we’re not. And I think that being able to communicate with each other and just sit and talk about the things that we feel and don’t feel, I think that has a lot to do with the race relations.

These racial tensions present constraints to physically active leisure, particularly in how African American community members might feel uncomfortable in a mixed-race leisure setting where the needs of the majority are primarily being addressed. Participants spoke about these issues in terms of individual attitudes people might have that prevent them from going into certain mixed-race leisure contexts, but also in terms of a constraint that exists between people (i.e. racial groups) which makes it more interpersonal. Finally, this race-related constraint may also be conceptualized as structural: part of the legacy of racism in America.

**Interpersonal constraints.**

Interpersonal constraints were the least prominent of the constraints categories in the data. They came up in the data much less than either intrapersonal constraints or structural constraints. Nevertheless, the main interpersonal constraint involved obligations to family
members, especially caretaking. In the focus group held at the local agency on aging, one participant mentioned that she lacked the time for healthy leisure, including physically active leisure. Another participant, Meg, followed up on her friend’s comment. “What [Cindy] didn't tell you is that she's with grandparents raising grandkids, and so am I. […] I have no spare time.” The group Meg references is what it sounds like: a group of older adults who are taking care of their grandchildren. As evidenced by this quote, a major consequence of family obligations that participants cited was a structural constraint: time. It was more that social obligations resulted in a lack of leisure time rather than another sort of alteration of leisure behavior.

Still, some participants noted that their family and caretaking obligations resulted in feeling too tired to be physically active. As Marge put it in the same focus group, “I'm […] raising a daughter and when you work all day and then you have to come home and cook supper and clean house and do laundry you really just don’t want to walk anymore.” As Marge said this, an older female participant laughs in the background and said, “Yup.” This indicates a lack of energy some participants felt as a result of their family and caretaking obligations. These interpersonal constraints, while important for some participants, were discussed less in the interviews and focus groups than either intrapersonal or structural constraints.

**Facilitators.**

Significant facilitators to physically active leisure that participants spoke about incorporated several key motivators and negotiation strategies to overcome constraints. These included organizational support and partnerships, the promotion of available opportunities for physically active leisure, and educating community members on the benefits and knowledge/skills of how to be active. Participants mentioned such negotiation strategies as planning, prioritizing, and cultivating a positive attitude. Perhaps most importantly, participants
cited the power of basic enjoyment, interest, and sense of accomplishment for motivating people to participate in physically active leisure.

Key facilitators overall involved the support of and partnerships between organizations in Carington. Evidence of organizational support included quotes about the various facilities made available to residents by Carington organizations, and the enabling features these facilities had such as all-weather availability and safety. Dana, the high school administrator, who in part was previously quoted (in the section on opportunities for physically active leisure in Carington), said:

We just built a brand new high school here so the old track is primarily made available to the public for use, who want to walk or jog or whatever. It’s lighted and, you know, safe and things of that nature so, available as an outside resources for those adults who want to [walk]. When it’s bad weather the Rec Complex has a suspended track indoors that they can walk [on] so walking facilities [are] available there year-round for people who want to do that.

This quote shows how the high school track facilitates physically active leisure by being available for public use. Dana also describes is a being safe and well-lit, qualities which help facilitate its use for physically active leisure. The quote also shows how the foundation’s recreation center facilitates physically active leisure by offering an indoor track where people can walk year-round regardless of weather conditions.

Fran, who works with the job-skills training and continuing education center catering to mostly low income and unemployed community members, also spoke about Carington’s community college as an organization that facilitates participation in physically active leisure. “They have yoga classes. They try to meet the needs of the community. If there was enough expressed interest in a certain class, they would create it for the community.” This shows how the community college actively creates programs based on community needs, including physically active leisure programs like yoga.
In addition, churches came to the fore as a key facilitator (or potential facilitator) for physically active leisure in the community. When asked who else researchers might contact for interviews, Holly said, “See what the churches are doing because maybe that’s an avenue for health promotion that isn’t being utilized.” This quote points to a common perception among participants that churches in Carington could facilitate physically active leisure among community members. When asked if any community resources focus specifically on minority adults, Evelyn—a retired leader in the community involved with her church, a university women’s association, child welfare, and teaching—stated, “No, I don’t think of anything in particular. I think that’s usually taken care of through the churches.” Here, Evelyn indicates the role of churches in the African American community in particular, and their unique position to address minority needs. Pastor Carver confirmed this idea, saying there has “to be a center spot that’s providing the information, encouraging people. […] The church becomes a very powerful entity to do that, if it would.” This quote confirms participants’ perception of churches as community organizations with a unique position to facilitate physically active leisure in Carington.

Participants indicated that churches could facilitate participation in physically active leisure throughout the community, not only in African American churches. As Phyllis, a retired business administrator, spoke about how to reach community members with a health-promotion intervention, she said, “You [could] go to the White churches, the Black churches, […] and I think you could pull people in that way. And then from there you could expand it farther.” This gets at the power churches may have in Carington to facilitate community members’ participation in physically active leisure. Dolly, a community leader who works at the local newspaper, agreed that churches could facilitate physically active leisure. “We have some
different churches that have walking programs, wellness type of programs, and they should be involved in those kinds of things.” She expresses here that churches not only can promote physically active leisure, but that perhaps they should. These quotes all illustrate how participants believe churches offer a way of promoting health in the community (including through physically active leisure).

While participants emphasized the potential that church organizations have to facilitate physically active leisure, participants also pointed out that organizational partnerships could act as facilitators. For instance, Scott, a community leader who works for the city parks and recreation department, said:

The city tends to take a major role in forming community activities, supporting local non-profit groups, not necessarily financially, but just working with partnerships with the [Carington] Foundation and some of these other groups that provide recreational opportunities in town.

These partnerships between the city parks and recreation department, the foundation, and other groups in town help provide recreational opportunities in Carington, including opportunities for physically active leisure. In this way, such community organizational partnerships serve as facilitators of physically active leisure.

Additionally, Fran is a community leader working at an area center that caters to low-income and unemployed community members by providing job skill training and continuing education. Fran described how a local nursing home partnered with the center in order to put on a health fair for seniors in order to provide them with health information. Fran said, “The [center] just had a local nursing home facility present a health fair for seniors.” In this way, community partnerships were able to facilitate healthy lifestyle choices, including physically active leisure.

Bill, a community leader working with the American Red Cross, indicated that the Carington foundation “partner[s] with schools and other clubs for the use of the facilities.” By
pooling resources, community partnerships help facilitate physically active leisure by making opportunities available to community members who might otherwise not have access to facilities. Barbara, a county health department administrator, summed it up in her interview by saying simply, “Collaboration is important.”

It is important to note here that community leaders brought up partnerships more than residents. Even so, the idea of partnerships as facilitators came up in the focus group held at the continuing education and job training center and the focus group located at the community agency in the mainly African American part of town. In the focus group at the job training center, Alex said:

I would have the [...] school boards to meet with the city government and lay out a program that would be beneficial to the local area. [...] You gotta pull things together. And that's why we’re getting ready to have a leadership breakfast. [...] What it’s all about is to try and cross those boundary lines to get people to understand, you know, we gotta work these things together.

In this quote, Alex emphasizes the importance of community partnerships to facilitate community health, including physically active leisure participation.

In the focus group held at the agency in the predominantly African American part of town, Nicole said, “You have to have people who want to work together, you can't say, we’ve got the Black youth center over here and we’ve got the White youth center over here.” She was referring to Carington’s separate recreation centers that tend to be segregated by race. Nicole stresses the importance here of partnering and pooling resources to the benefit of the whole community, including by bridging across racial lines. This partnering could help facilitate physically active leisure participation by opening up more resources—like another recreation center—to more community members.
Another main facilitator of physically active leisure that participants cited was promotion of available opportunities, or as Nicole put it, “getting the word out.” When asked about what sort of program is needed to promote healthy leisure, Dana, the high school administrator, said:

I think it would be wise to do a promotional type of thing? To let more people know what’s out there and available! […] You know, these types of programs are available at this time at this cost. […] People think, ‘Well I don’t know, I didn’t realize that they had a yoga class at the Rec Center,’ or ‘I didn’t know that they did water aerobics in the mornings on Monday, Wednesday, Friday,’ and ‘I didn’t know that they played Pinochle at the VFW on Tuesday mornings.’ You know? Making people more aware of what’s out there, what’s available for adults and maybe looking at and taking inventory of what types of recreational programs are available and then consolidating some type of resource that people could see and know about to make them more aware.

All of this gets at different ways of getting the word out on what opportunities for physically active leisure are already available in Carington.

Similarly, when a member of the research team asked Holly—the executive director of a center providing mental illness and substance abuse counseling—if she thinks a program promoting healthy leisure would be helpful, Holly touched on this idea of increasing awareness.

I do, I think that it would help increase the level of awareness and hopefully in doing that, would increase the participation. […] Probably educating the public about what is available, particularly for free because we do have such a large percentage of our population that is low income.

Again, Holly illustrates participants’ perception that increasing community members’ awareness of currently available opportunities for physically active leisure in Carington would facilitate participation. Molly, of the cultural society and foundation parks, echoed this sentiment when attempting to explain why more community members were not active. “I guess there again maybe just more ways of promoting what is available to people to take advantage of,” she offered as a way of facilitating participation in physically active leisure. Overall, the theme of increasing awareness of the community’s already existing opportunities came up many times among participants as a way to facilitate physically active leisure participation.
While some participants mentioned that raising awareness about what opportunities are available may be a facilitator of physically active leisure, some participants also felt that education was needed to build community members’ knowledge about the benefits of physically active leisure and how to participate. To illustrate, Barbara, a health department administrator, said, “Oh yeah, the more information you have, the better you are, you know. The more times they get the message and the more opportunities they have to make healthy changes, [the better.]” This gets at a need to educate community members on how to be healthy, including through physically active leisure. Rudy, who is a member of Carington’s city parks and recreation department, echoed this idea of getting information out to residents on the importance of healthy leisure, including physical activity. “What we try to do here in this department [is] to get the word out, to get to people to explain to them and try and help them understand the importance of [physical activity] and the value, not only for themselves but for their family.” This gets at how crucial some participants felt it was to educate community members on physically active leisure, including its importance and value. This quote highlights the fact that participants felt that educating people and getting the word out would be key in getting people to perceive benefits to physically active leisure, which in turn would hopefully increase participation.

When asked what a program to promote healthy leisure in Carington might include, Holly, executive director of a community resource center offering counseling on mental health and substance abuse issues, said, “Probably educating the public about what are the benefits, the potential health benefits for people if they do participate in those kinds of activities.” Again, this shows how participants viewed educating community members on the health benefits of physically active leisure might facilitate participation.
Nicole, a Salvation Army worker, said something similar when asked about what a program to promote healthy leisure in Carington should be. “Make it to their benefit, […] ‘cause they’re not going to see the healthy lifestyle benefit from the beginning. That’s going to be something that’s going to have to be gradual.” This quote shows how some participants felt that educating community members on the benefits of participating in physically active leisure may help facilitate participation, since members may not necessarily see these benefits from the beginning on their own.

In the focus group held at the hospital, Louise pointed to potential health benefits that, once community members perceived them, might facilitate participation in physically active leisure. “I walk for exercise trying to lose weight,” she said. If community members were all to experience weight loss or other health benefits from physically active leisure, it may help facilitate continued participation. Thus, education aiming to bolster community members’ positive expectations about what health benefits may come out of participation could be a useful facilitator.

Similarly, some participants emphasized having the knowledge/skills to engage in physically active leisure could be useful facilitators that some community members currently lack. Pastor Carver described a lack of information within the community. “We’re not educating people, we’re not giving enough material to people to put in their hands to tell them about their health and how to live healthy. And I think that, again, I think that the religious community can be very helpful in that area.” Again, Pastor Carver shows that churches in Carington could promote health (including physically active leisure) through educating people and putting informational material in their hands.
When asked what needs are particularly important to address for Carginton’s racial/ethnic minority community members in terms of promoting healthy leisure, Michael, the director of social services at the local hospital, added to this idea that educating community members on how to be more active could function as a valuable facilitator.

I think information would be helpful. [...] Helping [people in the community] to identify ways that they can exercise and have preventative health without having to spend a lot of money on expensive equipment or maybe get a gym membership, that type of thing. Helping them understand how they can either exercise in their home or out in public areas without having to spend a lot of money.

Here Michael demonstrates the notion among participants that people just need to be coached on ways to engage in physically active leisure despite constraints they may face, such as limited monetary resources. This kind of education on the knowledge/skills required to be active could act as a powerful facilitator for physically active leisure in Carington.

Participants mentioned several negotiation strategies that could act as potentially powerful facilitators. This included personal planning, prioritizing, and cultivating a positive attitude. As far as personal planning was concerned, one strategy participants described involved doing their physically active leisure first thing in the morning. In the focus group held at the continuing education and job training center, Mary began:

Mary: If I don't do mine the first thing in the morning or within a reasonable time, I can't wait till the afternoon, or I can't wait until the evening—then I'm not going to do it.
Moderator: You need to do it first thing?
Mary: Yeah.
Gus: But doing it in the morning, it just makes you [tired] for the rest of the day.
Mary: Oh yeah.
Fran: Okay, like [Joe] said, you have to be disciplined. (Female: Sure!) You have to make it a priority in your life.
This exchange speaks to two strategies participants had of facilitating physically active leisure. One strategy involved planning to do it first thing in the morning; the other strategy involved making physical activity a priority in life.

Lynn, in the focus group held at the community agency in the mainly African American part of town, indicated another negotiation strategy. “There [are] a lot of things you can’t afford to participate in, but if you do the simple things, you know like walking, that may keep you healthy.” Lynn brings up the idea that many opportunities for physically active leisure can be free of cost, providing a way of negotiating constraints involving money.

Annette, who operates a group home for developmentally disabled kids and young adults, also suggested making physically active leisure a priority as a strategy of negotiating many of life’s constraints, including time, family obligations, and an attitude that physical activity must be done on expensive gym equipment.

I think so often people say ‘I’m so busy.’ I think they make physical activity the last […] priority; it’s the last thing on the list, you know. There are so many things you have to do, you have to go to work and you have to take care of your family, and you have to be at this meeting or that, and then when the day gets down to the last hour it’s time to wash a load of laundry or some other small minute thing that we can think of that we could be exercising instead of, you know, and we don’t necessarily have to go to the track to walk, you can walk around the block of your house, you know? You don’t have to go to the gym to do your sit-ups and ride a bike, you can do that at home, you can do that at the end of your bed or anywhere at home, you know. And I think now, I think we’re so geared to seeing equipment, we think […] there has to be equipment there for us and [if] there’s not a riding bike and weights to lift and that kind of thing, I don’t think we really think about exercise. I think that we’re just guilty of not putting it in its proper perspective.

In this quote, Annette gets at the power individuals have in their own lives to be physically active without a gym membership or equipment, without having to take a large amount of time out of schedules perceived as busy. All that she says is required is prioritizing physically active leisure, taking the time to think about when and how and where it can realistically be done even in the
face of an assortment of compelling constraints. Lynn (in her quote above) gets at this idea as well, citing walking as a simple activity that does not require a lot of money. In this way, prioritizing physically active leisure and including it in a planned schedule may help Carington to be more active and negotiate constraints to physically active leisure.

Fran, head of the job-skill training and continuing education center, also brought up the idea of prioritizing. “I think it’s the kind of hectic lifestyle we live these days. I think most people would like to make the time but feel other things take priority.” Again, Fran recognizes a certain failure to prioritize physically active leisure in Carington, and—conversely—that prioritizing physical activity facilitates participation. Thinking of physically active leisure as a priority could act as a negotiation strategy in the face of time constraints, as Fran mentions.

Another negotiation strategy that participants touched on was cultivating a positive attitude. Molly, a community leader involved with the foundation’s parks and the cultural society, said, “Because of the economic situation here, I think we need to just be a little more positive in our thinking. […] I think more just a positive approach on life.” This quote illustrates that some participants felt that optimism would facilitate participation in healthy leisure (like physically active leisure). Overall, participants indicated several negotiation strategies to help facilitate physically active leisure, such as planning, prioritizing, and cultivating a positive attitude.

Still, tantamount to participation in physically active leisure are facilitators like enjoyment, interest, and a sense of accomplishment. When asked about what a program to promote healthy leisure might be like in Carington, Nicole, who works for the Salvation Army, pointed to the necessity of it being interesting and fun to community members.
It needs to be something that will hold their interest. [...] I don’t think people are going to be interested in ‘Oh well come down here and learn how to walk’ or ‘Come down here and learn,’ it needs to be a variety of things, [...] a series of different things, and try to encourage the people that would not normally participate in that. [...] Make it fun, they’ll come. Make it interesting.

Here Nicole emphasizes the importance of fun in facilitating participation. Another key motivator Nicole cites is to offer activities that appeal to community members’ interests.

Angela, a community leader who works with an organization catering to the needs of older adults, also expounded on this idea, saying that a program to promote healthy leisure would need to be structured around community members’ interests.

That’s one of the things that I feel like is needed more in a lot of the areas, for them to actually have that structure that somebody actually is helping get all these different things together. They go by people’s interest also. Like they’ll ask them ‘What are some of the things you’re interested in?’ and kind of go by that as to what they plan and what they do. And I think that’s a very needed thing in a lot of the communities.

This quote shows that some participants saw potential in facilitating physically active leisure by specifically asking community members about their interests and structuring leisure programs around that.

Not only did participants emphasize the importance of fun and personal interest in facilitating physically active leisure, but some participants also touched on the idea of a sense of accomplishment acting as a facilitator. For example, Dave, an African American community leader who works at an agency assisting mostly low-income families with issues like housing, talked about how a lot of free time can be wasted. He went on to point out that getting something accomplished during free-time is valuable and adds to the enjoyment and pleasure people might get from leisure, ultimately acting in this way as a facilitator.

What are we doing with the time that we have outside of work, you know, are we really getting anything accomplished, you know? Are we sitting around the yard drinking a beer, are we watching TV or movies or whatever it might be. [...] I think time is pretty much wasted, a lot,
even though you might consider yourself to be too tired or too busy to do this or that. I think it’s just a matter of taking it and reaping the enjoyment, the pleasure from doing it.

Dave in this quote shows how community members might feel that leisure time not spent accomplishing something is wasted, and that reaping enjoyment and pleasure from leisure are benefits that could encourage people to participate despite constraints like perceiving oneself as too tired or busy. This shows how accomplishment, enjoyment and pleasure all might work as facilitators for physically active leisure among Carington residents.

In all, participants point to important facilitators of physically active leisure throughout the data, including organizational support, partnerships, promotion of available opportunities, education on the benefits of physically active leisure and the knowledge/skills to engage in it, negotiation strategies like planning, prioritizing, and cultivating a positive attitude, and finally, the primacy of enjoyment, interest, and a sense of personal accomplishment.

Thus, in terms of the aims of this study, participants helped to describe the current state of physically active leisure in Carington and to identify key constraints to and facilitators of physically active leisure that might be used in interventions. Descriptions of physically active leisure included that Carington offers a wide array of physically active leisure opportunities, though community members are currently not active enough and underutilize leisure resources. Participants indicated that community members are cognizant of the health benefits of physically active leisure, but that for some, further education on the benefits and on how to be active may be needed. In terms of constraints, lack of motivation, a sense among African American community members of being uncomfortable outside of the African American community, transportation, time, money, a lack of available opportunities, and family obligations were all important. Key facilitators included organizational support and partnerships, the promotion of
available opportunities for physically active leisure, and educating community members on the benefits and knowledge/skills of how to be active. Participants mentioned such negotiation strategies as planning, prioritizing, and cultivating a positive attitude. Perhaps most importantly, participants cited the power of basic enjoyment, interest, and sense of accomplishment for motivating people to participate in physically active leisure. This description along with these key constraints and facilitators are important results with potential to influence physically active leisure interventions.
Discussion

Physically Active Leisure Views, Constraints, and Facilitators

The current paper has identified several key views participants hold about physically active leisure and health in Carington, as well as constraining and facilitating factors influencing physically active leisure and health in the area.

Physically active leisure came up frequently in both interviews and focus groups, indicating the importance of physically active leisure’s role in health according to participants, who were asked about healthy leisure activities in general. In terms of participants’ views on physically active leisure in Carington, many cited opportunities for physically active leisure as widely available, in part through prominent organizations and facilities. These included the Carington Foundation Recreation Center and parks, the city parks and recreation department, churches, schools (e.g., the area community college, the high school track), sports fields, and the Carington Youth Center located in the predominantly African American part of town. That participants cited so many opportunities for physically active leisure in the area shows the potential to support physically active leisure in Carington.

Still, participants also indicated an underutilization of these physically active leisure resources, hinting at a lack of motivation among community members which many participants explicitly mentioned, or other constraints. Participants also cited a general insufficiency of physical activity among community members, showing the presence in Carington of the broader societal trend in physical inactivity, overweight, and obesity (Flegal et al., 2002; Hedley, 2004; USDHHS, 2001), which has been shown to be especially pronounced in rural and racial/ethnic minority populations (Parks et al., 2003; NCHS, 2009). The emergence of this view among participants may reflect community members’ awareness of the problem (Liebman et al., 2003).
Also supporting this idea is the fact that many participants noted that community members are largely aware of physically active leisure’s health benefits, but are still not active enough, pointing again to a lack of motivation or other constraints.

Though participants saw physical activity overall as insufficient among Carington community members, walking was the most common form of physically active leisure in which members did participate. Walking may represent a potential route for facilitating physically active leisure in this setting, in that many community members may already have interest in and feel confident about their ability to perform this activity.

Despite the awareness participants indicated of the problem of inactivity in Carington, some participants nonetheless thought that education on the benefits of physically active leisure and how to be active would be helpful for community members. It may be that participants were trying to guess as to why community members are not active enough. Reasons like a lack of education may or may not be true of community members in general. Participants as a whole indicated they were aware of the health benefits of physically active leisure and knew how to go about being active, but still struggled to do it. In other words, education on benefits and building the skills to be active would not hurt, but may be insufficient for increasing participation in physically active leisure, since many participants saw themselves as sufficiently educated and capable of being active. What some participants saw as lacking, ultimately, was motivation (e.g., Ferrand, Perrin, & Nasarre, 2008; McDonough, Sabiston, Sedgwick, & Crocker, 2010).

Constraints came up more than any other theme both in the interviews and focus groups, confirming other studies’ findings that rural populations may face greater constraints to healthy leisure than other populations (Wilcox et al., 2000; Hartley, 2004; Lutfiyya et al., 2007; Phillips & McLeroy, 2004; Brownson et al., 2000). Structural constraints came up the most often across
both interviews and focus groups. These included transportation, time, money, a perceived lack of opportunities, and a few others like safety and weather. Structural constraints are outside of one’s personal responsibility and thus citing them risks no personal blame for behavior seen as unhealthy. Perhaps due to the straightforward and somewhat uncontrollable nature of structural constraints, a greater number of these were enumerated by participants, even though Crawford, Jackson, and Godbey’s (1991) hierarchical model of leisure constraints places structural constraints last among the three categories of constraints in terms of influence on participation. The implication of the hierarchical model is that structural constraints may be the easiest to overcome or negotiate, so long as there is underlying motivation to engage in the leisure activity. Prior research supports this idea about the primacy of motivation in constraint negotiation (Loucks-Atkinson & Mannell, 2007; Son et al., 2008). As an example, if a woman loves to swim but finds it difficult to get transportation all the way across town to the nearest swimming pool, the fact that she loves the activity may provide sufficient motivation nevertheless to find a way to continue participating in swimming. The presence or absence of structural constraints does not represent how people feel about leisure activities; such constraints may be cited as excuses not to participate when motivation is lacking, but could largely be overcome when sufficient motivation exists (Loucks-Atkinson & Mannell, 2007; Son et al., 2008).

That said, perhaps certain populations in fact face greater constraints than others. In the focus groups held at the community agency in the primarily African American part of town and at the area agency on aging, constraints overall came up more often than in the other two focus groups. Structural constraints in particular came up more often in the focus groups held at the community agency in the primarily African American part of town and at the area agency on aging. Structural constraints were also especially high in three of the five interviews with African
American community leaders. These results suggest that African American and perhaps older adult participants may perceive greater constraints, especially structural constraints. There is support in the literature that rural populations may face greater structural constraints than urban populations, such as fewer sidewalks, streetlights, and less access to facilities, and that African Americans tend to have higher rates of sedentary behavior in rural populations (Wilcox et al., 2000). This suggests that rural African Americans may face greater constraints on top of those that are common across racial/ethnic groups in rural areas. The findings in this study point to potentially greater perceived constraints to physically active leisure among African American participants, and potentially older adults as well, though this pattern is less clear in the data. Older adult participants often cited deteriorating health and mobility as reasons why better infrastructure was needed (e.g., places to sit along trails; smoother, more even walking surfaces), perhaps explaining this finding.

Of the three categories of constraints (intrapersonal, interpersonal, and structural), intrapersonal constraints came up the second most frequently in the data. Perhaps the fact that intrapersonal constraints came up as often as they did despite their sometimes personal nature and the difficulty many people may have in articulating them indicates the crucial role intrapersonal constraints might play for physically active leisure in Carington. The hierarchical model of constraints (Crawford, Jackson, & Godbey, 1991) posits that intrapersonal constraints will have the most influence on participation out of the three categories of constraints. Participants spoke about a pervading lack of motivation for physically active leisure, and underlying that, hopelessness, lack of vision/inspiration, lack of self-esteem, lack of initiative, attitudes, lack of interest, and lack of knowledge/awareness.
Participants mentioned interpersonal constraints the least out of the three types of constraints. Participants may not have considered their obligations to others directly as constraints to physically active leisure, but rather as a free choice to be with, care for, or try to please those who are important to them. Family obligations, as cited by some participants, may take time and energy away from participating in physically active leisure, but such obligations are conceptualized first and foremost as their own valued way of spending leisure time. This is perhaps one reason why participants mentioned interpersonal constraints the least when talking about constraints to healthy leisure—spending time with and doing things for significant others is healthy leisure for many participants, though it may not always be active (Iwasaki & Mannell, 2000; Son, Yarnal, & Kerstetter, 2010). Future studies on leisure and health might investigate the underreporting of interpersonal constraints for this reason. This study’s finding that interpersonal constraints came up the least for participants is in contrast to Wilcox et al.’s (2000) results that care giving duties were the top personal barrier for the rural women in their study. It may be that the samples merely differ in terms of what was most important for participants, or it may be that this study contained a limitation in terms of the way questions were asked that caused an underreporting of interpersonal constraints.

Although facilitators came up less frequently in the data than constraints, they were still mentioned often in both interviews and focus groups. Participants saw organizational support through programs, services, and facilities as well as through partnerships as facilitators of physically active leisure in Carington. Some of the most important organizations participants cited were churches, which may provide a unique avenue through which interventions might target African American rural community members, who may be at a greater risk for leisure time physical inactivity (Probst, Moore, Glover, & Samuels, 2004; Wilcox et al., 2000) and are among
the most understudied and underserved populations nationwide (Wilcox et al., 2000; Mueller et al., 1999). Partnerships came up often among community leaders, but rarely among residents. This may indicate leaders’ recognition of the importance of partnerships for promoting healthy leisure, while residents may not yet feel personally responsible for initiating partnerships among community organizations. Focus groups that did bring up partnerships were those held at the community agency in the mainly African American part of town and the local agency on aging. This may indicate these subpopulations’ (African American and older adult) distinct awareness of the ability for community organizations to facilitate physically active leisure by alleviating some of the relatively higher constraints they may face.

Another facilitator that participants cited included promotion of available physically active leisure opportunities, since many participants felt that opportunities were indeed widely available in Carington but being underutilized. Participants also noted that education on physically active leisure benefits and how to be active could facilitate participation. Participants also provided strategies to negotiate constraints. These strategies included planning, prioritizing, and cultivating a positive attitude. Perhaps most importantly, participants pointed to fun, enjoyment, interest, and a sense of personal accomplishment as key facilitators of physically active leisure. These findings are consistent with previous research (e.g. Ferrand et al., 2008; McDonough et al., 2010) that found these intrinsic motivators to be crucial to participation. The major implications of all facilitators that participants spoke about are that these concepts may be incorporated into physically active leisure interventions to improve health and well-being in Carington.

Since some participants may have perceived greater constraints and/or may have recognized that some community members may face greater constraints than others, many
participants may have concluded that organizational support is needed to remove structural constraints and allow access to recreation resources. However, the fact that intrapersonal constraints and facilitators like fun, enjoyment, interest, and a sense of accomplishment figured so prominently in the data, together with the fact that many participants who indicated an awareness of the health benefits of physically active leisure and the wide availability of physically active leisure opportunities still struggled with being active themselves, suggests that the removal of structural constraints may not be enough to increase participation. The key to increasing participation in Carington seems to be through increasing motivation, in part through increasing the enjoyment, fun, pleasure, interest, and sense of accomplishment participants get through engaging in physically active leisure.

The hierarchical model of constraints (Crawford, Jackson, & Godbey, 1991) predicts the preeminence of intrapersonal constraints in influencing leisure participation. Studies have shown the critical role of motivation in predicting participation in physically active leisure, in part (if not entirely) through its influence on constraint negotiation (Loucks-Atkinson & Mannell, 2007; Son et al., 2008). Self-efficacy is an important factor, if not the crux in influencing motivation, because self-efficacy can be modified through interventions (Bandura, 2004). Many studies have shown that self-efficacy predicts participation in physical activity (Beets et al., 2007; Martin et al., 2008; Orsega-Smith et al., 2007; Sallis & Owen, 1999; Sharma et al., 2005; Von Ah et al., 2004; Wallace et al., 2000; Wilcox et al., 2002; Wilcox et al., 2006; Zizzi et al., 2006), including Loucks-Atkinson and Mannell’s (2007) study that showed the powerful link between high self-efficacy for constraint negotiation, high motivation for constraint negotiation, and participation despite constraints. A study by Son, Mowen, and Kerstetter (2008) supported the assertion that motivation affects participation through its influence on negotiation, and that constraints can be
entirely offset by negotiation strategies. Thus, while decreasing constraints would probably not hurt participation, such steps may not be effective in increasing it. *The key factor is increasing motivation* (in part through increasing self-efficacy and enjoyment) for both physically active leisure *and for* negotiating constraints to physically active leisure *so that community members will participate despite constraints.*

**Physically Active Leisure Intervention Strategies**

Given these findings, how do leisure and health researchers and programmers design interventions that will be effective in this racially diverse rural population and similar settings? Bandura (2004) has provided a guide based in social cognitive theory. Health behavior interventions based on social cognitive models have been shown to be more effective than interventions developed without a basis in theory (Abraham & Sheeran, 2000). Relevant to the current study, one strategy might be to apply themes that arose from the data along with salient constructs of social cognitive theory in order to better inform potential theory-based interventions hoping to promote physically active leisure in a rural adult population, including considerations for racial minorities.

Important to note is that Bandura (2004) theorizes that individuals will perceive sociocultural impediments and facilitators (i.e. structural constraints and “structural” facilitators) differently based on their self-efficacy for the behavior in question. Thus, bolstering self-efficacy for physical activity may have an impact on how individuals view what structural constraints and facilitators exist to physically active leisure, in addition to increasing motivation. As follows, participants in this study who perceived greater constraints might perceive fewer constraints if they had higher levels of self-efficacy for constraint negotiation and for physical activity. Self-efficacy is perhaps the most important construct that social cognitive theory proposes will
influence behavior, because its influence is theorized to be both direct and indirect, through the perception of sociocultural impediments/facilitators, outcome expectations, and goals (Bandura, 2004). This underscores the importance of increasing self-efficacy as a strategy for interventions to employ.

However, for maximum effect, it would be best to address all constructs the theory proposes to increase participation in healthy behaviors like physically active leisure. These constructs include self-efficacy, sociostructural impediments (i.e. constraints) and facilitators, goals (both proximal and distal), and outcome expectations (physical, social, and self-evaluative). Thus, a comprehensive intervention based on social cognitive theory would address all of these, by doing the following: bolstering participants’ self-efficacy for physical activity and for constraint negotiation; helping participants to address the constraints they face through developing negotiation strategies and/or by actually changing what constraints exist; helping participants to utilize the facilitators available to them and also potentially helping to create new ones; guiding participants to set specific long- and short-term physical activity goals; and coaching participants on envisioning realistic positive outcomes (physical, social, and self-evaluative) for participating in physical activity. Results from this study show the importance of making physically active leisure fun, interesting, enjoyable, and rewarding for participants as well, since this will directly influence how motivated they are to engage in the behavior.

Bandura (2004) also suggests that interventions tailor their methods to individuals’ levels of initial self-efficacy, by dividing participants into three groups based on self-efficacy levels: high, medium, or low. In this “three-fold stepwise implementation model” (Bandura, 2004), minimal guidance is given to those with high efficacy, more guidance (perhaps through print and by phone) to those with medium levels, and the most guidance (face-to-face where possible)
given to those with low levels of self-efficacy. This way, interventions are tailored to address the level of difficulty participants believe they can surmount, and increase in difficulty as they progress to give them mastery experiences, a sense of personal accomplishment, and higher self-efficacy in order, ultimately, to increase motivation and participation.

Bandura (2004) outlined the ways in which social cognitive theory could be applied for use in health promotion interventions. He allowed that community health campaigns can help bolster individual self-efficacy, combining with pre-intervention self-efficacy levels to increase likelihood of engaging in the behavior. However, this sort of “one-way mass communication” (Bandura, 2004, p. 149) is limited by a lack of interaction and individualization, while always being secondary to “socially mediated pathways” (p. 150) of behavior influence (comprised of the communication path media messages take through social networks and community settings). In other words, mass marketing campaigns will be less effective than community-based programs where individuals’ personal social networks are involved. Thus, in Carington, it is important to utilize existing community organizations and leaders to help set up community-based physically active leisure programs (Ashe et al., 2009).

In order for interactive, individually-tailored interventions to be effective, Bandura (2004) stressed, it is necessary to target known social cognitive determinants of physical activity (i.e. the constructs of social cognitive theory). Furthermore, social support that is appropriate for building participants’ self-efficacy for physically active leisure is important for optimally effective interventions to include. In other words, program directors should take care to foster a supportive and encouraging social environment where participants can build confidence in their abilities. The present study has pointed to the potential for community organizations, such as
churches and recreation organizations, to provide social environments that are particularly conducive to supporting physically active leisure in local communities.

As a convenient way of administering a health-promoting intervention, Bandura (2004) has suggested an interactive computer-based program that provides participants feedback based on their level of self-efficacy, the particular constraints they face, and the degree of progress they make. He emphasizes that such a program would need to motivate participants and help them gain self-regulatory skills through having them “learn to monitor their health behavior and the circumstances under which it occurs, and how to use proximal goals to motivate themselves and guide their behavior. They also need to learn how to create incentives for themselves and to enlist social supports to sustain their efforts,” (Bandrua, 2004, p. 151). These are all skills that program implementers can help participants achieve. In Carington, organizations like the center for job skills training and continuing education may be able to design an online physical activity intervention which could additionally benefit community members through computer skills training.

Bandura has also recommended using the self-regulatory delivery system developed by DeBusk and others (1994). This involves a health care setting with a physician and program implementer being in touch about a patient, who has access to a computerized system (set up by the program implementer and having both a database and the self-regulatory programs). The patient sends progress reports to the program implementer, who in turn is in touch with the patient via the telephone. There are a few drawbacks to this system. First, requiring “patients” to go through a health care provider requires that they have access to affordable health care, which many rural adults do not, in particular rural minorities (Eberhardt et al., 2001; Parks et al., 2003; Probst et al., 2004; NCHS, 2009). Second, this requirement also increases the likelihood that
people receiving this intervention will first have to be sick. Someone may only get a “prescription” to use this type of intervention once a physician is already treating them for disease, rather than the intervention being available to as many people as possible to prevent disease in the first place. Third, requiring a health care setting is not necessary and excludes other potential settings that could transform health in the community. Leisure settings are ideal for this purpose, as many studies already show the link between leisure and health promotion (Ainsworth et al., 2007; Chia-Yih et al., 2010; Godbey et al., 2005; Iwasaki et al., 2001; Son et al., 2009). Thus, recreation professionals could be trained in administering the sort of tailored, computerized self-regulatory programs that Bandura describes in addition to the traditional facility-based physically active leisure programs typically offered. Plus, recreation professionals are in a better position than anyone else in the community to coordinate groups of people all wishing to engage in physically active leisure to better their health. Partnerships between such recreation professionals and health care providers would be ideal, but people should not have to wait for their doctor to suggest an intervention before they are able to engage in a program to help them change their health behavior if they so desire. The results of this study point to the important role lay health advocates might have for public health through guiding physically active leisure intervention programs.

In the light of data revealed by the current study, the above intervention techniques might be applied in the following ways. Since participants have identified the views, constraints, and facilitators of this particular population, an intervention can be tailored to best meet those needs. Interventions could draw on and expand participants’ knowledge that physically active leisure is good for health and that they may not be active enough currently. Interventions could be designed specifically to address the constraints identified by participants, including most
importantly a lack of motivation overall. This may be addressed through mastery experiences designed to boost self-efficacy, as discussed above. Also important to address are any feelings of uneasiness African American community members may have about seeking leisure resources outside of the African American community. This could include offering physically active leisure options perceived by African American community members as more appealing and striving for a diverse workforce at leisure organizations. Additionally, programs could be offered through African American church organizations. Obligations to family might be partially addressed through intergenerational activities. Interventions should still address structural constraints by providing affordable programs available to all community members and making sure participants have adequate transportation or do not need transportation in order to participate in interventions. Alerting community members to the availability of programs and how to participate is also key. Time constraints could be addressed in part by helping participants to plan and schedule when, where, and how they will participate in physically active leisure and still honor their other priorities and commitments. This speaks to the negotiation strategies that participants suggested might help facilitate physically active leisure in Carington, including planning, prioritizing, and cultivating a positive attitude.

Finally, by pointing to facilitators of physically active leisure, participants have shown exactly what they believe will help facilitate physically active leisure in Carington. Existing organizations within the community are currently helping facilitate physically active leisure and potentially could expand that encouragement. Organizations (for example, churches, as participants noted most prominently) could act as centers for distributing information on physical activity, including benefits, and its local availability (e.g., a “how to be active in Carington” pamphlet and/or website). Local organizations could and do provide their facilities for use by the
public to promote physically active leisure; they could help form groups of people who participate in physical activity together and offer encouragement (ultimately helping to build each participants’ motivation for the activity); and they can form partnerships to coordinate intervention efforts and share resources. Perhaps the most crucial facilitating factors participants pointed out are enjoyment, interest, and a sense of personal accomplishment. An effective intervention would take into account participants’ interests and help them achieve important behavior goals, thereby providing them with a sense of personal accomplishment.

In order to bolster participants’ self-efficacy for physical activity and for negotiating constraints to physical activity, and following Bandura’s aforementioned tiered approach, a program might include methods of practicing physical activity in ways that are initially quite easy and which become increasingly difficult, thus giving participants the chance to achieve mastery at each of the different levels. Participants then have experiences to draw on that prove their capability. This sort of practice may also decrease the constraints participants perceive or increase perceived facilitators, involves setting goals suited to the level of difficulty undertaken, and hopefully will begin to show what positive outcomes (physical, social, and self-evaluative) participants can expect from continued participation in physically active leisure.

Ultimately, it is worth investigating views, facilitators, and constraints before attempting to tailor physical activity interventions in order to best match intervention strategies with the needs of the specific community (Bandura, 2004; Phillips & McLeod, 2004; Wilcox et al., 2000). Inquiries could use information about participants’ views, constraints, and facilitators in order to promote physically active leisure participation in several key ways. First, a successful intervention would bolster participants’ self-efficacy for physical activity and for constraint negotiation in order to increase motivation. Second, it would help participants to address the
constraints they face by developing negotiation strategies and/or by changing what constraints exist. Third, a successful intervention would help participants utilize the facilitators available to them while also potentially helping to create new ones. Fourth, it would guide participants to set specific long- and short-term physical activity goals, and fifth, a successful intervention would coach participants on envisioning positive outcomes (physical, social, and self-evaluative) for participating in physical activity. Finally, and perhaps most importantly, information gathered on participants’ interests could help interventions to make physically active leisure programs fun and enjoyable, most directly motivating community members to participate.

For Carington in particular, one idea comes to the fore for a physically active leisure intervention based in social cognitive theory and the data presented in this study. For example, because churches emerged as potential facilitators of physically active leisure, church organizations represent one starting point for an intervention. Also, walking emerged in the data as something community members currently participate in with relative frequency, and therefore probably enjoy and/or find easy to do. One idea would be for churches to offer “walking hour” after Sunday morning services (instead of coffee hour which many churches have as a way for their congregations to mingle, offering coffee and snacks after services). Specified routes through free community parks could be followed, and multiple generations could participate free of cost. The only transportation required would be getting to and from church, something the congregations would be doing already anyway. Through church organizations, African American community members could be reached, as well as the wider community at large. “Walking hour” programs could offer different levels of difficulty in the walks they do, perhaps even working toward “jogging hour.” The easiest level would be a short stroll, working up to a longer brisk walk, then perhaps intervals of jogging and walking, and finally a jog. Churches could partner
with each other and other organizations for the weekly events, and form groups to meet and go walking and/or jogging on other days of the week as well. These would not have to be tied to church activities, but they could be, having (for example) Bible study at a local park after walking there together and then walking back afterward. One way the program might be fun is through fostering friendships and social interaction on the walks. Another strategy for making it fun, enjoyable, and interesting might be to make the program a game, for instance by having similar ability-level groups keep track of steps taken with pedometers or distance traveled by local landmarks and trying to be the group with the most steps or distance. These could even be used as church fundraisers as many organizations do already, having community members sponsor one another in a 5-kilometer or other race once or twice a year. Of course, “walking hour” is only one idea, but results from this study point to many ways in which programs might address physically active leisure needs in Carington and similar settings.

**Future Directions**

As with many qualitative studies, the current paper focuses on a nonrandomly-selected sample that may not be representative of the population at large. It is impossible to generalize from the results of this study that all rural adults in America feel the same way as those who participated in this study’s interviews and focus groups. That said, the richness and depth of information gleaned from the personal interviews and focus groups shed light on a particularly understudied and underserved population. This sort of investigative, descriptive information is necessary for understanding and best serving underserved communities for which existing interventions were not designed. Now that this study has identified potentially important determinants of physically active leisure in a population of racially diverse rural adults, future research might use larger samples and quantitative methods to confirm the importance of these
factors in similar settings and in the greater population of rural adults. The results of the current study indicate that such studies should take care to allow for the particular needs of minority subpopulations in rural areas.

Another potential limitation in this study has to do with the script of interview questions. The data examined in this study were drawn from a larger project with a broader scope not necessarily focusing on physically active leisure, and therefore, even though focus group participants were specifically asked about their physically active leisure, interviewees were not. More relevant and possibly revealing information may have come out of the interviews if questions had been included specifically pertaining to physically active leisure. Future studies on leisure and health might take care to ask about specific domains of healthy leisure (such as physical, social, and spiritual, a feature the focus group script in this study did include).

Fitting with the pattern of African American participants facing greater constraints, participants indicated an additional intrapersonal constraint that African Americans in Carington might face on top of the others, which was feeling uncomfortable or unwelcome outside of the African American community. More research is needed to confirm this finding, though previous studies have suggested that rural African Americans may face greater constraints to healthy leisure overall when compared to urban/suburban populations and White community members (Brownson et al., 2000; Wilcox, et al., 2000).

Additionally, future research might look at integrating community organizational facilitation (including through partnerships) specifically into social cognitive theory. As the theory currently stands, such a concept would fit nicely into the sociostructural impediments/facilitators construct. The theory overall focuses mainly on individual-level factors, and it could open new avenues for interventions to pursue if future studies fleshed out the community-level
factors a bit more in social cognitive theory. This study points to a starting place for such research in community-level organizational facilitation (or potential facilitation) of physically active leisure.

The most promising direction for future research involves actually implementing an intervention such as Bandura (2004) described and tracking its effectiveness over a length of time. Further investigative studies would need to be done with different populations in order to best tailor interventions to those settings. In racially diverse, rural settings, this study may have pointed to important views, constraints, and facilitators affecting this understudied and underserved population.

The future of physically active leisure and health in Carington is unclear. Still, this study has helped to uncover participants’ fundamental views on physically active leisure and health, and offers results that are crucial for informing potential interventions, particularly through increasing motivation for physically active leisure and for constraint negotiation. Participants pointed to specific constraints such interventions must address and specific facilitators on which such interventions might draw. Ultimately, coupling this information with a social cognitive theory-based approach offers great promise for the development of effective, health-promoting, physically active leisure interventions in a racially diverse, rural adult population on which little research has focused thus far.
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Appendix A

Semi-Structured Interview Guide, Carington Project

[Introductory script, including the purpose of the interview, which is to seek input to help guide the other phases of the research project.]

1. What resources does your community have to promote the health and well-being of its residents?
   a. Are there any community resources that are particularly helpful in promoting the health and well-being of racial/ethnic minority residents?

2. What do you feel are your community’s needs in terms of improving residents’ health and well-being?
   a. Are there any needs that you feel are particularly important for racial/ethnic minority residents to help them improve their health and well-being?

[Explain the common definition of leisure, describe the broad domains of leisure-based self-care, and provide some examples of healthy leisure behaviors. Then ask:]

3. What are some healthy leisure behaviors that you feel residents do not participate enough in?
   a. Are there barriers that keep people from engaging in healthy leisure activities?
   b. Do you feel that there is a need to provide education or a program to try to increase participation in healthy leisure behaviors?

4. Would it be useful for our research group to work with your community’s organizations to provide a health education or health promotion program that focuses on improving residents’ healthy leisure behaviors?
   a. If that program could be anything, what would you want it to look like?
   b. What organizations would you recommend that we contact for possible partnerships?
Appendix B

Focus Group Questioning Route, Carington Project

Introduction:

1. Participant and researcher introductions and establishment of ground rules (e.g., each person will get a turn to respond to questions, try not to interrupt others, etc.).

Opening Question:

I would like each of you to take turns answering the following question:

1. What is your favorite free-time, leisure activity?

Introductory Question:

1. What does it mean to you for a person to be in good health?

Transition Question:

1. Thinking back to your favorite free-time leisure activity, do you feel that this activity keeps you in good health?

Key Questions:

1. What physical activities do you participate in regularly during your free time that you feel keep you healthy?
   1a. Can you tell me more about how they keep you healthy? [Probe]
   1b. What challenges do you face in doing these physical activities?
   1c. What strategies do you use to overcome these obstacles?

2. What social leisure activities do you participate in regularly that you feel keep you healthy?
   2a. How so? Can you tell me more about that? [Probes]
   2b. What challenges do you face in participating in these social activities?
   2c. What strategies do you use to overcome these obstacles?

3. What are the spiritual activities you participate in regularly during your free time that you feel keep you healthy?
   3a. How are these activities beneficial to your health? [Probe]
   3b. What challenges do you face in doing these spiritual activities?
   3c. What strategies do you use to overcome these obstacles?
4. Are there any other leisure activities other than the physical, social and spiritual activities you already mentioned that you feel keep you healthy?
   4a. How are these activities beneficial to your health? [Probe]
   4b. What challenges do you face in doing these activities?
   4c. What strategies do you use to overcome these obstacles?

5. Are some leisure activities more important than others in keeping you healthy?

6. Compared to visiting the doctor, taking medications, and other medical treatments, how important would you say leisure activities are in keeping you healthy?

7. Are there any physical, social and/or spiritual leisure activities that you would like to participate in that you don’t?
   7a. What are they? Why don’t you? [Probes]

8. Have any of you recently started a physical, social and/or spiritual leisure activity that you’ve either never done before or that you had stopped doing for awhile?
   8a. What led you to start this(these) new activity(ies)?

9. What are the community organizations that help you keep doing the healthy leisure activities you enjoy?

10. If you could design a program to improve your community’s health and well-being, what would that program look like?
    10a. What types of activities would you like to have in your program(event)?

Ending Questions

1. Of all the issues we’ve discussed today, which one is most important to you?
2. [Summarize key themes and findings for participants to ensure accuracy of interpretations. Then ask:]
   2a. Is this an adequate summary?
   2b. Is there anything we should have talked about but didn’t?

Thank individuals for participating.