

Sedentary behaviour change: barriers and strategies reported by individuals with type 2 diabetes during a multi-component intervention

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Abstract

Introduction Engaging in high volumes of sedentary behaviour increases the risk of adverse health outcomes, especially for individuals with Type 2 diabetes mellitus (T2DM). Understanding likely influences on behaviour and effective strategies for reducing sedentary time, as explored in this study, can inform future intervention development and implementation.

Methods A randomised controlled feasibility trial was undertaken to evaluate a remotely delivered sedentary behaviour intervention in adults with T2DM. As part of the process evaluation, intervention participants (n = 35) were asked to report the barriers they experienced, and strategies adopted, in their efforts to reduce sitting time.

Results Using template analysis, 44 statements of barriers (from n = 18) and 99 statements of attempted behaviour change strategies (from n = 17) from two time periods were analysed. Themes were similar across 3- and 6-month data for barriers [fatigue/sleep (e.g., feeling drowsy), disability/health, work-related (e.g., work tasks and facilities), and context (social or environmental contextual barriers)]. The themes for strategies reflected behaviours associated with ways to break up sitting, increasing incidental physical activity, and adding in purposeful physical activity.

Conclusions Barriers reflected various individual and contextual factors, while change strategies centred on breaking up sitting through substitution of other behaviours and the use of different types of physical activity. Such information may prove useful in future interventions to reduce sedentary behaviour.

Keywords Barriers · Behaviour change · Diabetes · Sedentary behaviour · Physical activity · Intervention strategies

Introduction

Sedentary behaviour is defined as any behaviour during waking hours that comprises low energy sitting, reclining or lying [1]. This is typically referred to as ‘sitting’ or ‘sitting time’, but not involving active forms of sitting such as seated exercise or wheeling, nor conventional sleep time. Higher volumes of sedentary behaviour

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in individuals with Type 2 diabetes mellitus (T2DM) are adversely associated with a number of health outcomes, including poorer cardiometabolic health, increased glycaemia, and depression [e.g. [2, 3]. One strategy to improve cardiometabolic biomarkers in those with T2DM and impaired glycaemia is to break up sitting regularly with standing or light physical activity [4, 5]. Recommendations for managing T2DM, therefore, include reducing and breaking up sedentary behaviour [6].

The REGulate your Sitting Time (RESIT) intervention was developed to support individuals with T2DM to reduce and break up sitting. A randomised controlled feasibility trial was undertaken to assess the feasibility and acceptability of delivering and evaluating the RESIT intervention in ambulatory individuals living with T2DM. The intervention was acceptable to participants and promising for reducing daily and prolonged sitting, and improving health and wellbeing [8].

Documenting barriers and strategies is important for identifying how people with T2DM in the intervention managed their sedentary behaviour. This will provide insights for future intervention development and implementation and is the focus of the present paper.

Methods

Study design

The methods and core findings of the randomised controlled feasibility trial are described fully elsewhere [7, 8]. In brief, participants were ambulatory individuals with T2DM who were individually randomised to the intervention (RESIT, designed to reduce sitting throughout the waking day) or control (usual care) conditions for six months. The intervention was delivered remotely and included an interactive online education session, health coach support, and choice of wearables, smartphone apps, and computer software that supported self-monitoring of sitting, feedback and prompts to break up periods of sedentary behaviour.

A process evaluation was undertaken using a mixed-methods approach. Process evaluation data were collected via questionnaires from study participants. Semi-structured individual interviews were completed with intervention and control participants, and health coaches who delivered 1-to-1 sessions as part of the RESIT intervention package. For the purposes of the current paper, only data from intervention participants concerning perceived barriers and strategies for sedentary behaviour change are reported. For context, process evaluation showed that 82% reported fully completing the online education and most agreed that it was understandable, useful, and motivating. Most participants (86%) reported using the technology support offered at 3 months.

Ethical approval for the study was granted by the West of Scotland National Health Services Research Ethics Committee (reference 20/WS/0080). Informed consent was provided by each participant.

Data collection

Questionnaires

Process evaluation questionnaires were completed at 3-months and again at the end of the intervention at 6-months. These included open-ended questions whereby participants were asked to “list any barriers that you have or are experiencing when it comes to trying to reduce your sitting time”. In addition, participants were asked to “list all of the strategies you have used to sit less at work and/or at home (e.g., stand during TV adverts)”.

Data analysis

Open-ended responses on the questionnaires concerning barriers and strategies were grouped into coherent themes using Template Analysis [10]. Each reported statement was entered into MindGenius (V20; MindGenius,

Glasgow) and grouped by themes and sub-themes. This was performed separately for barriers and strategies at each the 3- and 6-month time points. An open inductive approach was used in preference to a deductive approach with a known framework.

Results and discussion

The intervention participants ($n = 35$) were aged 60 ± 11 years, 49% of the sample were female, 60% were of Black, Asian and minority ethnicity, and 40% were of White ethnicity. There were 34% of participants in full-time work, 11% in part-time work, 40% were retired, with the remaining participants being disabled (6%), students (6%) or unemployed (3%).

Barriers

At 3 months, 17 participants wrote single or multiple responses to the barriers they perceived in reducing their sitting time during the intervention, and 18 provided responses at 6 months. There were 24 separate statements provided at 3 months and 20 at 6 months. No discernible differences in themes were detected at 3- and 6-months. Figure 1 shows the main themes for barriers across the two time periods: fatigue/sleep, disability/health, work-related, and context. Details of individual responses are provided in Supplementary Tables 1 and 2. Responses across the two time periods are essentially from the same participants.

Comments were made concerning barriers to sitting less at work. Structural constraints were noted, such as having a busy workday and working long hours. Other remarks were in reference to work tasks and facilities. For example, it was mentioned that working from home was a barrier [11] and this was in reference to not possessing a sit-to-stand desk, while another participant mentioned that they were sitting for long periods in meetings. Equally, there are strong social constraints and expectations at work that pose challenges to reducing sitting in the work environment [12]. These barriers can be addressed through social and environmental changes as identified by participants in the present study (see [Strategies](#)).

Previous studies have identified a range of barriers to reducing sitting in the workplace, such as limited knowledge, forgetting to break up sitting, physical health, social norms, heavy workloads, and lack of motivation [13]. There has been limited exploration of barriers to reducing sitting during participation in interventions. Process evaluations of multicomponent workplace interventions to reduce sitting in office workers have identified musculoskeletal, office environment/culture, workload, and ergonomic issues as barriers to behaviour change [14, 15]. Findings from the present intervention provide broadly consistent high-level themes, but we have identified more detailed barriers and strategies than previous research. These findings will help to better inform future intervention development and delivery within office workplaces.

There is an implicit assumption in sedentary behaviour intervention studies that all participants can change their behaviour with appropriate social, psychological, and environmental approaches. However, our data highlight a significant number of statements made by participants identifying health-related barriers. One theme concerned fatigue and sleep, with statements made about exhaustion, tiredness from work, lack of sleep, and feeling drowsy—all were identified as barriers to reducing sitting. Alongside these statements were those made

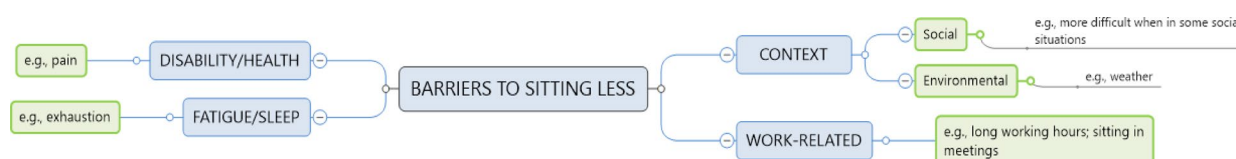


Fig. 1 Barriers to reducing and breaking up sitting identified at 3 and 6 months

concerning health and disability, such as pain, disability, and injury that may be more prevalent in individuals with T2DM than the general population. These novel findings emphasise the importance of identifying underlying characteristics of participants and adapting interventions to facilitate more inclusive strategies and support. This study also demonstrates, for the first time, barriers that overlap across themes, such as fatigue at work ('work related') and general exhaustion ('fatigue/sleep').

Participants made some important statements about barriers that are depicted by the theme 'context'; these are clustered around social or environmental contextual barriers. This has been identified in prior research in different settings, such as the workplace [12].

Social barriers included those driven by the social context, such as difficulty breaking up sitting when visiting friends or out socialising (where not sitting is seen as socially inappropriate). Time of day was also important, with participants finding it more difficult to reduce sitting in the evening, which may relate to behavioural routine or the feeling of tiredness already identified. These temporal and social barriers to reducing sedentary time should be considered within intervention designs to yield even greater behavioural changes. Targeting certain times of the day may be more appropriate than general messages regarding reductions in sitting across the day. Addressing underlying causes of fatigue (e.g., poor sleep, work patterns and demands) should also be considered to maximise behavioural change.

The main environmental contextual barrier identified was the weather as this affected participant's ability to substitute indoor sedentary behaviours for active behaviours outside of the home. Given the vagaries of the British weather, statements concerning negative influences referred to different types of weather, such as being too wet, or too hot, therefore preventing time outside where participants would be less sedentary and more active. The weather has been identified as a barrier to reducing sedentary behaviour in previous research, supporting the findings from the RESIT intervention [16]. The COVID-19 pandemic was also identified (this study took place during periods of community infection and lockdowns) whereby there was a fear of venturing outside, hence more time was likely to be sedentary inside the home. Thus, it may be important for interventions to support individuals with strategies for reducing sedentary behaviour in the home to enable successful behaviour change during periods of bad weather or home confinement (see [Strategies](#)).

Strategies

At 3 months, 17 participants provided single or multiple responses to the strategies they adopted for reducing sitting, and 15 provided responses at 6 months. There were 62 separate statements provided at 3 months and 37 at 6 months. Small differences were detected between 3- and 6-month data in the themes, particularly in relation to work context. Figures 2 and 3 show the main themes for the strategies adopted across the two time periods. Details of individual responses are provided in Supplementary Tables 3 and 4. As for barriers, responses across the two time periods are essentially from the same participants.

For 3- and 6-month data, home-related strategies referred to both sitting and physical activity. There were many responses concerning reducing or breaking up sitting, including the use of standing tasks and home-based activities (e.g., being in the garden)—essentially replacement behaviours for sedentary sitting. Common standing tasks included use of a smartphone to text or speak, hobbies (e.g., jigsaws), or remembering or intending to stand more. There were also comments reflecting the use of certain prompts or reminders. The latter could be an alarm set on a smartphone that prompted less sitting or, similarly, aim for standing every 30 min. Prompts/cues were used, such as breaking up sitting during TV advert/commercial breaks or purchasing a sit-to-stand desk to remind and prompt periodic changes in posture. These responses show that prompts and reminders can take the form of technologically driven change agents, or those related more to behaviours and environmental cues. These answers suggest that using cues and prompts is a useful strategy, particularly given that sedentary behaviour is often habitual [17].

In addition, participants provided many strategies that focused on movement. While some studies have shown that physical activity only partially attenuates the deleterious effects of sedentary behaviour on health outcomes

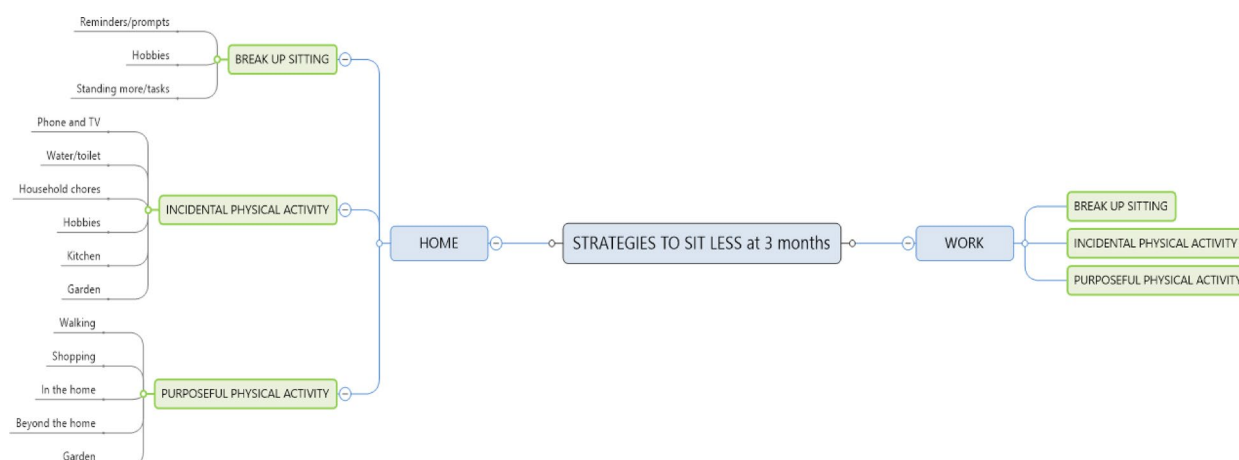


Fig. 2 Strategies for reducing and breaking up sitting identified at 3 months

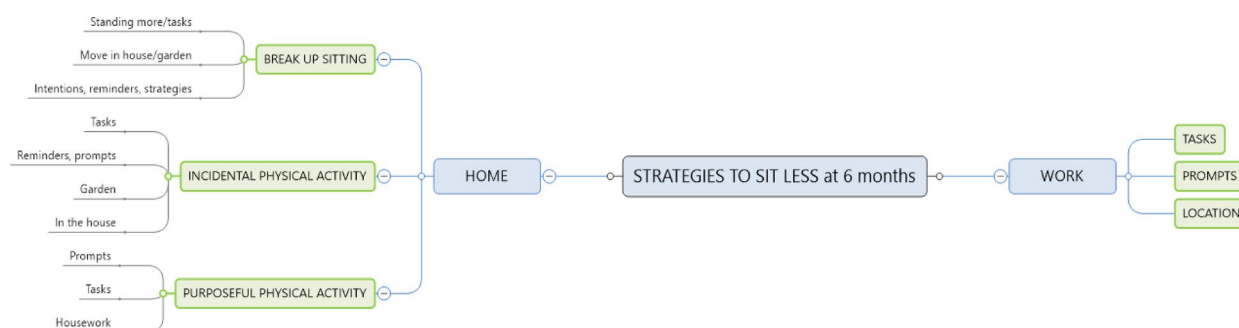


Fig. 3 Strategies for reducing and breaking up sitting identified at 6 months

[18], other evidence demonstrates that higher levels of moderate-to-vigorous physical activity (MVPA) can significantly decrease the risk of chronic disease and mortality in individuals with high levels of sedentary time [19, 20]. Physical activity, therefore, is an important behaviour to promote alongside reducing sedentary behaviour. This is consistent with the 24-h model of movement behaviour where time spent in, say, sedentary behaviour, could detract from time spent in MVPA, at least over a defined 24-h period [21]. Equally, sedentary time may be increased at the expense of sleep, which would not be recommended. It is important, therefore, to understand if and how participants attempting to reduce sedentary behaviour use physical activity within their strategies. In this context, the present study identified two main types of physical activity that were utilised: incidental and purposeful. There is likely some overlap between the two and the distinction is not exact, but these themes provide useful information and possibilities for behaviour change.

Incidental physical activity tended to be activity associated with another task, whereas purposeful activity was where the main intention was to be physically active.

Responses concerning incidental physical activity, similar to the theme of breaking up sitting, concerned the use of prompts (e.g., TV adverts), as well as adopting some active tasks. Essentially, the movement was incidental and less purposeful and planned. This included time in the garden, moving about the house, and walking during phone calls. The duration and intensity of such activities are likely to be quite low, but somewhat variable.

Purposeful physical activity involved planned walks, use of technology to prompt specific activities, setting up a small gym in the house, using the stairs more frequently, and trying to walk more often to the shops. In all cases, physical activity was the substitute for sitting, whether the choice reflected less conscious decision making (incidental) or was more planned (purposeful). As stated, the line between incidental and purposeful activity

behaviours is somewhat blurred and we would need information on participants' motives to be more precise with this distinction.

Participants showed that movement can be part of their strategy to be less sedentary, although significant increases in physical activity duration and intensity were not easily identified. Most activities reflected low intensity behaviours that could fit into daily routines without too much difficulty. These findings demonstrate an important role for both incidental and purposeful physical activity in reducing sedentary behaviour and should be a focus for future interventions. For example, some researchers advocate short bouts of physical activity throughout the day—these would be seen as 'purposeful'—to not only break up sedentary time, but also to provide a health stimulus through physical activity [22, 23]. It has also been suggested that greater intensity of activity should be prompted through daily tasks [24]. Moreover, it is contested as to how much effect mere standing will have on health rather than more overt physical activity [19, 25]. Embedding behaviour change strategies to support incidental and purposeful physical activity should be encouraged to support reductions in sedentary behaviour.

Strategies emanating from the work context showed some differences between the 3- and 6-month data. At 3 months, work-based strategies included the use of incidental and purposeful physical activity. Examples of incidental movement included obtaining a wireless headset enabling standing and moving during online meetings or phone calls, walking to see colleagues rather than email or phone, and attempting to use the stairs rather than a lift/elevator. Strategies for breaking up sitting at work were also identified. These included working standing up and using a smartphone app to provide reminders to sit less.

At 6 months, themes were identified for the work context that reflected tasks undertaken (e.g., standing for phone calls and reading documents), prompts (e.g., reminders), and location (the ability to move more when in the office rather than working from home). The latter was referring to the context of where work took place and the restrictions that this provided (e.g., in meetings with little to no autonomy to change expected sedentary behaviours). With working from home becoming more prevalent and characterised by increased sitting time [11], this may need further investigation as the vast majority of occupational sedentary behaviour interventions have been undertaken in the employing office workplace.

Strengths and limitations

Strengths of the study include the use of free-response words or statements given by participants to understand their perspective on the barriers and strategies to engaging in a sedentary behaviour intervention. However, not all participants responded with comments, and for those that did, some were brief and lacking context (see the study's process evaluation paper for more in-depth responses arising from interviews with participants) [26]. Confidence of participants and their ability to articulate responses may have affected the data provided. A further second limitation was the influence of the COVID-19 pandemic. The intervention took place during restrictions and lockdowns, meaning the social context of the study may not reflect conditions outside of this period. That said, barriers and strategies reflecting the home and work contexts are likely to be reasonably representative of normal conditions. The participants were living with T2DM, so the findings cannot necessarily be generalised to other population groups.

Conclusions

The purpose of this short paper was to present more detailed findings concerning the perceived barriers and strategies for behaviour change in an intervention designed to reduce sitting time in adults with T2DM. Themes were similar across 3- and 6-month time points for barriers (fatigue/sleep, disability/health, work-related, and context) and themes for strategies reflected behaviours associated with breaking up sitting, incidental physical activity, and purposeful physical activity. We believe that this is the most comprehensive set of self-reported barriers and

strategies for reducing sitting time in adults with chronic disease. Given that the statements identified are from participants actively working to reduce their sitting, including at home and work, we can claim that they have good ecological validity.

In conclusion, we have provided novel and practical insights regarding ecologically valid barriers and strategies encountered or adopted when engaging in an intervention to reduce sitting time in adults with T2DM. Barriers reflected individual (e.g., fatigue) and contextual factors (e.g., at work), and strategies centred on breaking up sitting through replacement with physical activity, both incidental and purposeful. Such information should be considered in the development and implementation of interventions.

Supplementary Information The online version contains supplementary material available at <https://doi.org/10.1186/s44167-026-00112-3>.

Author contribution DPB led the main feasibility trial. SJHB and DPB wrote the main manuscript text and SJHB prepared figures 1–3. MLB, EC, and ERH collected data. SJHB led data analysis for this paper. All authors edited and critically reviewed the manuscript.

Data availability All data supporting the findings of this study are available within the paper and its Supplementary Information.

Declarations

Competing Interest SJHB is a member of the Editorial Board of the *Journal of Activity, Sedentary, and Sleep Behaviors*. He has no other perceived conflicts of interest. All other authors declare that they have no competing interests.

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