

Health Behaviour, Exercise Self-Efficacy, Physical Activity Status and Psychological Distress among Police Personnel: An Integrated Theoretical Concept Paper

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ABSTRACT

Police work exposes officers to recurrent occupational stressors, including high job demands, threat exposure, irregular schedules and limited recovery time. Although prior research links occupational stress, lifestyle practices, exercise-related beliefs, physical activity and mental health, these constructs are often examined separately, leaving limited theoretical explanation of how they operate together within police populations, particularly in Nigeria. This theoretical concept paper addresses that gap by integrating Pearlin's stress process perspective, Bandura's Self-Efficacy Theory and Flay and Petraitis' Theory of Triadic Influence. Using a theory-integration approach, the paper synthesises established conceptual and empirical literature to specify direct, parallel mediation, sequential mediation and moderated pathways. Health behaviour is deliberately defined as non-physical-activity health practices, healthy diet, sleep hygiene, stress management, preventive health-seeking and avoidance of harmful coping, so that physical activity status remains conceptually distinct as a behavioural mediator. The model proposes that positive health behaviour may reduce psychological distress directly and indirectly by strengthening exercise self-efficacy and increasing physical activity. Age, gender and years of service are proposed as demographic moderators, while peer norms, organisational support and work conditions provide contextual influences. The paper contributes a conceptually differentiated and testable framework for future police-health research and identifies intervention points for wellness programmes in Nigeria and comparable high-stress occupational settings.

Keywords: psychological distress; health behaviour; exercise self-efficacy; physical activity; police personnel; Nigeria; theoretical framework

INTRODUCTION

Psychological distress among police personnel remains a major occupational health concern because policing combines physical danger, emotional labour, public scrutiny, traumatic exposure and organisational pressure. Distress in this paper refers to a broad state of emotional suffering expressed through symptoms of stress, anxiety, depression, emotional exhaustion and reduced coping capacity (Kessler et al., 2003; Lovibond & Lovibond, 1995; Maslach & Leiter, 2016). Although these symptoms are not limited to policing, they may be intensified in law enforcement because officers are repeatedly exposed to unpredictable and high-risk events while working within strict hierarchical structures (Violanti et al., 2016).

The Nigerian policing environment provides an important context for theoretical development. The Nigeria Police Act (2020) assigns the police responsibility for preventing and detecting crime, protecting lives and property, maintaining public safety and enforcing the law. These functions require psychological stability, physical readiness and sustained occupational functioning. When institutional demands exceed available

coping resources, officers may experience distress that affects health, judgement, interpersonal conduct and job performance (Pearlin et al., 1981; Pearlin, 1999).

Despite growing evidence that health-promoting practices, self-efficacy and physical activity are associated with better psychological outcomes, the police-health literature commonly treats occupational stress, general lifestyle practices and exercise-related mechanisms as separate domains. This fragmentation leaves unresolved whether non-activity health behaviours affect distress directly, through exercise confidence, through actual physical activity, or through a sequence linking these processes. The gap is especially important in Nigerian police settings, where occupational demands are high but theoretically integrated wellness models remain underdeveloped (Bandura, 1997; Penedo & Dahn, 2005; Violanti et al., 2016).

Accordingly, this paper develops an integrated model in which non-physical-activity health behaviour is the predictor, psychological distress is the outcome, exercise self-efficacy and physical activity status operate as distinct mediating mechanisms, and age, gender and years of service are potential demographic moderators. The core argument is that positive health behaviour may reduce psychological distress directly, but important effects may also operate through exercise confidence and subsequent engagement in physical activity (Bandura, 1977, 1997; McAuley & Blissmer, 2000; Penedo & Dahn, 2005).

Approach to Theoretical Integration

This is a theoretical concept paper rather than an empirical study or systematic review. It adopts a theory-integration approach: relevant constructs are conceptually delimited, complementary mechanisms are drawn from Pearlin's stress process perspective, Bandura's Self-Efficacy Theory and the Theory of Triadic Influence, and the resulting relationships are translated into testable propositions. Supporting empirical literature is used to establish theoretical plausibility and clarify mechanisms rather than to claim exhaustive evidence coverage (Bandura, 1997; Flay & Petraitis, 1994; Pearlin et al., 1981).

CONCEPTUAL CLARIFICATION

Psychological Distress

Psychological distress is conceptualised as an adverse emotional state that includes symptoms of stress, anxiety and depression. In occupational settings, distress often emerges when workers perceive that the demands placed on them exceed their ability to cope (Kessler et al., 2003; Pearlin et al., 1981). Among police personnel, such demands may include exposure to violence, traumatic incidents, long working hours, public hostility, operational uncertainty and organisational constraints (Violanti et al., 2016).

In this paper, psychological distress is treated as the outcome construct. It is not presented merely as an individual weakness, but as a response shaped by work demands, personal coping resources, behavioural patterns and environmental support. The Depression Anxiety Stress Scales tradition also supports operationalisation of distress through depression, anxiety and stress symptoms (Lovibond & Lovibond, 1995).

Health Behaviour

Health behaviour is operationally defined in this paper as non-physical-activity lifestyle and self-care practices adopted to protect, maintain or improve health. These practices include healthy diet, sleep hygiene, stress management, preventive health-seeking and avoidance of harmful coping practices. To prevent construct contamination, physical activity and exercise are explicitly excluded from the health behaviour construct and are modelled separately as physical activity status in Section 2.4. This boundary preserves conceptual and empirical discriminant validity between the predictor and the behavioural mediator (Flay & Petraitis, 1994).

Health behaviour is positioned as the independent construct in the model. Positive non-activity health practices may reduce distress by improving recovery, strengthening perceived control and reducing reliance on maladaptive coping. However, knowledge of healthy living does not necessarily translate into exercise

participation; officers may understand the value of healthy routines yet remain physically inactive because of fatigue, shift work, limited facilities or low confidence (Bandura, 1997; McAuley & Blissmer, 2000).

Exercise Self-Efficacy

Exercise self-efficacy refers to an officer's confidence in the ability to initiate and maintain exercise despite barriers. It is not simply motivation; it is a belief about personal capability under difficult circumstances (Bandura, 1977, 1997). For police personnel, relevant barriers may include shift work, emotional exhaustion, limited facilities, lack of peer encouragement, poor fitness culture and domestic responsibilities.

Within this concept paper, exercise self-efficacy is treated as a cognitive mediator. It explains why some officers are more able than others to translate a general health orientation into regular physical activity. Officers with higher exercise self-efficacy are more likely to set exercise goals, persist when tired, resume activity after interruptions and view physical activity as a manageable coping strategy rather than an additional burden (McAuley & Blissmer, 2000; Williams & French, 2011).

Physical Activity Status

Physical activity status refers to the actual level, frequency, intensity and consistency of bodily movement or exercise. It includes structured exercise, occupational movement, aerobic activity, muscular fitness activities and flexibility-related routines. Global guidelines recommend that adults engage in regular moderate-to-vigorous aerobic activity and muscle-strengthening activity across the week (Bull et al., 2020; Piercy et al., 2018).

In the proposed model, physical activity status is a behavioural mediator and is conceptually distinct from the health behaviour predictor. Whereas exercise self-efficacy describes perceived capability, physical activity status reflects actual behavioural engagement. Sustained physical activity may support psychological well-being through improved sleep, reduced physiological arousal, better mood regulation, stronger self-concept and increased resilience (Penedo & Dahn, 2005; Reiner et al., 2013; Warburton et al., 2006).

THEORETICAL FOUNDATIONS

Pearlin's Stress Process Perspective

Pearlin's stress process perspective provides the broad foundation for this paper. The model explains distress as an outcome of the relationship between stressors and coping resources. When stressors exceed the individual's available resources, psychological distress becomes more likely (Pearlin et al., 1981; Pearlin, 1999). In policing, stressors may be continuous and cumulative, making coping resources essential for mental health protection.

Non-activity health behaviour, exercise self-efficacy and physical activity status can be interpreted as distinct coping resources within Pearlin's model. Positive health practices may reduce the physiological and psychological burden of stress, exercise self-efficacy may strengthen confidence in coping through activity, and physical activity may function as an active behavioural coping strategy that supports emotional regulation and recovery (Pearlin, 1999; Penedo & Dahn, 2005).

Bandura's Self-Efficacy Theory

Bandura's Self-Efficacy Theory explains how beliefs about personal capability influence motivation, persistence and behavioural performance. The theory is especially relevant to health-related action because individuals are more likely to initiate and maintain behaviours when they believe they can perform them successfully (Bandura, 1977, 1997). Self-efficacy influences effort, perseverance, emotional reaction and recovery after setbacks.

In this paper, exercise self-efficacy is the domain-specific form of self-efficacy most relevant to physical activity. A police officer who believes that exercise can be maintained despite work pressure is more likely to engage in activity than an officer who sees exercise as impossible under current occupational conditions (McAuley & Blissmer, 2000). The theory also implies that self-efficacy can be strengthened through mastery experiences, role modelling, encouragement and gradual reduction of perceived barriers (Bandura, 1997; Williams & French, 2011).

Theory of Triadic Influence

The Theory of Triadic Influence explains health behaviour as the product of interacting intrapersonal, social and environmental streams of influence (Flay & Petraitis, 1994). It is useful for police wellness because health-related practices are not determined only by personal choice; they are shaped by beliefs, peer norms, command structure, organisational culture, access to facilities and the wider work environment.

From this perspective, health behaviour and exercise-related action may be encouraged or weakened by three interacting domains. The intrapersonal domain includes perceived control and health beliefs; the social domain includes peer support, supervisor encouragement and group norms around fitness; and the environmental domain includes workload, shift patterns, fitness facilities, welfare policies and availability of structured wellness programmes (Flay & Petraitis, 1994). These contextual influences are therefore represented in the integrated model without being collapsed into the focal predictor or mediators.

INTEGRATED THEORETICAL ARGUMENT

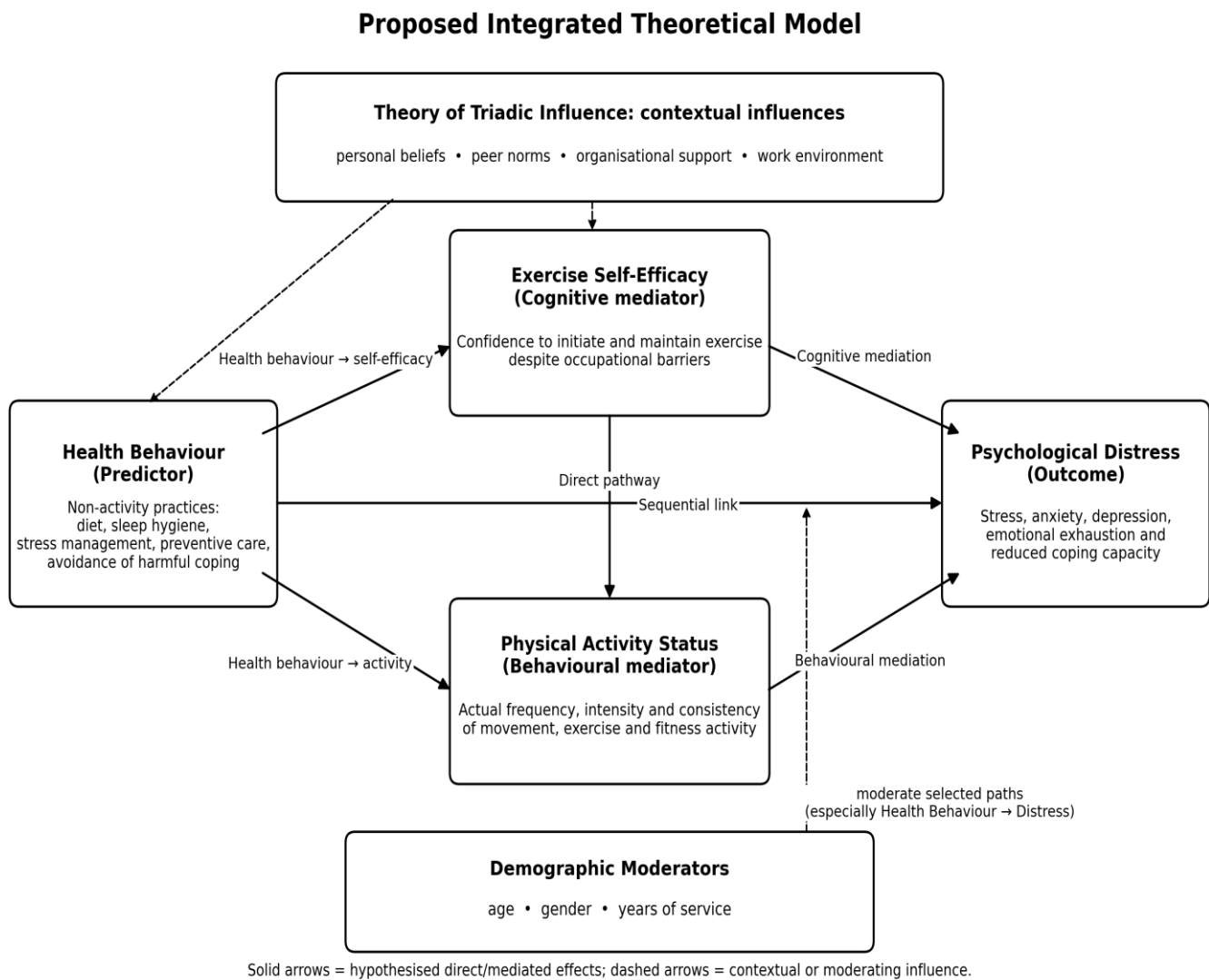
The integrated theoretical argument is that psychological distress among police personnel can be better understood by linking stress exposure with non-activity health practices, exercise confidence, actual physical activity and institutional context. Pearlin's perspective explains why distress occurs when stressors overwhelm coping resources (Pearlin et al., 1981; Pearlin, 1999). Bandura's theory explains how belief in personal capability affects action (Bandura, 1977, 1997). The Theory of Triadic Influence explains how personal, social and organisational contexts shape health-related behaviour (Flay & Petraitis, 1994).

The model proposes complementary direct and indirect pathways. First, non-activity health behaviour may have a direct inverse association with psychological distress because sleep hygiene, stress management, preventive care and avoidance of harmful coping may support recovery and general well-being. Second, a cognitive indirect pathway is proposed in which positive health behaviour strengthens exercise self-efficacy, and greater exercise self-efficacy is associated with lower distress through greater perceived control and coping confidence. Third, a behavioural indirect pathway is proposed in which positive health behaviour supports greater physical activity status, which may improve mood, sleep and stress recovery (Bandura, 1997; Penedo & Dahn, 2005; Reiner et al., 2013).

A sequential pathway is also proposed: health behaviour may strengthen exercise self-efficacy, stronger self-efficacy may increase physical activity status, and sustained physical activity may then reduce psychological distress. This sequence connects a general health orientation with belief, action and mental health outcome and offers a practical intervention logic: wellness programmes should not only provide health information but also build confidence, remove exercise barriers and create conditions for sustained activity (Bandura, 1997; Williams & French, 2011).

Age, gender and years of service are positioned as demographic moderators because officers may differ in physiological capacity, exposure history, role expectations and access to support. Older officers may face constraints that affect activity, while long-serving officers may carry cumulative exposure to trauma, fatigue and organisational frustration. These differences may alter the strength of selected structural relationships, particularly the association between health behaviour and psychological distress (Pearlin, 1999; Violanti et al., 2016). The complete path structure is presented in Figure 1.

Figure 1 *Proposed integrated theoretical model linking health behaviour, exercise self-efficacy, physical activity status and psychological distress among police personnel*



Note. Health behaviour excludes physical activity/exercise. Solid arrows represent hypothesised direct or mediated effects; dashed arrows represent contextual or moderating influences. The path labels are conceptual and do not imply estimated coefficients.

KEY CONSTRUCTS AND THEORETICAL FUNCTIONS

Table 1 *Core constructs and theoretical functions in the proposed model*

Construct	Theoretical role	Explanation in the model
Health behaviour	Independent construct	Non-physical-activity lifestyle and self-care practices such as diet, sleep hygiene, stress management, preventive health-seeking and avoidance of harmful coping. Physical activity is excluded and modelled separately.
Exercise self-efficacy	Cognitive mediator	Confidence to initiate and sustain exercise despite occupational barriers such as fatigue, shift work and limited support (Bandura, 1997; McAuley & Blissmer, 2000).
Physical activity	Behavioural	Actual frequency, intensity and consistency of movement, exercise and fitness-related participation (Bull et al., 2020; Piercy et al.,

status	mediator	2018).
Psychological distress	Outcome construct	Stress, anxiety, depression, emotional exhaustion and reduced coping capacity (Kessler et al., 2003; Lovibond & Lovibond, 1995; Maslach & Leiter, 2016).
Age, gender and years of service	Moderating constructs	Potentially strengthen or weaken selected relationships by shaping exposure, capacity, role expectations and access to support (Pearlin, 1999; Violanti et al., 2016).
Triadic contextual influences	Contextual explanation	Personal beliefs, peer norms, organisational support and work environment help explain differences in health-related practices and exercise-related action (Flay & Petraitis, 1994).

THEORETICAL PROPOSITIONS

Proposition 1: Positive non-activity health behaviour is likely to be associated with lower psychological distress among police personnel.

Proposition 2: Exercise self-efficacy is likely to mediate the relationship between health behaviour and psychological distress.

Proposition 3: Physical activity status is likely to mediate the relationship between health behaviour and psychological distress.

Proposition 4: Exercise self-efficacy is likely to predict physical activity status because officers who believe they can exercise despite barriers are more likely to sustain physical activity.

Proposition 5: Health behaviour may influence psychological distress through a sequential pathway in which health behaviour strengthens exercise self-efficacy, exercise self-efficacy increases physical activity status, and physical activity status reduces psychological distress.

Proposition 6: Age, gender and years of service may moderate the relationship between health behaviour and psychological distress and may condition selected indirect pathways.

Proposition 7: Organisational support, peer norms and access to fitness resources may strengthen the translation of positive health orientation and exercise self-efficacy into sustained physical activity.

IMPLICATIONS FOR THEORY

The paper contributes to theory by integrating stress, self-efficacy and triadic influence perspectives into a single framework for police mental health. Many discussions of police distress emphasise occupational stress but give less attention to the cognitive and behavioural mechanisms through which health-related practices might influence distress (Bandura, 1997; Flay & Petraitis, 1994; Pearlin, 1999).

A central conceptual contribution is the explicit separation of non-activity health behaviour from physical activity status. Exercise self-efficacy represents belief and perceived capability, whereas physical activity status represents action and behavioural engagement. Treating general health practices, exercise confidence and physical activity as distinct constructs avoids construct overlap and permits future studies to test direct, parallel and sequential mediation with clearer discriminant validity (McAuley & Blissmer, 2000; Williams & French, 2011).

The inclusion of demographic moderators also recognises that police personnel are not a uniform group. Gendered occupational experiences, ageing and accumulated years of service may alter exposure to stressors, available resources and responses to wellness interventions (Pearlin, 1999; Violanti et al., 2016).

IMPLICATIONS FOR EMPIRICAL RESEARCH

Future empirical studies can test the model using cross-sectional designs for initial model assessment and longitudinal designs for stronger temporal inference. Health behaviour should be measured using a scale or composite that covers diet, sleep hygiene, stress management, preventive health-seeking and harmful coping while explicitly excluding physical activity or exercise items. Exercise self-efficacy should be measured separately through barrier-specific confidence scales, physical activity status through validated self-report instruments or objective methods such as step counts and activity trackers, and psychological distress through validated screening tools such as the Depression Anxiety Stress Scales (Lovibond & Lovibond, 1995).

Before testing structural paths, researchers should establish reliability, convergent validity and discriminant validity among health behaviour, exercise self-efficacy, physical activity status and psychological distress. Structural equation modelling is well suited to simultaneous estimation of direct, parallel indirect, sequential indirect and moderated pathways. Longitudinal or repeated-measures designs would be especially valuable for examining whether changes in health behaviour and self-efficacy precede later changes in physical activity and distress (Pearlin et al., 1981; Williams & French, 2011).

The framework may also be evaluated across settings and subgroups. Although developed with Nigerian police personnel, particularly officers in Ondo State, in mind, comparative testing across commands, states and other law-enforcement or tactical occupations would clarify whether the proposed pathways are context-specific or generalisable. Measurement invariance and multigroup analyses could further determine whether model parameters differ by age, gender or years of service (Nigeria Police Act, 2020; Violanti et al., 2016).

IMPLICATIONS FOR POLICE WELLNESS PRACTICE

The model suggests that police wellness programmes should not focus only on physical fitness tests or general health lectures. Such approaches may have limited impact when officers lack exercise confidence, facilities, peer support or time. More comprehensive programmes should combine non-activity health promotion, graded exercise, peer modelling, supervisor support, flexible scheduling and regular feedback (Bandura, 1997; Williams & French, 2011).

Interventions should specifically build exercise self-efficacy. This can be achieved through progressive training targets, visible role models within the command, encouragement from supervisors, group-based activity, recognition of improvement and counselling that helps officers manage fatigue and anxiety. These strategies can make exercise a more realistic coping resource under occupational constraints (Bandura, 1997; McAuley & Blissmer, 2000).

The model also supports demographic tailoring. Older officers may require lower-impact aerobic activity, flexibility work and injury prevention; female officers may benefit from gender-sensitive facilities, flexible schedules and supportive group structures; and long-serving officers may need stress-recovery programmes, health screening and gradual reconditioning. A uniform wellness approach may not adequately address these different needs (Pearlin, 1999; Violanti et al., 2016).

LIMITATIONS AND FUTURE DIRECTIONS

Several limitations should guide interpretation of the proposed framework. First, this is a conceptual paper and does not provide primary empirical estimates or a systematic synthesis of the literature; the proposed relationships therefore represent theoretically grounded hypotheses rather than causal conclusions. Second, the model is intentionally parsimonious and may omit relevant determinants such as rank, trauma exposure, organisational justice, social support, socioeconomic circumstances and comorbid health conditions. Third, combining several non-activity practices into a broad health behaviour construct may mask domain-specific effects, while reliance on self-report measures in future studies could increase common-method and recall bias.

The framework is also context-sensitive. It was developed with Nigerian police personnel, particularly the Ondo State context, in mind, and the proposed moderator effects have not yet been established empirically. Cross-sectional testing would be unable to determine temporal ordering among health behaviour, exercise self-

efficacy, physical activity and distress, and reciprocal relationships are plausible; for example, severe distress may itself reduce confidence and physical activity. These issues should be addressed before the model is treated as explanatory beyond the populations in which it is tested.

Future research should therefore prioritise longitudinal, multilevel and intervention designs; use objective physical activity indicators alongside self-report data; compare alternative structural models; and test measurement invariance across age, gender and years-of-service groups. Multi-command and multi-state studies would strengthen external validity, while intervention trials could examine whether strengthening non-activity health practices and exercise self-efficacy produces sustained increases in physical activity and subsequent reductions in psychological distress.

CONCLUSION

This theoretical concept paper proposes an integrated model for understanding the relationship between non-activity health behaviour and psychological distress among police personnel. Drawing on Pearlin's stress process perspective, Bandura's Self-Efficacy Theory and the Theory of Triadic Influence, the framework distinguishes general health practices from exercise-specific confidence and actual physical activity and links them through direct, parallel indirect and sequential pathways (Bandura, 1977, 1997; Flay & Petraitis, 1994; Pearlin et al., 1981; Pearlin, 1999).

Exercise self-efficacy represents the belief that officers can remain physically active despite barriers, whereas physical activity status represents actual movement and exercise. Age, gender and years of service may moderate selected relationships, while peer norms, organisational support and work conditions provide contextual influences. By resolving construct overlap and specifying empirically testable pathways, the model provides a clearer basis for future police-health research and for context-sensitive wellness interventions in Nigeria and comparable high-stress occupational settings.

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