EASMH

European Alliance for Sport and Mental Health

TOOLKIT

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Training module n. 1

Definition of mental health; definition of mental disorders; dimensional approach to mental disorders; essential clinical features of severe mental disorders; personal and societal burden associated to mental disorders

Mental health: a state of well-being that is more than the absence of mental disorder, in which an individual can realize his/her own abilities, cope with the normal stress of life, work productively, and make a contribution to the community. It is influenced by several socioeconomic, biological and environmental factors.

Mental disorders: clinically significant disturbances in **cognition**, **emotion regulation**, or **behavior** due to psychological, biological, or developmental factors which can impact on daily functioning.

Categorical classification of mental disorders: in order to communicate with each other shared descriptions of mental disorders, practitioners and researchers make use of American Psychiatric Association's DSM-5 or WHO's ICD, where several **criteria** to be met are provided for each psychiatric diagnosis. This is the most widely used approach.

Dimensional approach to mental disorders: an individual's psychopathologic status is assessed by considering symptoms which afferent to several dimensions, regardless of boundaries between disorders and between disorders and normality.

Severe mental disorders: they include schizophrenia and psychotic disorders, depressive disorders and bipolar disorders.

Schizophrenia: it is characterized by **positive symptoms** (delusions, hallucinations and abnormal perceptions), **negative symptoms** (loss or decreased ability to plan, speak, express emotions or find pleasure), **disorganized thoughts, speech and behavior**, and **cognitive symptoms** (impairments in attention, concentration and memory).

Depressive disorders: single or recurrent episodes in which most of the day, nearly every day, patients feel **sadness, emptiness or hopelessness**; **irritability**; **diminished interest or pleasure**; **sleep disturbance; tiredness and lack of energy; reduced or increased appetite**; **anxiety, agitation or restlessness; cognitive slowdown; feelings of guilty; thoughts of death;** or **somatic symptoms**.

Bipolar disorders: **type I**, in which one manic episode may be preceded or followed by hypomanic or major depressive episodes; **type II,** characterized by at least one major depressive episode and at least one hypomanic episode, without ever manic episodes; **cyclothymic disorder,** defined by periods of hypomanic and depressive symptoms for at least two years. In manic (more severe) and hypomanic episodes, patients feel **abnormally upbeat, jumpy or wired;** with **increased activity, energy and sense of well-being**; **decreased need for sleep; unusual talkativeness; racing thoughts; distractibility; and poor decision making.**

Burden: it can be quantified by "disability-adjusted life-years" (DALY), which represents the loss of one healthy year of life. Major depression is the leading cause of disability worldwide and the second in terms of years of life lived with disability (YLD).

Treatment strategies for patients suffering from severe mental disorders (SMI): they are based on a personalized and tailored approach which integrates **pharmacological (anxiolytics, antidepressants, mood stabilizers, antipsychotics)** and **non-pharmacological** interventions.

Anxiolytics (benzodiazepines): they have sedative, hypnotic, anxiolytic, anticonvulsant, and muscle relaxant effects. Well tolerated and effective in the short term, they can become addicting over time.

Antidepressants: Selective serotonin reuptake inhibitors (**SSRIs**) are the most commonly prescribed antidepressants together with Serotonin and noradrenaline reuptake inhibitors (**SNRIs**). Their long-term use could cause sexual problems, weight gain, feeling of numbness and addiction. Tricyclics present impactful side effects, while Monoamine oxidase inhibitors (MAOIs) are no longer widely prescribed.

Mood stabilizers: they are used when mood is unstable, as well as in bipolar disorder, but also to augment the effect of other medications. Lithium, approved to treat mania and the maintenance phase of bipolar disorder, has proven to have anti-suicide benefits too. Anticonvulsants, in adjusted dosage, fall into this class.

Antipsychotics: both typical and atypical antipsychotics block receptors in the dopamine pathway. Despite being less likely to cause extrapyramidal adverse effects, atypical antipsychotics are associated with metabolic problems (diabetes, stroke and cardiovascular disorders).

Non-pharmacological treatments: psychotherapies (CBT, IPT, and less formal supportive therapies based on counselling, mindfulness or self-help) have been found to be effective in patients with severe mental disorders as well as **psychosocial interventions** (family interventions, social skill training, etc.) which focus on personal resources and targets. **Lifestyle** improvements (diet, exercise, relaxation, sleep habits) represent an emergent aspect of the integrated approach in mental healthcare.

Training module n. 2

Relationship with patient; how to engage a patient with SMI in a sport-based intervention

Therapeutic relationship: it is an alliance between an expert and an help-seeker aimed to understand and solve the latter's problem. It is crucial to the success of interventions in healthcare settings and it includes trust, genuine interest, empathy, positive regards and self-awareness. Physicians have to **listen actively** and create new levels of **understanding** about what patients tell, in order to collect salient information among inflections, metaphors, imageries, sequences of associations, and interesting linguistic selections. Also movements, gestures and facial expressions represent a language to be compared to speech in order to catch any incongruencies.

Practical tips for fostering therapeutic relationship: 1) introduce yourself to the patients using his/her name; 2) make sure patient's privacy and needs are met; 3) make sure you actively listen and understand patient's concerns, sometimes by restating what he/she has verbalized; 4) use concrete and clear words; 5) maintain eye contact without staring too long, smile at intervals, speak calmly and slowly; 6) maintain professional boundaries.

Active listening involves: emphasizing understanding by verbalizing emotions; helping the patient to evaluate his/her own feelings; making feedbacks, questions, and opinions; increasing concentration and avoiding elements of distraction; enhancing non-verbal cues like nodding and making eye contact; restating in order to convey interest and encourage to keep talking.

Engaging a patient with severe mental illness in sport-based interventions: since people suffering from severe mental illness have a significantly higher risk of obesity, hyperglycaemia and metabolic syndrome and experience a lower life expectancy of around 15-20 years in comparison to the general population, the improvement of physical health represents the primary incentive for engaging in exercise. Weight loss represents the most popular motivating factor, even though physical activity seems to give a modest contribution to this purpose. Exercise can improve psychological well-being among people with SMI and reduce depression, whereas 75% of patients viewed stress reduction and mood enhancement as motivating factors. However, stress, depression and low energy as well as lack of socio-ecological support represent barriers to engage in sport-based programmes. The potentiality and the utility of these interventions should be explained to the patient, whose expectations and attitudes are important to consider.

Characteristics of the sport-based intervention/programme: initial activities are useful to build confidence, to assess personal attitudes and skills and to provide clear instructions. Interventions should be flexible, fun-game based and inclusive, with a moderate sense of competition and personalized levels of physical exertion.

Training module n. 3

Evaluation of verbal and non-verbal communication skills

Non-verbal communication: a good relationship between patients and healthcare professionals is based on verbal and non-verbal communication. The latter doesn't use words, but facial expressions, cues, gestures, vocal styles and spatial closeness. Compared to verbal, non-verbal communication might create more often confusion and misunderstandings and it needs more time and the physical presence of interlocutors. Non-verbal behaviours have been shown to convey interest, intimacy and balance of power. Moreover, a good non-verbal communication predicts patient satisfaction to treatment.

Good/bad non-verbal communication skills: an open posture indicates openness to discuss, a close one means lack of interest. Relaxed posture and arms, good eye contact, nodding, smiling and using gesture are indicative of a positive body language.

First impression in non-verbal communication: make sure you look professional in wearing and confident through an upright posture, shoulders low and back, arms relaxed at your side, forehead, chin and chest facing up and out just slightly, and legs around shoulder-width apart. A genuine smile, involving eyes as well as mouth, and an eyebrow flash represent universal gestures of trust and happiness to meet the interlocutor. People who nod to acknowledge their audience or on meeting someone are rated higher in overall performance.

Practical skills to improve good non-verbal communication skills: maintain eye contact, nod your head when agreeing, smile and show interest, lean forward to show speaker your interest, use a tone of voice matching your message.

The personal space: it is the region surrounding a person which they regard as psychologically theirs, as described in 1966 by Hall who introduced the concept of "proxemic". Permitting a person to enter personal space and entering somebody else's personal space are indicators of perception of those people's relationship. It can be distinguished in intimate space (45 cm; confidential exchanges), personal distance (1.2 m; regular conversations), social distance (3.7 m; business, new groups) and public distance (7.6 m; larger audience). It is highly variable, based on everyday-life circumstances and cultural differences.

Training module n. 4

Individual patient assessment for preferences in sport activities

Choosing exercise interventions: since there is no evidence that one particular exercise is clearly more effective than any other, individual's adherence, values, preferences and attitudes should be criteria to consider when choosing exercise interventions. Social support, stage of changes, general physical health and prior adherence to physical activity represent factors of engagement. Having a companion to exercise with, the availability of equipment and effective travel channels to engage in physical activity are positively associated with several types of physical activity.

Evaluating previous experiences in sport activity: make sure to ask about sports played during childhood and currently, the best sport experiences, opportunities in the community and their impact on participation, purposes and opinions.

Improving the engagement in sport-based rehab interventions: Capability (level of physical activity), opportunity and motivation (including enjoyment and satisfying) combine together to drive behaviour.

Assessment of individual preferences: patients should be asked to compile a questionnaire based on the work of Aboagye et al. (2021), whose results should be discussed during the following meeting. Type of exercise, design, intensity, frequency, proximity and incentives represent domains of options.

Assessment of levels of motivation over time: Physical Activity and Leisure Motivation Scale (PALMS) should be provided over time in order to evaluate the changes in motivation levels reported by patients.

Assessment of patient's attitude toward sport activities: discussing about the meaning of "attitude", its formation from experiences and influences, negative experiences (failures, embarrassment, feeling incompetent) and derived negative attitudes, disliking about sport (long duration, dangers, difficulties, efforts).

Training module n. 5

Goals setting – Development of an individualized programme for sport-based activities

Goal setting and performance: it is an approach for motivating patients explaining them the relationship between conscious goal (aim of an action) and task performance. Hence, individuals can focus on goal-related actions ignoring irrelevant activities, invest efforts in goal pursuit – the more the greater difficulty – and discovery and develop task-relevant strategy. Patients with a stronger initial alliance are more likely to achieve a goal suggestion. Difficulty, specificity, proximity, source and types impact goal setting effect. Both short-term and long-term goals facilitate goal attainment, as the former can be indicators in the progress toward the latter. Performance goals are focused on the attainment of desired performance outcomes, whereas learning goals are focused on developing task-relevant strategies (e.g., new complex tasks). Ability, goal commitment, feedback, task complexity, task knowledge and resources are moderator influencing the relationship between goal setting and performance.

How setting a goal with SMI patients: setting clear and simple goals; taking small steps; getting support and help; sharing goals with others; having hope and believing in him/herself; tracking successes and challenges.

S.M.A.R.T. goals: Specific, Measurables, Attainable, Relevant and Time-bound (SMART) approach allows to identify reasonable and more likely achievable goals. The more well-defined the pathway to reaching the goal becomes, the easier it is to follow. It identifies clear, actionable steps and a scheduled end-point where non-judgmental evaluation can take place. This method doesn't push to go far and beyond, but it actually provides a direction and helps to get organized. Working towards clearly defined goals improves outcomes across a wide variety of illness states and therapy types and helps to build and strengthen the therapeutic alliance. Being **specific** helps to incorporate the method into the goal, not just the outcome: goal becomes a clear instruction. **Measuring and tracking** progresses can help in keeping from cheating, adjusting goals and watching for trends. **Attainability** can be got breaking large goals into smaller: they should be ambitious but not impossible to achieve. Each step should make sense and have some levels of personal importance, meaningfulness and **relevance**: if you don't care about the goal, you are unlikely to work on it. The more confidence an individual has in their capacity to undertake and execute a task, the more likely they are to be successful. **Time** should be realistic, well-scheduled and not too far off into the future.

Training module n. 6

Motivational interviewing

The process of change: it is articulated in several stages: precontemplation (no intention to change); contemplation (awareness a problem exists); preparation; action (modification of behavior); maintenance; relapse.

Motivational interviewing (MI): it is a collaborative, person-centred and goal-oriented method for eliciting and strengthening intrinsic motivation for change within an atmosphere of acceptance and compassion. It sits between following (good listening) and directing (giving information and advice). The clinician must abandon the impulse to solve the patient's problems and allow the patient to articulate his/her own solutions.

Core elements of MI: partnership, a collaborative relation between professional (expert in helping to change) and patient (expert in his/her own life); **evocation** of priorities, values and wisdom to explore reasons for change; **acceptance** of patient choices and needs without judgement; **compassion** to achieve patient's wellbeing. Use of these principles enables the patient to express his or her view of benefits and drawbacks associated with a particular behaviour pattern and determine what action, if any, to take. Ultimately the decision resides within the patient, not the clinician.

Four General Principles of MI (RULE): Resist telling patients what they have to do; **Understand** the motivation, values and abilities; **Listen** with empathy; **Empower** to achieve goals, identifying techniques and overcoming barriers.

MI Strategies:

- **Getting permission**.
- making **OARS**: **Open-ended question** in order to stimulate reflections on how change may be meaningful or possible; **Affirmations** of strengths, efforts and past success; **Reflective listening** by repeating, rephrasing or offering a deeper guess about what the person is trying to communicate; **Summaries** and recaps.
- **Elicit-Provide-Elicit (Asking, Listening, Informing)**: eliciting patient's interest, soliciting information or advice neutrally and eliciting patient's reaction.

Essential elements in the process of motivational conversation: engaging to establish a productive working relationship through careful listening, **focusing** to agree on a shared purpose, **evoking** patient's "why", ideas and motivations, and **planning** how to change.

Measuring motivation: Patient's levels of willingness, confidence and readiness can be measured with very effective **"rulers"**. A motivational interviewer needs training, experience and empathy, the latter useful to listen with rapport and understanding, creating an environment in which patients feel heard. Using empathy, patients are more likely to share true feelings.

EASMH Project Monitoring tools

Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS): administered to participants/patients to assess their mental wellbeing at WEEK 0 – START, at WEEK 6 – MID and at WEEK 12 – END.

Questionnaire Training Feedback (QTF): administered to participants/patients after the training sessions (after the FIRST, after 3 WEEKS, after 6 WEEKS, after 9 WEEKS, at WEEK 12 – END).

Sport Intervention Feedback (SIF): compiled by coach to collect information about feasibility of sport interventions at WEEK 6 – MID and at WEEK 12 – END.

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ECOS European Culture and Sport Organization

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