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This paper aimed to describe the use of the *Physical Activity Group* technique in a mental health facility. It presents a qualitative analysis of experiences reported by a Physical Educator and a Nursing Technician regarding intervention in the practice of physical activity (PA) for subjects with severe mental illness (SMI). The instrument used was an open semi-structured interview, allowing new ideas to be brought up during its elaboration. Results indicate that PA plays an essential role in therapeutic projects, especially when it takes part in groups' procedures coordinated by trained professionals. Additionally, multidisciplinary work is fundamental on patient adherence and further attendance to this intervention. Finally, mental health practices should assist social rehabilitation, favour the beingness and promote human dignity.

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Physical Activity and Mental Health: A Multidisciplinary Team

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ABSTRACT

This paper aimed to describe the use of the Physical Activity Group technique in a mental health facility. It presents a qualitative analysis of experiences reported by a Physical Educator and a Nursing Technician regarding intervention in the practice of physical activity (PA) for subjects with severe mental illness (SMI). The instrument used was an open semi-structured interview, allowing new ideas to be brought up during its elaboration. Results indicate that PA plays an essential role in therapeutic projects, especially when it takes part in groups' procedures coordinated by trained professionals. Additionally, multidisciplinary work is fundamental on patient adherence and further attendance to this intervention. Finally, mental health practices should assist social rehabilitation, favour the beingness and promote human dignity.

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I. INTRODUCTION

Physical activity (PA) in health promotion and disease prevention has gained importance in recent decades. Fighting inactivity has become a significant global challenge. According to the specificities of each age group, the World Health Organization (WHO, 2010), aware of this issue, published recommendations regarding PA practice. Currently, the concept of health (WHO, 1992) is defined as “a state of complete physical, mental and social well-being, and not simply, the absence of disease or illness”. Consequently, health programs are becoming more complex,

demanding integrated actions. Different perspectives of scientific knowledge contribute to making them more cohesive and adequate to specific objectives. It is also necessary to consider the social context of the population. Thus, Physical Education Professionals started working in unusual places, such as Psychosocial Care Centers (CAPS) and others related to the psych area. It is interesting to note that a survey of 620 psychologists indicates that many of them consider themselves willing and potentially able to promote PA as part of the psychological treatment of patients and would like to work in programs of this nature (Burton, Pakenham, & Brown, 2010).

However, there is still a need to clarify the consequences of PA practice in individuals with severe mental illness (SMI), especially concerning the psychic repercussions from the dynamic point of view. The World Health Organization organizes its recommendations for PA practice by age groups. But the psychological benefits appear discreetly: “reduced symptoms of anxiety and depression” (age group between 5 to 17 years); in individuals between 18 and 64 years old, and over 65 years old, a “decreased risk of NCDs (non-communicable diseases) and depression”, (WHO, 2010, p.7).

It is essential to highlight that PA is considered walking and structured exercise, including group physical activity or sport (Soundy, Faulkner, & Taylor, 2007). In a critical review of the literature, Alexandratos, Barnett and Thomas (2012) investigated the impact of exercise on mental health and quality of life of people with SMI. The authors concluded that exercise could contribute to mood, concentration, sleep patterns and

alleviate psychotic symptoms. At the same time, they list other additional benefits: increased quality of life through social interaction, meaningful use of time. Considering the specific needs of that population, they recommend further investigations to get more data about the practice of exercises. They reinforce that new studies should focus on psychological assessments to provide more evidence on the therapeutic effectiveness of this practice.

Subsequently, Lourenço et al. (2017) have recommended that nursing care professionals add PA and other educational practices to their mental health programs. At the same time, the article reflects on the role of PA in psychosocial rehabilitation. It is essential to emphasize “the need for further studies regarding scientific evidence of physical activity to health, concerning weight gain and the prevention of metabolic syndrome” (p.7).

Also, the professionals should adhere to PA practice in mental health facilities; since it is a viable, low-cost and, potentially therapeutic tool in treating these patients, whether in day-care centers (outpatients) or a situation of intensive care (inpatients). Thus, “PA practice in mental health facilities depends on the way managers understand care interventions and the elaboration of treatment programs (...) the value that caregivers confer to this practice, and the availability of everyone to provide support” (Zago & Padilha, 2017, p.620).

In addition, adequate social support offered to patients with SMI can act in the opposite direction to the barriers they report, hindering access to PA, such as anxiety and depressive symptoms (Bonsaksen, 2011). Nursing professionals, physical education professionals, and psychologists should play that role.

In a survey carried out at the CAPS in the city of Goiânia (Goiás State, Brazil) to analyze the main interventional characteristics of the Physical Education Professional, Furtado et al. (2015) point out that the work routine seems to be concentrated in therapeutic care activities (therapeutic workshops). Therefore, the Physical

Education Professional has legitimized his performance in Units that care for patients with SMI in the national territory. However, this performance would include discreet participation in family care activities and joint consultations, which would indicate a certain distance from the area of Physical Education concerning the clinical dimension of care and multi-professional work. On the other hand, a recent study points to the importance of integrating Physical Education as an auxiliary science to Psychiatry, according to an interdisciplinary perspective of mental health treatment (Melo, Oliveira & Vasconcelos-Raposo, 2014).

Subsequently, Furtado, Cavalari Neto, Rios, Martinez and Oliveira (2016) sought to understand the work routine of Physical Education Professionals at CAPS, paying attention to the daily and practical actions that give identity to the area. Thus, they point to two related categories: therapeutic care (63.8% of activities) and the planning, organization, and evaluation of therapeutic care (36.2% of activities). In addition, most therapeutic workshops involved body practices, showing the identity of Physical Education.

The history of the emergence and evolution of group psychotherapy in health institutions since the last century leaves no doubt that the group constitutes an adequate therapeutic tool for patients with SMI. Furthermore, PA can mediate between the components of the group. Thus, this practice is considered a new intervention in mental health facilities, especially in situations of impaired verbal communication, mutism or delusional processes (Zago & Terzis, 2012; Zago, Terzis, & Padilha, 2014; Zago & Padilha, 2017).

II. METHOD

2.1 Context

In this way, caregivers, mainly psychotherapists, nursing technicians and physical education professionals, acted in this unconventional setting so that patients could re-establish links with external reality. As follows, the Nursing Technician and the Physical Education

Professional had as main functions: to monitor, observe and participate, notably, in PA group practice, with the patients, sometimes, forming the subgroups, according to the spontaneous emergence of this demand.

It was essential to work on the engagement of the professionals with the development of this group technique. The researcher highlighted the intervention proposal's objectives and negotiated the administrative preparations, such as time, duration and frequency of the session (Foulkes, 1967), and others related to the unique characteristics of this group. The institution's manager must be attentive to the efficiency of this intervention and, especially, to the organization of the mental health facility staff to support the development of the procedure (Kadis, Krasner, & Foulkes, 1967).

The subjects were SMI patients from a Psychosocial Care Center, which constituted a small group (Kaës, 2005). Sixteen patients participated (aged between 27 and 56 years). The group was mixed in gender (15 men and one woman); there was a plurality of diagnosis. New patient admissions and dropouts were allowed (an open group) (Foulkes & Anthony, 1967). The frequency of sessions was once a week, with the duration of two hours each.

Participants met to PA practice in a Community Social Center, which is attached to the same Institution as the Psychosocial Care Center. According to the *Physical Activity Group* technique (Zago, 2014), the Psychologist and the Nursing Technician initially mobilized the patients at the Psychosocial Care Center. Then, there was the walk to the Community Social Center, as a therapeutic follow-up. The Physical Education Professional is the reference there for the group practice. In addition to the Psychotherapist, the Nursing Technician accompanied the group ensuring support to some physical demand (pain and general complaints) or psychic (motor agitation, etc.). At the Community Social Center, two 'captains' drew up the teams. Then there was the PA group practice within 30 min. After that, the professionals offered a free discussion moment (symbolic moment) for 20

min. At last, the group returned to the Psychosocial Care Center.

2.2 Participants

Two professionals responded to a semi-structured interview: a Physical Education Professional (a licensed professional inserted in a Community Social Center, Campinas region, State of São Paulo, Brazil); a Nursing Technician (professional inserted in a Psychosocial Care Center which is part of the same Institution).

2.3 Procedure

The semi-structured interviews were carried out individually in the respective units they worked (appropriate place). As this was a semi-structured interview, the author added other questions to those previously elaborated (Turato, 2010). Both interviewees consented to the transcription of the recordings. The researcher chose and analyzed excerpts of the interviews as they endorsed and explained how the group procedure could be a therapeutic assistant for patients with SMI. The professionals verbally communicated their impressions about the group activity stemming from the so-called triggering questions (Fontanella, Campos & Turato, 2006): 1-) How did you perceive adherence to group activity? 2-) How did you participate in this activity? 3-) How did you perceive the group's relationship with the community? 4-) What are your impressions of the relationships between patients during the process? 5-) How did you perceive the relationship between the professionals involved in the development of the activity? 6-) Would you like to add anything else?

2.4 Analysis

Finally, the content analysis followed the seven steps of the method proposed by Clinical-qualitative Content Analysis technique: 1) Editing material for analysis; 2) Floating reading; 3) Construction of the units of analysis; 4) Construction of codes of meaning; 5) General refining of the codes and the Construction of categories; 6) Discussion; 7) Validity. Therefore, the analysis involves a critical reflection on the

procedure carried out at each seven steps (Faria-Schützer, Surita, Alves, Bastos, Campos, & Turato, 2021).

III. RESULTS AND DISCUSSION

3.1 Adherence

Both professionals bring considerations regarding the patients' adherence to this intervention proposal. The Professional of Physical Education (PE) point that PA should have a playful character: "We have to offer something pleasurable for them. Something that gives them pleasure; then success is guaranteed (...). Sport is a facilitator" (S. L., Santos, personal communication, August 15, 2014) In turn, the Nursing Technician (NT) considers that the proposal should make sense to the patients: "As much as you try, as the other users try, the team tries, if the initiative came not from the patient, I find it very difficult. The first point is this" (W. C., Soier, personal communication, August, 30, 2014).

PE states that group PA practice is an essential ally for patients with SMI: "I think the mental health patient at this level does not join the group as often. This group of sports they manage to support (...) sport is just a tool to continue his treatment" (Santos, 2014). Therefore, he corroborates the considerations of other authors (Zago & Terzis, 2012).

In addition, PA can also be a strategy for establishing patients' bonds to the mental facility. In this way, it can favor the treatment process as a whole: "sports group can keep users inserted in the Unit as well. It is what makes him adhere to the treatment" (Santos, 2014).

WHO (2010) not only recognizes the benefits of PA, but also recommends this practice. In global terms, it fights against physical inactivity for the maintenance and promotion of health. Furthermore, it has called for concrete action by governments in this regard. There seems to be a lack of pragmatism complying with those guidelines in mental health facilities. Thus, PE signals: "today it is fashionable to talk about PA, (...) it is good for this, it is good for that, (...)

However, there is a lack of engagement in this practice in primary care units and mental health facilities" (Santos, 2014). This statement highlights the vital role of caregivers (doctors, psychologists, nurses, etc.) in patients' adherence and attendance to this therapeutic proposal (Zago & Terzis, 2014; Zago & Padilha, 2017; Daltio, 2018). Even though mental health professionals have recognized the therapeutic effects of PA, few recommend this practice to their patients (Mcentee & Halgin, 1996; Zago & Padilha, 2017; Daltio, 2018). In this sense, PE adds: "I think there is a need for greater involvement of the caregivers so that we can reach a greater number of users" (Santos, 2014).

Using an organicist theory viewpoint, NT comments the patient's adherence to this propose: "In case of a group procedure that implies physical movement (...) it is more complicated. Taking into consideration their lifestyle, some of them prefer to be more isolated" (Soier, 2014). It corroborates the findings of other authors, such as Leibovich & Iancu (2007), Johnstone et al. (2009), concerning non-adherence of that population's sedentary lifestyle, and sometimes social isolation. Literature suggests that patients with SMI have low levels of participation in PA when compared to control groups of subjects that do not fall into this category (Nyboe & Lund, 2012). Furthermore, NT points out: the cooking group (...) fills the kitchen, it happens inside here (...) No! Sports group is different. You have to leave the mental health facility to reach the Community Social Center and return to the Unit afterwards" (Soier, 2014).

3.2 Becoming a group

Both professionals did not have formal knowledge about group formation. Despite this, they describe group emergence: "I think we had a return in every week. I think this was strengthening the bond with us and the group itself, right? With each other" (Santos, 2014). NT points out: "At the beginning, I was a little insecure; whether it was going to work or not; and then in the course (...) they believed in them more. Being in a group, something that didn't happen before" (Soier, 2014). Groups gradually structure themselves as

units during the analytical work when identification processes are favored, links are established between the participants and between them and the coordinator (s). In this sense, Freudian social psychology postulates that identification places itself as “the most remote expression of an emotional bond with another person” (Freud, 1921/1996, p.115). In this sense, at the beginning of the process of forming a group, there is “a first, uncertain, protoplasmic body, in which the limits of the interior and exterior are still mobile: the differences in the structure of space are only outlined” (Kaës, 1976, p. 93).

At the same time, there was insecurity, distrust, fear of failure in their depositions. The PE puts his impressions: “We started in a very discreet way; going slow like this, patients afraid of not working. Would the group succeed, or not?” (Santos, 2014). At the same time, NT is categorical: “Because when it started, it was doubt, uncertainty” (Soier, 2014). At the beginning of the development of a group activity, anxiety about the unknown is expected (Pichon-Rivière, 1971). Furthermore, these narratives of group formation are not restricted to the moment of performing the group activity: “When I go to CAPS, sometimes, it is just like that. This group is constituted. They talk to each other, they stay together” (Santos, 2014). Moreover, he reports identification processes “is a group since they identify themselves with each other. They like the same thing, in this case, sport, football” (Santos, 2014). PE highlights the structuring of affective bonds between the group members in a way that stands out: “what I perceive is that a group is constituted. As if it were a group of friends that we created” (Santos, 2014). A very expressive testimony, in each section, resuming: “we created it” (Santos, 2014), signals a group matrix that was being woven: “The mother is the one who generated a person. The matrix is a common ground where a group or a crowd was generated” (Neri, 1995). Then he adds: “you end up creating a group, with your face, with the people you like, that you are involved with, you end up taking it to life too. It has had such an effect” (Santos, 2014). At this moment, there is a signal of the effectiveness of the proposal. The

benefits would not be restricted to the group space. The professionals seem to observe the construction of the feeling of brotherhood among the participants. In this sense, at a given moment, the NT comments: “the few who embraced the group, embraced which other, one missing the other” (Soier, 2014). Thus, the community of brothers “is not present at the beginning of the work, but is born when the members become aware of being a group” (Neri, 1995, p.215).

3.3 *The conviviality*

Both professionals bring considerations about PA practice's benefits (physical and psychic ones); that is, they report incorporating a broad concept of health. NT speeches contemplate the therapeutic character of this procedure: “it was not just playing and leaving. No! Afterwards, there was a conversation” (Soier, 2014). The ‘conversation’ refers to the moment for spontaneous verbal expression, the language, the interdiscursive processes: “I think the conversation at the end made the difference” (Soier, 2014). Thus, he retrieves past experiences and comments: “before that, the group played ball (...) and returned” (Soier, 2014). This professional recognizes the importance of the so-called ‘symbolic moment’ (space reserved for effective use of the free speech): “In the end, those conversations were a possibility for them to unwind” (Soier, 2014). Later, he also reports the social aspect of the procedure when he says: “the group was not just an activity, but to live with the people there” (Soier, 2014). Here the intention of the proposal is reinforced in terms of social rehabilitation, ‘coexist’ in its broadest meaning, by electing a Community Social Center as a place to carry out the activity. In this sense, Owens et al. (2010) investigated the promotion of well-being in mental health facilities from users and professionals’ perspectives. Partnerships with community social centers, such as those that provide PA practice, are essential. The scientific literature points out that PA can reduce social isolation and promote the engagement of individuals with SMI in mental health facilities, offering safe opportunities for social interaction (Carter-Morris & Faulkner, 2003; Zago & Terzis, 2012; Zago & Padilha, 2017).

PE seems to emphasize the coexistence, which can be understood in terms of the intersubjectivity that group activity favored in every detail. This proposal highlighted this by locating collective PA in a community center: “This is therapeutic. The patient comes here, lives with other people. This helps in his treatment too. Rescue him of his daily life. I think this is an answer for the therapeutics” (Santos, 2014).

3.4 The group technique

PE considers essential the offer of qualified interventional activities: “where they (patients) were, it was not a Health Service Unit with prepared professionals; it was something more punctual, an activity and that's it” (Santos, 2014). The environment and its surroundings are perceived as enabling or inhibiting the group therapeutic process: “it was a public space, they went with the CAPS staff; they stayed more with themselves” (Santos, 2014). Some barriers reported by patients with SMI to participate in PA programs refer to the offered environment, for example: fear of unsafe conditions, fear of discrimination (Mcdevitt, Snyder, Miller & Wilbur, 2006). On the other hand, PE points out the need for programs for PA practice, concerned with the profile, characteristics, and specific demands of the public: “When they came to the Community Social Center, there was another proposal, which is health promotion, in fact. A team is already prepared (...) a qualified offer” (Santos, 2014).

3.5 Relationships Practice

The professionals recover their initial fears regarding the encounter between patients and people in the community: “In the beginning, I think there was more our fear than that of patients” (Santos, 2014), especially concerning the proximity to children: “There was football, the children showed up” (Santos, 2014). In the same way, NT comments: “At the beginning, I was a little insecure. We didn't know what the reaction from the community and the patients would be” (Soier, 2014). These comments seem to report the social segregation often experienced by patients considered as “crazy”. The initial expectations and

fears presented in the statements refer to a profound cleavage in society regarding what is “healthy” and “sick”, “normal”, and “abnormal” (Bleger, 1991). Notably, the separation between two groups is suggested in this excerpt: the patients and the community.

Later, both are surprised by the results of this practice. Undoubtedly, there is a significant investment from these professionals. There is an effort to transform ideologies (Psychiatric Reform) into practical actions. A “peripatetic clinic” should be a clinic that leaves mental facilities (Lancetti, 2006). The professionals would invest in patients’ potentialities without denying their particular difficulties. PE seems to signal a process of building together up: “We were experimenting. I think the process went well. In the beginning, they were already interacting with each other. There was no distance between the children and the patients, or the community itself” (Santos, 2014). Right afterwards, he said: “Users were very calm (...) it was easy” (Santos, 2014). He refers to the patients as “users” (the term is common one in mental health facilities), instead of “patients”. In this sense there appears the constant search for overcoming segregation, categorization, and the subject's rescue. Besides, NT comments: “Then the time passed, we started to see that the patients were joining the community” (Soier, 2014). Then he points out: “I thought they developed close bondings with one another” (Soier, 2014). The comments seem to corroborate that this group technique provides opportunities for establishing bonds and social rehabilitation. Professionals reinforce that it can unit or reunite patients with the local community and vice versa. PE adds that: “we assist the patient. Then, he can manage to interact with children, with adults, with the community in general” (Santos, 2014). Furthermore, NT brings an observation that addresses social belonging: “I thought it was cool that the patient remembered the names of the other community participants. And the participants also remember the patients' names” (Soier, 2014). Soon after, he concludes that “you created a friendship between them, companionship, it was cool” (Soier, 2014). In this sense, it is understood that the group activity

avored socialization processes, enabling the learning of relationships (Foulkes & Anthony, 1967).

PE speeches reflect the concept of an expanded clinic, which has become one of the guiding principles of Mental Health practices in Brazil (Campos, 2003). Strikingly, he expresses the choice for a clinic in which the disease is part of the subject's life but never totally dislocates him: "We don't work aiming at a diagnosis, we work aiming at people" (Santos, 2014). Contrary to the notion of the traditional clinic, in which the subject is reduced to a disease, or a diseased organ, this professional adds: "In this place (Community Social Center) they are not only recognized by their madness, but by the subjects that they are" (Santos, 2014). Thus, the expanded clinic understands the subject as biological, social and subjective. Once again, this professional shows his commitment to the expanded clinic in this excerpt: "I think that the Community Social Center is the one that performs the Psychosocial rehabilitation" Santos, 2014).

3.6 Multidisciplinary Approach

Health promotion and disease prevention require multiple theoretical-scientific perspectives. Both professionals expressed the power of clinical practice by different views, "So as not to get something contaminated by a single bias. In our case, we had three areas thinking together. It is different if everyone was a psychologist or physical educator" (Santos, 2014). In addition, NT underlined professional collaboration: "each one completed the other's work" (Soier, 2014). However, sharing knowledge and actions requires availability; it should be a daily "exercise". But, in the institutional routine, this dialogue is not always possible. Certainly, existential diversity makes up collectiveness. In this way, dealing with differences is fundamental for coexistence in groups. "Of course, there are things that one think in a way that is not so equal to what the others think, but one learns from others" (Santos, 2014). In the course of the interview, NT resumed the strength of the collective work: "I think what has made a difference for the group maintenance was this: I am here, you (psychologist), and the

(physical educator professional) from there (...) it was not centered on one person" (Soier, 2014). In addition, he underlined the caregiver's roles and functions in group procedure: "my technical training permitted me to be here (CAPS) with them, to make this bridge, to take them there (Community Social Center), to care" (Soier, 2014). The literature calls attention to the nursing area's essential role in encouraging and assisting patients to PA practice (Happell, Phung-Platania & Scott, 2011). Then, he points out: "PE's academic education allowed the opportunity for the activity practice" (Soier, 2014). His comment seems to circumscribe the performance of the physical educator professional to the practice of PA. Even though PA benefits can go beyond those expected in body movement (Daltio, 2018), finally, the area of psychology would be marked by favoring verbal communication: "I think that psychologist offered a moment for conversation" (Soier, 2014). He concludes by emphasizing, once again, the singular and plural character of this procedure: "I think these three things formed one" (Soier, 2014).

VI. CONCLUDING DISCUSSION

Health promotion and disease prevention strategies should count on plural theoretical-scientific perspectives. Both professionals interviewed emphasized the importance of the collectiveness, which is constructed, deconstructed and reconstructed in a continuous dialectical movement.

The technique effectiveness resides in the joint work of professionals with different educational trajectories, who, by sharing knowledge and practices, propitiate the development of multifaceted therapeutic projects. The aim is to rescue subjects and legitimate their condition as citizens. Indeed, mental health practices should promote social rehabilitation and genuine "coexistence" in benefit to human dignity.

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