4.3 Managing people and situations

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4.3.1 Introduction

Historically, the relationship between physician and patient has been of critical importance to the success of a treatment. Accordingly, respect, attention, a good bedside manner, concern, and the ability to meet the patient's needs (identify their illness, provide relief, and, above all else, cure them) are fundamental. This is an interaction involving two individuals with different personal, cultural, and societal characteristics, in which one party is in need of help and the other provides it.

In addition, the patient's personality will be a determining factor in how their illness presents from a clinical standpoint. One hundred and thirty years ago, Claude Bernard said that "there are no diseases, only sick people." "Many doctors have substituted the use of technology for the clinical method for diagnostic objectives or treatments, given that using it would require the doctor to spend more time and dedication on the patient."

> *"The greatest mistake in the treatment of diseases is that there are physicians for the body and physicians for the soul, although the two cannot be separated." Plato*

Hence the need for sports medicine development to focus on the person and not the patient. There is a fundamental commitment within medicine, and that is to provide all of the care needed to mitigate pain, prevent eventual complications and reduce feelings of suffering, be they physical or psychological. For this reason, medical-scientific knowledge is at the core of any medical intervention, but an understanding of how to consider the individual and empathize with suffering, as well as the obligation to try and offer a better quality of life, are just as important. This approach means that we are acting upon a person: guaranteeing health in an overarching sense and increasing the patient's sense of being cared for.

This vision of medical intervention results in a need for fundamental sentiments such as empathy, an understanding of reality, and unconditional acceptance on the part of the professional:

- **Empathy**, because it bestows the ability to understand the unique nature of the person being cared for.
- **An understanding of reality** because we need to ensure our ability to deliver a diagnosis and, at the same time, show solidarity with the patient's concern and suffering and be ready to help.
- **Unconditional acceptance** requires us to accept the patient and their condition without making value judgments about their lifestyle. This improves and facilitates a patent's adherence to treatment. It builds confidence in the medical intervention and leads to a better prognosis with regard to the remission of symptoms.

We will now highlight a set of psychological skills that medical personnel must be trained in so as to foster a more effective physician-patient relationship.

- **Assertive communication:** Encourages a natural and comfortable relationship in situations that are far from easy, as is the case when managing an injury.
- **Self-regulation skills:** Emotional control in both verbal and non-verbal communication.
- **Problem-solving skills:** Facilitate the decision-making process as a source of support for the athlete/patient.
- **Emotional support:** Encourages change and provides support for decision making (Prochaska, 1997).

In order to address the necessary skills that medical personnel must acquire to improve interaction with the athlete/patient, this document focuses on four key topics that will provide tools to be used during a medical intervention.

4.3.2 The player's environment

It is important that all of the people in an athlete's environment are aware of the importance of their behavior and their emotions, as well as their consequences in all areas related to an athlete's well-being.

The athlete's environment refers to the entire universe of people that exercise some influence over the athlete, and who are agents for change at any given time during the course of the athlete's career.

The most pertinent groups surrounding the athlete may include:

- **Family environment:** the people who shape their beliefs and behaviors, and who are present in their life from the moment they are born.
- Sport **environment:** The coaching staff, medical professionals, sports facilities staff; all of the individuals with whom they come into contact from the moment they begin playing the sport onwards.
- **Social environment:** the athlete's teammates and peers. The influence that teammates and other peers have is unassailable, especially during childhood and adolescence, which are the most important stages for developing our personal beliefs and values. This stage, when that influence is greatest, coincides with taking up a sport and beginning an athletic career.

To add nuance, we have to consider actors who interact with the athlete on a day-to-day basis (coaches, physical trainers, physiotherapists, physicians, teammates, personnel), but if we are discussing the person, then the number of actors increases to include family, friends, classmates and teachers, the Club and the sport. Each of these is a point of reference, as well as the closest transmitter of values and beliefs, as well as knowledge. The way we perceive, interpret and, ultimately, decide how to react in our day-to-day life configures a belief system. As stated by Ramsey, "beliefs become a map inscribed in our system, guiding us, or better yet, leading us in the world in order to fulfill our needs."

This **belief system** shapes our life and our way of being and behaving; in other words, the beliefs we have determine the meaning that we assign to our experiences, which need to be taken into account during any medical intervention so as to establish a good rapport with the athlete.

All of the professionals who are part of the athlete's environment - be they coaching staff, parents, health professionals, physiotherapists or physical trainers - and who are looking to facilitate interactions with the athlete, can follow the advice below:

- Review their values and beliefs with the aim of developing a more professional, rigorous approach, without falling prey to **trends.**
- Be informed about behaviors that serve as precursors to high-risk conduct and which may be indicators that such conduct is forthcoming, as well as symptoms that may lead to unhealthy behavior - or that allow unhealthy behavior to continue - that will make athletic progress challenging.
- Use the information available about each athlete (age, performance level, athletic specialty, expectations - both the athlete's own and those of their immediate circle) in order to establish realistic goals in medical interventions.
- Avoid practices that do not take into account the needs and goals of the athletes.
- Understand the different parts of the athletic season (pre-season, training, competition, vacation) when developing a treatment plan.
- Encourage dialogue with other applied sports science specialists who participate in the development of an athlete's career (coaches, physiotherapists, physical trainers, psychologists and tutors, among others).
- Be aware of the morphological changes that occur in early adolescence. In many sports, these coincide with an increase in workload and a greater number of training sessions which are responsible for physical change. The function of the environment is to run in parallel with these natural and necessary changes, which are not negative changes in terms of their impact on athletic performance, but are changes to which the athlete needs to adapt as quickly and seamlessly as possible.
- Be aware of the athlete's progress in their sport and not just of the results they have achieved. Report regularly and positively on all progress made.

4.3.3 Motivation toward the patient

"When we are no longer able to change a situation, we are challenged to change ourselves."
"If we know what we want to achieve, then we must focus on how to do so."
Víktor Frank

One of the terms that may best explain success (or failure) in sports and in other areas of life is the motivation that one has to reach goals. When talking about motivation, or a 'motivating agent', there seems to be the idea that there is a recipe for which we must name the ingredients and the order of steps to be followed. However, each of us has the ability to motive ourselves as well as to motivate others. It's not a question of making a list of techniques, but rather about identifying our personal strengths, leveraging them and applying them in our professional lives as well as our emotional, family and social lives.
Throughout this reading, we will examine how physicians can become motivated to motivate their patients, given that, as with coaches, the physician is the best change agent with regard to the patient's behavior.

In the literature, the term **motivation** is used in a variety of ways:

The direction and intensity of one's effort (Sage, 1977) is a definition that is frequently used as a starting point for motivational theories in sports psychology. In addition to this concept, we can add others related to personality traits, the impact of external influences, or the consequences of a behavior.
Once we know what it is we're discussing, it is important to remember that there are two fundamental components to motivation (figure 1):
The first component relates to **direction**: what is the individual seeking, approaching or attracted to? Ultimately, the subject of our attention determines our path.
The second component, which is no less important, is **intensity**, which refers to the quantity of effort used in a specific situation to continue in a given direction. How much are we willing to pay to achieve a specific goal? What are the obstacles and opportunities we encounter? What personal traits do we have for achieving our goal?
On one hand, we choose a path, or set a goal or a target; and on the other hand, we either know, or must consider, how much it will cost, what we will need, how long it will take us or how much time we have. These two components are critical in order to ensure that our motivation is not undermined and that we can tolerate frustration (which will, of course, decrease our motivation) as we pursue the goal we have set.

That being said, in the case of the relationship between a physician and a patient/athlete, the physician is the one who determines the direction and intensity. This is due to the fact that the goal, or the driver, of a medical intervention is to cure or reduce the symptoms of an illness; it is the physician, therefore, who will define it. During this process, keeping in mind the patient's goal (direction and intensity) will allow the physician to address unrealistic expectations. The chronicity or temporary nature of a

pathological picture should not become an obstacle which causes us to lose sight of the most important part of an illness or injury: ensuring that our patients maintain a high level of interest for dealing with it as best they can and focusing on improving their condition.

In an athletic environment, a very similar process occurs when the athlete contracts an illness or suffers an injury that removes them from the field of play. Both situations assume a sudden change in their initial goals. Often this is driven by the different professionals who work with him, from the coach to physicians, physiotherapists, physical trainers and psychologists.

Communication plays a key role in this process, in which our most important task is defining a goal which will determine the athlete's attention, for which we can establish timelines and anticipate situations and reactions. The communication style we use can lead to an optimal motivational climate, in which the patient follows medical guidelines: this is belief in and commitment to treatment.
There are two ways to improve communication between physician and patient:

- **Assertive Model:** Ideas, opinions or perceptions are communicated in a clear and concrete way, based on two factors: the ability to take action based on self-confidence without aiming to hinder the recipient.
- Consulting **Model:** In addition to the aforementioned model, we suggest another style, which is that of help, guidance and advice in order to identify a common goal during a medical intervention.

Either one will improve communication with the patient as long as they feel better heard and cared for.

A physician often has to assess symptoms (which are not always well-defined) and analyze a variety of diagnostic tests, both of which require time spent on tasks other than the immediate physician-patient goal of finding a cure or establishing the absence of a disease. To this we add the patient's own uncertainties, which place the entire responsibility for the diagnosis - as well as that of future decisions and any consequences they may have - on the physician. It is important to have excellent communication skills, meaning that one must have the resources to address a myriad of situations that may occur during a professional career, leading to the type of relationship that will stand the test of time.

In these situations it is impossible **not to communicate** (Watzlawick, 1991). During a medical consultation, something is always communicated. At the very least, we should aim for this communication to be efficient and focused on the main goals of both the physician and the patient.

When we talk about an assertive communication style, we refer to delivering a message:

Clearly → to the patient.

In a straightforward manner → without uncertainty (where the diagnosis permits).

Appropriately → focused on the patient's needs.

These three characteristics will allow us to become aware of a physician's personal communication style. In order to deliver a message, there must be a message recipient and, therefore, a listener: listening must be active and empathetic. The message has emotionally-charged content that we need to be able to perceive and, above all else, handle.

With a consulting model (figure 3), we are able to go even further. This method uses resources that have already been internalized by the physician in order to treat the patient, in order to generate even small changes in their behavior, beliefs or attitudes, without the patient feeling pushed into doing so. It simply happens because what is being sought in counseling is the patient's involvement. Health is not something that should be forced on someone. This model enables the patient to commit to the part of treatment which involves them, meaning that they will feel directly involved in their own progress because they exercise control over themselves (table 1). Within this model, information suggests something more than merely the transmission of content related to illness and treatment. It involves putting the patient in touch with some of the emotional reactions that these episodes usually trigger, as well as foreseeing family, social or professional consequences, resistance to change and the patient's personal resources. It means helping them face their emotions and become personally aware of their condition, but with the support of the physician, who is the expert on the matter.

Last, but not least, the physician must open up channels with the patient's community, which can often serve as a facilitator for positive progress in treating an illness.

Figure 1: Consulting Model

- Reinforce the patient's claims
- Listen, prioritizing the athlete's claims
- Take the patient's goals into account
- Accept ambivalence on the part of the patient
- Guide the patient toward acceptance of their reality
- Assess using milestones, without undue pressure
- Take the patient's lifestyle into account

Source: Galilea, Merayo, 2017.

Up until this point, we have talked about how physicians can integrate motivational resources in order to keep the patient's level of commitment and motivation high. But we cannot wrap up without first drawing your attention to a topic that often generates unhealthy attitudes with regard to the physician-patient relationship: namely, the level of emotional involvement on the part of the health professional, be it too little or too much. After discussing goal-setting, designing an action plan for the patient which indicates (insofar as is possible) timeframes, and outlining everything with a communication style that is well-suited to the patient, and which also respects the physician's personal style, we can't forget that for the patient, being supported, listened to and feeling important (even if the consultation lasts just ten minutes) is the driving force that will help them begin to confront their condition.

As noted previously, an injury brings about moments of crisis, uncertainty and doubt. In order for the patient not to remain stuck in a phase that prevents them from looking forward toward recovery, it is necessary to offer them an opportunity to express their doubts, questions and fears. Sometimes uncertainties do not arise during the consultation itself, but afterward, when they find themselves alone, ruminating on a variety of scenarios related to their situation. Having an *a posteriori* space to address their concerns will decrease the patient's degree of anxiety; they will feel emotionally supported and will be able to adhere quickly to the planned treatment.

While a physician cannot become emotionally involved, distance is not the best method by which to establish a smooth relationship with the patient and their relatives. The ability to detect their emotions and show that you have understood them will not reflect negatively on the physician.

4.3.4 Psychological variables in Athletes: approaches and tools

Throughout section 3, we will provide tools that the physician and patient can use to work together on adherence to injury rehabilitation. The patient can be taught these techniques in order to be able to reflect on their current situation and where they are headed. These techniques also allow for relationship-building and coordination between the medical professional and the patient, as well as for assessment of any progress made.

Motivation

In section 2, we discussed the motivation which a medical professional needs to project in their role as motivator for a patient/athlete. A health professional is a change agent with regard to a patient's behavior.

Goal-setting allows us to determine the most appropriate goals at any given time, according to the situation in which we find ourselves. This exercise will serve as a roadmap, a guide for the patient: what do they want to do; when do they need to achieve it by; and what concrete actions do they need to carry out in order to achieve it? With this tool, both patient and physician can assess progress and take daily steps forward.

In order to be able to set goals successfully, the goals must have the following characteristics:

- Explicit: well-defined so that they can be understood and analyzed.
- Precise: they specify what they are referring to.
- Meaningful: to the patient's recovery.
- Defined time parameters.
- Achievable: the goals can be reached.
- Observable.
- Measurable.

Table 1: Example of Goal-Setting Techniques

Short-term goals	Date of completion	Steps to be taken

Source: Developed by the authors.

Achieving short-term goals not only moves the patient closer to their final goal (complete recovery) but it also allows them to work on motivation and self-confidence in the short- and long-term.

Attention: Being Present

Attention is a crucial psychological variable for high-level athletes with regard to achieving athletic success. From the very beginning, in order to learn technique and to master, practice, and strengthen skills, there is a base level of attention and focus needed.

During an athlete's rehabilitation, attention is equally important: concentrating on the 'here and now' and, in many instances, relearning what has already been learned. This not only helps prevent certain injuries, but it also needs to be taken into account when an athlete is recovering.

Another technique that encourages attention is visualization. Alongside relaxation, it can assist with recovery, treatment adherence and patient motivation in terms of treatment.

Using information provided by the medical team, the patient will be able to apply visualization techniques to the injured area (Palmi, 1988), in which they will work on mental imagery, allowing for the ideomotor effect (also known as the Carpenter effect). This effect can be defined as the feeling a person experiences at a neuromuscular level when they imagine themselves performing an action, or when they are carrying out an external visual inspection, leading to electrical activity that activates the cerebral areas which control the movement patterns of the imagined gesture.

Visualization can be performed in two ways:

- External: the patient imagines themselves as a spectator watching themselves perform exercises recommended by the professional.
- Internal: the patient imagines the sensations that they feel when they do those exercises.

The more realistic the visualization is, the more impact it will have on the patient; they can imagine their actual training facility, its smells, sounds, textures, etc. These two forms of visualization are not mutually exclusive. We can even say that they are complementary, in that they both help with the patient's self-esteem and motivation when the images are associated with positive feelings and successful situations.

Activation

Another variable to understand in the world of sports is the optimal activation level needed in each athletic situation and, more importantly, how to manage it according to the player's circumstances. Taking into account the context in which we find ourselves, both physician and patient must understand and manage the existing activation level during the medical process.

Relaxation techniques are one resource for helping the athlete to endure various situations that may arise during illness or convalescence (uncertainty, pain, fear), and which can help maintain control over our activation level, increasing or decreasing the amount of activity needed based on the situation in which the patient finds themselves.

There are different types of relaxation: we recommend using the one that best suits the subject and will help them achieve their objective (optimal activation level) more quickly.

- **Jacobson's relaxation technique**, which focuses on stretching the entire body zone-by-zone.
- Autogenic relaxation: **autogenic training.**
- Mindfulness.
- Others (music, relaxing imagery, personal routines, etc.)

The most important thing is to experiment and find the technique which is best suited to the individual and with which they are most comfortable.

Self-Confidence

We can define self-confidence as a person's belief in their ability to perform a desired behavior to a satisfactory level. It is the ability to believe in yourself and in the self-efficacy that will enable you to reach your maximum potential.

When a physician treats an injured athlete, self-confidence is affected. In some cases it will be temporary, especially if the athlete feels they are improving rapidly and the recovery time is short; in others, depending on the seriousness of the injury and the time needed for rehabilitation, it can be longer-lasting.

We suggest undertaking exercises for identifying personal strengths and areas for improvement. This is applicable to recovery from a sports-related injury as a tool that helps us become aware of the resources we have at our disposal and how they can be used.

Below, we suggest another task that encourages the patient to reflect on their emotions in order to work on their self-esteem, which will, in turn, have an impact on their self-confidence.

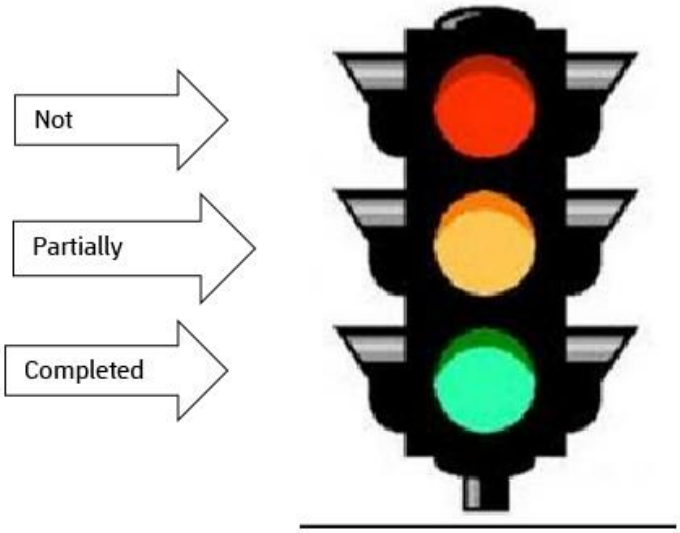
Table 2: Sample Exercise for Increasing Self-Confidence

Goal: where and when	Do 6 sets of an exercise that really challenges me.
How capable do I feel of accomplishing it?	**1 2 3 4 5 6 7 8 9 10**
Outcome	I completed it in its entirety.
What did I learn about myself?	I didn't finish and stopped doing the sets. I'm proud of myself. I'm satisfied with my day. Doing these things makes me feel capable of anything. ....

Source: Developed by the authors.

Another visual, easy-to-use tool is the **stoplight technique:**

Figure 2: Stoplight Technique



Source: Developed by the authors.

This technique connects the colors of a stoplight with the completion (or incompletion) of recovery milestones identified by the physician while, at the same time, associating the color with the feeling that comes from completing the proposed medical actions.

Table 3: Application of the Stoplight Technique

Monday	Tuesday	Wednesday	Thursday	Friday
X	X	X	X	X
X	X	X	X	X

Source: Prepared by the authors.

After reaching the recommended milestones, the patient takes time to fill the grid in with colors, thinking about their performance and their feelings associated with it. For example:

1. If I completed what I set out to do, how do I feel? Happy, proud, responsible, capable.
2. If I have partially completed it? I feel good, but I could have pushed myself more; today was not my day.
3. If I did not complete what I set out to do? Cheated, sad, reluctant.

This exercise can spur on the patient to work on their awareness of positive emotions associated with recovery and to feel more capable of what is being asked of them. In the case of negative feelings stemming from not meeting established goals, it will help to suggest new goals to work on the following day.

Another suggestion to make to the patient is to establish a reward system to apply they are meeting their minor goals, so as to reinforce the behavior that led them to do so. With regard to situations in which the subject has lost confidence, we must tell them to think about their achievements, all of the goals they have reached and progress they have made over time. One bad day is not synonymous with failure, but rather represents new challenges for the following day.

4.3.5 Psychological approach to an athlete's injury

Injuries to athletes are often considered a professional risk. However, injuries don't come out of nowhere: they have causes. Some of them are the result of an interaction within the athletic environment (such as a playing field in poor condition, bad weather) or with other people or objects (a collision with a teammate or an opponent). In addition, when reviewing the scientific literature, examples of injuries caused by personal issues frequently appear: a poorly-executed warm-up, a lack of skill, fatigue, lack of attention, poorly managed stress, etc.

Some aspects of injuries caused by an athlete's own behavior are a window into the athlete's character, mental health and personal circumstances. According to Cratty (1993), athletes who are predisposed to injury tend to feel insecure and very anxious. Those who worry too much tend to attribute their injuries to causes such as a lack of concentration or attention and/or insufficient bodily awareness. Similarly, athletes who overtrain, are exhausted or are highly irritable also tend to be predisposed to injury. This is especially true when they are undergoing significant changes in their life, such as a new training facility, a change of coach, a disagreement with an

sporting organization, a death in the family, marital problems, or starting or ending formal education (Bramwell, Masuda & Holmes, 1975). Just as we have this information, we do not have the facilities to measure these factors and their impact on athletes. With this data, it is necessary to emphasize the importance we should place on psychological variables from a medical perspective when treating an injury.

Not all athletes react the same way when dealing with the psychosocial factors that can indirectly lead to injury. However, there is a consensus with regard to recognizing certain emotional reactions or adaptive stages. We can identify 5 stages: denial; anger; adjustment; a sense of loss and depression; and, finally, acceptance. These have much in common with the psychological reactions that make up the "grieving process" (Glover Weisenfeld, 1985; Kavanaugh, 1972; Kübler-Ross, 1969).

Whether these stages are or are not sequential, progressive, or even evident is not as important for health professionals or coaches as is the need to find a way to move from denial to acceptance as quickly as possible. Athletes who cannot accept the fact that they are injured are not capable of focusing on the process of rehabilitation, thereby decreasing or delaying the possibility of a full recovery.

In Buceta's work on prevention of and recovery from injuries, some adverse effects with regard to athletic performance as a result of injury were observed:

1. For the affected athlete, injuries mean bodily dysfunction that causes pain, is the source of irritation, restricts personal autonomy, and increases the risk of greater dysfunction.

2. Depending on their severity, injuries may lead to a drastic reduction in athletic activity, sometimes for a long period of time or, in the worst cases, permanently.

3. Injuries bring with them important changes not only in the injured player's athletic environment (reshuffling, re-signings, terminations, transfers, etc.) but also in their personal, professional and social spheres.

4. Injuries are typically accompanied by symptoms of a depressive nature, anger, contrariness, resentment and/or irritability that may have an enormous impact on the behavior and well-being of the injured party and those around them.

5. Injury rehabilitation requires time, dedication and effort, not to mention a positive attitude which fosters consistency, tenacity and the ability to withstand pain and frustration.

One thing to keep in mind is the difference in behavior between an injured athlete and the athlete who feigns injury or symptoms, which leads to a drop-off in his performance. Firstly, the attitude toward injury is different between the two: athletes who are injured feel consternation and regret when injured because they can't use their talent and effort to help achieve team and personal goals; those who are feigning injury always put team goals on the back burner. Moreover, the implications for treatment, the length of the rehabilitation process and how to assess the intervention also differ between the two. An injured athlete tries to attend all team training sessions and matches, participates assiduously in rehabilitation sessions and makes an effort to follow the instructions given by physicians, physiotherapists and sports psychologists. Their goal is to return to training and competition as soon as possible. On the other hand, the athlete who is feigning injury is using treatment as the perfect excuse to miss out on training and competition, while also ensuring that their simulated misfortune gains them attention and sympathy from those around them (Buceta, 1996).

Buceta (1996) examines the following situational variables that can prompt sports injuries:

1. Stressful events of a general nature (family problems, financial troubles, loss of loved ones, minor daily challenges, etc.).

2. Stressful events related to athletic activities (changes in team or coach, changes in level of play, status changes, etc.).

3. Athletic lifestyle (frequent travel, changes in residence, strict self-discipline, etc.).

4. Training-specific demands (continued demands for improvement, constant over-exertion, perpetual assessment, etc.)

5. Competition-specific demands (uncertainty with regard to the results, a lack of control over one's own performance, social assessment, frustration with poor results, etc.).

6. Other situations related to athletic activity (interactions with the media, negotiations with managers, etc.).

7. Specific factors associated with the occurrence of previous injuries (movements or actions that have a special physical risk). (Buceta, 1996).

Based on this, it makes more sense to suggest an interdisciplinary approach to injury, both with regard to prevention and rehabilitation. Palmi (1995) suggests the following:

a) Improve specific training for sports professionals (risk awareness and risk reduction);

b) Improve the athlete's psychological resources (individualized mental training programs);

c) Plan training and competition, taking into account realistic goals and progressive demands (training, competition, mental load, rest);

d) Improve the technical resources that may be able to decrease injury risk. (Palmi, 1995)

The Kübler-Ross Model (1969), adapted for injuries:

In the initial period following an injury, athletes typically **do not accept** the evidence and show surprise instead. This leads to a range of behaviors relating to denial of the severity of the situation. Not adhering to medical recommendations for rehabilitation is one such behavior. This makes rehabilitation more difficult.

In the second stage, we deal with **an emotional response** (anger, rage): when the injured athlete accepts their condition and its severity, they may experience high levels of frustration. The athlete may direct this back at himself or herself, or towards those who surround him or her.

Next comes **awakening.** Once the athlete has accepted the reality of the situation, they usually think of future possibilities with a certain degree of optimism, trying to imagine scenarios that will not put them back in their current position.

In the fourth stage, **depression**, having accepted the severity of the injury and the very real consequences that it will have, among them absence from competitions taking place during the season, the athlete experiences a high degree of uncertainty, showing responses characteristic of a depressive state.

Acceptance is the final stage of this theoretical model. Once depression has been overcome, the athlete is able to focus on optimizing their rehabilitation process, as well as setting goals to meet upon return to training and competition.

Palmi (2001) affirms that emotional support for an injured player plays a fundamental role within a successful recovery process. This is due in part to the fact that when athletes perceive this support, it helps them overcome obstacles. This support can be divided into three different categories:

- Support from the medical team.
- Support from the athletic team.
- Support from family and close friends.

Below are some recommendations that can help in providing support:

Guidelines for working with the injured athlete

1. Build a rapport, creating a solid therapeutic relationship with the injured athlete: In order to do this, the physician must address the injury while taking into account the affected athlete's perspective. To do so, they must understand the possible repercussions for their performance in the short- and medium-term. In this way, they can develop a relationship based on trust, showing cooperation with and commitment to the athlete, which will lead to better adhesion to treatment.

2. Keep the athlete constantly informed with regard to the injury and their progress: From the very first moment, provide specific information about the severity of the situation and all of the factors which need to be taken into account for a successful recovery. As part of this, it is important to coordinate with the player and the coaching staff to establish short- and medium-term goals. This will only make sense if followed by full backing of the athlete throughout the recovery process, as well as upon their return to play.

3. Ability to confront situations with varying degrees of severity: Develop resources and identify the athlete's own resources when it comes time to successfully move forward in the injury process. Among the psychological techniques which have been found to be useful during the rehabilitation process are: positive self-talk, visualization, stress control, and focusing on the present moment.

4. Assistance from the athlete's inner circle: Emotional highs and lows often occur when an athlete resumes athletic activity following injury. This has to do with a number of factors, such as athletic performance or participation in competitions as well as the sensations and symptoms related to the injury itself. For this reason, the influence of the people closest to the player, both inside and outside the team or club, is critical. This means that the physician's involvement in this area is a determining factor in the success of resuming athletic activity.

In conclusion, it is important that all of the people in an athlete's environment are aware of the importance of their behavior and their emotions, as well as their consequences in all areas related to an athlete's well-being. Positive gestures during the formative years in sports can serve to develop healthy habits in the adult stages. Families and coaching staff, as described in the paragraphs above, are points of reference and providers, not only of knowledge, but also of values and beliefs.

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