Clinical Psychologist/Sport Studies Specialist
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As the field of sport psychology continues to increase in popularity from year to year, the question of who is qualified to perform which services to which athletes becomes a critical issue for the professions and the athletes. (Danish & Hale 1981;1982; Heyman 1982; Nideffer, Feltz, & Salmela, 1982; Dishman, 1983). In 1983 the U.S. Olympic Committee established guidelines for sport psychology services that differentiate skills in clinical, educational, and research areas. (Clarke, et. al., 1983; Heyman, 1984). This presentation will discuss a sport psychology consultation model that combines the expertise of a sport studies specialist and a clinical psychologist. The sport studies specialist has the knowledge of the specific sport, knows the sub-culture of the sport, knows how to relate to coaches in a non-threatening manner, understands the nature of the athlete's experience in dealing with performance pressures and peer pressures, and is also sensitive to the specific demands of team versus individual sports, open versus closed sports, and contact versus noncontact sports.

The clinical psychologist brings to this model the clinical skills to work with the specific psychological needs of the athlete - such as social skills training, marriage and family conflict resolution, self concept issues, developmental stage problems, and identity crises in adapting to the world beyond the sport. Since the elite athlete is involved in a lifestyle that does not fit the norm for his or her age contemporaries, the psychologist who is not familiar with the specific demands of the daily routine including its pressures and expectations for the elite athlete, is operating in a cultural void.

The question for both clinical psychologists and sport studies specialists who train elite athletes is when to recognize the limits of one's expertise and the need for consultation or a joint venture. The case we are presenting involves a world class female track and field athlete referred for treatment of a psychological crisis during the final training year before the Olympic trials. She was referred to the first author (the clinical psychologist) by her orthopedic surgeon for help in eliminating what appeared to be psychological blocks to her performance since some significant injuries during her last race.

Although the psychologist had had experience with the use of hypnosis and guided imagery for pain control and habit control, and although the psychologist had some experience working with national collegiate level gymnasts with Ken Ravizza on psychological issues related to performance, she had not previously worked with track and field athletes, nor with an athlete with the singular goal of going for the gold in a particular Olympic event. Thus, she declined to work with the athlete without a sport specialist as consultant and co-worker. She explained this to the athlete, and with the athlete's consent, approached a colleague with many years of experience and specific expertise working with collegiate and professional athletes in the role of "mental trainer". Ken Ravizza had consulted with teams and individual athletes for many years providing an educationally based mental skills training program for performance enhancement. Using relaxation, imagery, stress management and
concentration methods as they relate directly to performance.

For one year we worked as a team. The psychologist saw the athlete weekly — building a therapeutic alliance, working with crises in the family, using hypnosis and guided imagery for relaxation in personal as well as performance situations. Where performance issues became the focus, the sports specialist was brought to the sessions (8). The emotional family context of the athlete's situation was shared with the sports specialist as well so that a three way communication remained open throughout the treatment year. Occasionally, sessions with the sport specialist and athlete alone took place (10) in which concentration on performance skills were the focus. The sport specialist also spent some time with the athlete at the track and talked with the coach. Thus, each professional had a unique role as well as a co-joint role in the process.

Our jointly determined goal for the year was to aid the athlete in psychological distress to be in the best possible physical and mental state for the Olympic trials and games. We agreed that anything that would interfere with this goal would be postponed for later. Thus, some major decisions about divorce and long term career plans were entertained but not implemented. The consideration of life after the Olympics was to be beyond the range of our treatment. During the year we confronted issues of family violence, loneliness and isolation, denial, of fear of failure, interactions and confrontations with coaches, competitors, co-workers and relatives. Crises included athletic injuries, children's illnesses, threats of marital separation, and financial mismanagement.

Going into the final week before the trials, our athlete was in a cast with a sprained ankle, feeling that she was overtraining but not willing to contradict coach's—prescriptions in spite of "dead legs". There was no support from her husband and her children were in another state with grandmother. At the moment of truth, the Olympic trials, our athlete ran in pain, made it through the first heat, but was eliminated in the second. She was not heard from for two weeks. She communicated only with her good friend, her physical therapist. After her self imposed isolation, she called to report that she was alive and going to Europe to finish the remainder of the 1984 track and field schedule and reconsider her life plans.

The Feedback:

For our feedback and for our athlete's continuing support, we met with her occasionally throughout the next year. One year after the Olympic trials and two years after the beginning of our initial contact, the athlete, the psychologist, and the sport specialist sat down to do a psychological autopsy. The following is the athlete's feedback about the venture. She recalled her recognition that her training was going too slowly. She was having constant injuries, had personal problems on her mind, was afraid to win and knew that if she were going to be a winner, she needed "the edge". For her, "winners don't associate with losers" and "second place is the first loser". Although no one in her family had ever been to a mental health professional, and were not supportive of her doing so, she was prepared to see a psychologist because her orthopedist highly recommended the specific individual. She then agreed to see the sport specialist because the psychologist highly recommended him. Her first impression of therapy was that "this chick is gonna try get into my head." Her intention was to make this task difficult for the psychologist by not
offering any information not specifically requested. She wasn't bothered to discover that the psychologist didn't know "diddly squat" about track and field and she planned to use the therapy solely for the hypnosis and relaxation. However, she was surprised at how quickly she developed trust and found herself revealing intimate matters.

In retrospect she wished she had made some major decisions about divorce and changing coaches early on, but realizes that she was not ready to do so at the time and, indeed, would not have been able to effect those changes during the year of therapy, without having destroyed her chances to attempt the Olympic goal. Although she did not make the team, she is proud that she stuck to her task in spite of all the impediments. After the critical year was over, she was able to move independently on many of the issues we worked through. Within one year of the Olympics and the official end of therapy, she has separated from her husband, begun to develop a social life, changed to a less authoritarian coach and ran her personal best. She has changed her perspective on winning to a pleasant surprise if first (which is happening more often than in the past), a reasonable pride if second, and an acceptable reality if lower. She is open as to the 1988 Olympics, and has alternate career plans as well. She is in her best training shape ever, and feels calm and relaxed. She still uses the hypnosis and imagery both in her training and her personal life. Finally, she requested further psychotherapy to do additional work on her personal life, and she is referring another athlete for therapy.

As for the professionals' perspective on this therapeutic adventure, the following insights were valuable: The psychologist would have lost all credibility without consultation on the facts and jargon of the particular sport as the athlete's jargon was an early weapon to maintain distance. The consultation model provided the ability to defer to the expert consultant, rather than fake it or worse yet, pronounce athletic jargon off limits in a power struggle to control the sessions. The technical aspects offered by the sport specialist in terms of precise and explicit details of performance skills and pressures meant that the psychologist could engage in guided imagery and hypnosis without risk of inducing further physical injury or of impeding performance because of ignorance of body mechanics and the sports milieu. On the other hand, the sport specialist was able to refer what initially appeared as a performance issue, when a complication arose. For example, on imaging her anticipated performance on the day of her event in the Olympic Games, our athlete described the gold medal being placed over her head - but then being removed this was an instance in which the sport specialist was happy to have a clinician in the room. Finally, the availability of both a clinical psychologist and a sport specialist enabled complex situations crossing professional boundaries to be addressed competently. Thus, we could avoid upsetting a delicate balance of an athlete who has to work with a coach whom she idolizes and yet fears is causing her to overtrain her body.

This has been an exciting adventure for all of us. We all learned from each other and each plans to elaborate on the experience. Our athlete moves on with technical skills and psychological insights. The psychologist has obtained an educational experience in the dynamics and social systems of female track and field athletes. The sports specialist has increased awareness of the psychological interplay of performance and psychodynamics. We have high respect for each other's talents and
professions and we have a clearer understanding of our own limits. As a result of this project, we plan to continue the consultation model, perhaps more efficiently using less joint sessions since we better understand what will be happening with the other in our absence.

REFERENCES


