Outline

• Unit II: Counseling Athletes who are Injured
  – Students Responsibility
    • Read Chapters 9-15
    • Written Test (Final)
      – Chapters 9-15
PART II

• Integrated Rehab Model: A Team Approach (Chapter 9)
• Patient-practitioner interactions (Chapter 10)
• Adherence to Rehab (notes)
• Social Support Interventions (Chapter 11)
• Mental Skills that Enhance Recovery (notes & Chapter 12)
• Modeling & Injury Rehabilitation (Chapter 13)
• Healing Imagery (Chapter 14)
• Counseling Athletes with permanent disabilities (Chapter 15)
• Summary
Integrated Rehabilitation Model: A Team Approach
(Chapter 9)
Psychological Model of Psychological Response to Athletic Injury and Rehabilitation
Model of Post-injury Responses

- Identifies the sports medicine team members whom injured athletes at different levels of sport participation may interact.
- Identify the social-psychological impact of athletic injury (Anderson & Williams, 1988)
- Incorporated the stress model of injury (Wiese & Weiss, 1987)
Ultimate Goal of the Model

• Clinical Model in assessing post injury cognitive and emotional responses for planning appropriate physiological and psychological interventions.
Members of Sports Team by Competitive Level

• Who should be involved at each level.
Psychology of the Injured: Part II
Athletic Trainers Role

• Controlled communication is a primary responsibility during initial management of injury (Wiese & Weiss, 1987)
  – Role of first responder
    • What they say
    • How they say it
    • Diagnoses must be avoided
    • Be reassuring, calm, and professional
Role of the Athletic Trainer

- At High School and College level the AT plans, monitor, and evaluates rehab programs this means the AT has constant contact with the athlete.
  - Rehab must be viewed as an educational process
  - Psychosocial role is vital
    - Support, encouragement, and reassurance
    - Positive communication that includes good listening skills
    - Focus is on adherence to rehab through praise, rewards, and corrective feedback.
Role of Athletic Trainer

• Trainers help the athlete set performance based goals
• Trainers need to find appropriate motivation strategies
• Trainers need to provide social support
  – Athlete needs to maintain their social support network (coaches, teammates, etc)
Coaches Role

• Coaches pay little attention to injured athletes
  – The usual causes are the coach knows little about the athlete’s life outside of sport, the rehab required, athletes attempt to return to competition, and stress response of injury on a athlete.
Coaches Role

• They need to care about injured athlete
• Understand the rehab
• Keep the injured athlete integrated with the team
  – Attend practice
  – Use them as referee in scrimmage
  – Evaluate others performance
  – Keep score/times/statistics
Psychological Reactions to Athletic Injury

• Athlete experiences:
  – Excess of medically based information
  – Loss of physical capability
  – Emotions of withdrawing from a desired activity.
  – Dependency on others.
Three C’s of Recovery

- *Competence*- Rehab can be completed
- *Control*- Athlete has the ability to take command of their rehab program
- *Commitment*- Athlete has the willingness to stay on their rehab program.

(Fisher’s aspects of self-confidence in the recovery phase)
Patient-Practitioner Interaction of Injury Rehabilitation
(Chapter 10)

- Patient Practitioner Communication
- Patient-Practitioner Perceptions
- Adherence to Rehab
- Referral Process
Patient Practitioner Communication

• Received little AT empirical attention.
• Studied extensively in medical literature
• Results have indicated:
  – Poor patient-practitioners communication discourages future use of medical services (Taylor, 1995)
  – Poor patient-practitioners communication hampers adherence to rehab (Meichenbaum & Turk, 1987)
Poor Communication

- Patient
  - Anxiety
  - Inexperience with the medical disorder
  - Lack of intelligence

- Practitioner
  - Not listening
  - Using jargon
  - Technical language
  - Displaying worry
  - Depersonalize the patient
Patient –Practitioner Perceptions

• Rehabilitation Regimen
  – Athlete and AT have significant disagreement about rehab program (Kahanov & Fairchild, 1994).
  – Patients to expect to complete their rehab on an average 42% quicker then AT estimates.
  – 77% of sport injury patients who were prescribed home rehab exercises misunderstood the rehab program (Webborn, et al, 1997)
Patient-Practitioner Perceptions

• Recovery Progress
  – Perception of poor rehab is linked to negative emotional responses in athletes (McDonad & Hardy, 1990).
  – AT trainers and athlete’s rating of injury disruptiveness is similar but athletes tend to overestimate the severity (Crossman & Jamieson, 1985).
  – Athletes consistently perceive recovery as complete well before AT perception.
  – Coaches do not see “eye to eye” with AT perceptions the athletes return to competition
Attribution for Recovery

• Instilling a sense of self responsibility for rehab by the athlete (Gordon et al, 1991)

• Depends on the rate of recovery
  – Slow recovery are less likely to accept responsibility
  – Faster recovery more likely they will engage in their own self-recovery
Psychological Distress

• Emotional distress is inversely related to rehab adherence and outcome.

Distress

Need to assess distress

Adherence & Outcome

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Adherence to Rehab (PT & AT)

• Adherence rates range from 40-91% (Brewer, 2002)
  – Positive determinates of patient adherence:
    • Self-motivation
    • Pain tolerance
    • Being involved and choices
    • Hardiness (Wittig & Schurr, 1994)
  – Negative determinates
    • Ego involvement & Trait anxiety
Adherence to Rehab

- Environmental Factors
  - Positive determinates
    - Self-efficacy of the treatments (Duda, et al, 1989)
    - Comfort of rehab setting (Brewer, et al, 1994)
    - Convenience of rehab scheduling (Fields, et al, 1995)
    - Perceived exertion during rehab (Brewer, et al, 1988)
    - AT trainer expectancy of patient adherence.
Adherence-Enhancing Strategies

• Based on previously injured athletes (Fisher, et al, 1993).
  – AT’s & PT’s who are caring, honest, & encouraging
  – who educate the client
  – Who use goal setting and monitor the clients progress
  – Who do not use threats or scare tactics in gaining adherence have higher rates of adherences in their clients.
Three Practical Suggestions

1. Listen before you fix
2. Listen for the “but”
3. Value Patient Input
Referral Process

• 5-13% of injured athletes experience clinical meaningful levels of psychological issues

• Before referring, consult with mental health professionals about the athlete
  – There is no perfect time refer
  – Need to explain to athlete why you are referring them and to whom.
  – Always follow up about the athlete after referral
Using the Referral Process Effectively

• Recognize there are certain conditions which require referral
  – Eating disorders
  – Depression

• Establish a team of sport-medicine professionals.
Strategies in Referral

• Reactive referral
  – Injured athlete shows signs of depression, eating disorders, or anxiety.
  – Unfortunately, the majority of AT (76%) never refer the athlete (Larson, et al., 1996)

• Proactive referral
  – Preventive approach (Assessing each athlete level of stress)
  – Provide tracking athlete nutritional requirements
  – Provide psychological skills training related to management of stress
Athlete Perception of Referral

• In reactive referral,
  – athlete usually is in denial
  – Being referred to psychologist is perceived as weakness
  – Goes against the norm of team and being an athlete

• In proactive referral,
  – The sport-medicine team is part of the sport
  – Team is made up of specialist the athlete can go to when having difficulty
Reducing Problems in being Referred

• Introduce the sport-medicine team at the beginning of the season
• Discuss the roles of each member of the team
• Emphasize that specialists is important in achieving a complete recovery
• Once referred, keep a complete history including both psychological and medical information
• Eliminate the feelings of abandonment after being referred
Summary

• Poor communication between athlete and AT & PT relates to:
  – Athlete’s compliance of Rehab
  – Most athlete’s will have heightened levels of anxiety
  – Depersonalizing the athlete, using technical jargon, and not listening to the athlete are poor communication strategies.
Summary (Continued)

• Perception of poor rehab (time) is linked to allot of negative responses
• Most athletes overestimate, and disagree with the AT or PT on when they can return to play.
• Most coaches disagree with AT or PT when the athlete should return to play.
Summary (continued)

- The athlete who is self-motivated, optimistic, high self-efficacy, high pain tolerance, hardy, and is provided choices rehab successfully.
- Ego involved athletes highly neurotic, pessimistic, lowly motivated, low pain tolerance, and possess low self-efficacy, rehab will be longer and usually unsuccessful.
Summary (continued)

• AT & PT’s must refer athletes if they experience signs of depression, high anxiety, abuse, assault, and eating disorders.

• AT & PT’s are required to develop and know their referral procedures, the sport-medical team, and be knowledgeable in signs and assessment of psychological disorders (depression, high anxiety, & eating disorders).
Four Pillars of Psychological Rehab

1. Education
2. Social Support
3. Goal Setting
4. Mental Training

The first three fall within the AT and PT’s scope of responsibility and ability.
Primary Responsibility of AT

- Differentiate between benign pain and pain associated with re-injury and to determine a relatively safe level of physical activity.
- Create a sense of calm and security in the midst of pain and fear of further injury.
Education

• Nature of the injury
  – Macrotrauma
  – Microtrauma
  – Severity & length of rehab

• Rehab Strategies
  – Protocol
  – Plan

• Amount and Degree of Pain
Social Support & Injury
(Chapter 11)
Social Support Interventions

- Supported athletes are generally more mentally and physically healthy due to health sustaining and stress reducing functions of social support (Shumaker & Brownell, 1984)
  - Coach
  - Parents
  - Teammate
  - AT & PT
Social Support Interventions

• Social support is critical in the rehab of the injured athlete (Rotella & Heyman, 1986)

• Social support is an effective psychological technique that motivates the athlete during rehab (Hardy & Crace, 1990)
Social Support

• Emotional support
  – Behaviors that comfort and indicate that they are your side.
  – Listening

• Informational support
  – Behaviors that acknowledge your efforts, helps confirm your perceptions

• Tangible support
  – Financial assistance, and rehab knowledge
Providing Emotional Support

• Listen carefully
• Keep in contact with coaches, teammates, AT, PT, and parents.
• Create an open environment
Providing Informational Support

• AT should develop a context expertise in as many injuries as possible.
• Deliver effective feedback
• Use of technical modalities
• Create sharing opportunities between injured athletes
  – Have successfully rehab athletes with similar injuries openly discuss the issues
Tangible Support

• NATA trainer needs to know rules and regulations of the sport about the type of support from booster, alumni, coach, etc.
• Let the athlete know exactly what you can and will do as well as what you cannot and will not do!
• Best tangible support is services received at the time it is requested.
• Refrain from putting the athlete in a state of indebtedness......give it freely.
Goal Setting
Is Goal Setting Effective?

Research has shown that goal setting is an extremely powerful technique for promoting rehab, but it must be correctly implemented.
Why Goal Setting Works

Athletes who set performance (rather than outcome) goals experience less anxiety, more confidence and greater levels of satisfaction during rehab.
Performance & Outcome Goals

- Strengthen the thigh muscles and gain more flexibility in hamstrings.
  - Strategies
    - Leg lifts
    - Partial Squats
    - Walk backward on treadmill at 15 degree incline
    - Hamstring Stretch
  - Return to running
  - Compete in state meet
  - Win conference
  - Qualify for State
Principles of Goal Setting

1. *Set specific goals.* Specific goals, as compared with general “do your best” goals, are most effective for producing behavioral change.
   
   - I am going to do 25 reps at 15% of my body weight on required tasks.
   - I am going rehab 5 days per week.

2. *Set difficult but realistic goals.* Goals should be “moderately” difficult.
Principles of Goal Setting

3. *Set long- and short-term goals.* Link long- and short-term goals to the outcome which is full recover and return to the sport.

4. *Set performance and process goals, as well as outcome goals.* For every outcome goal, set several performance and process goals that will lead to the desired outcome.
Principles of Goal Setting

5. *Set and state verbally each daily rehab session goals*

6. *Record goals.* “Ink it, don’t think it.”

7. *Develop goal-achievement strategies.* Develop specific goal-achievement strategies that include how much and how often things will be done in an effort to achieve full recovery. Be flexible, however.
Principles of Goal Setting

8. Consider participants’ personalities and motivations. Consider factors such as self-motivation, optimism, hardiness, anxiety, ego involvement.

9. Foster an individual’s goal commitment. (next slide)
Ways that help athletes commit to rehab goals

- Write them down
- State them to others
- Keep a log
- Provide the athlete constant feedback about their rehab
- Incorporate them into rehab session
- Engage others to help!
Goal Setting System

• Identify functional, clinical, and psychological goals during post surgery, initial injury, or early rehab phase.
• Develop a system to record, prioritize, and evaluate the goals (wheel of awareness model)
• The number of goals attained depends on the severity of the injury and approximate length of time of recovery.
  – Microtrauma will take longer, have more set backs, and be more frustrating.
  – Macotrauma is straightforward in recovery.
Goal Setting System

- Usually identify 2-3 different goals during the rehab during any given phase of recovery.
  - Phase 1: Post-operative Phase (1-2 weeks)
  - Phase 2: Initial Rehab Phase (3-4 weeks)
  - Phase 3: Middle Rehab Phase (5-6 weeks)
  - Phase 4: Return to Competition Phase
(Goals should reflect functional, clinical, and psychological skills that are appropriate at each phase)
Goal Setting System

• Develop Weekly or Daily Goal Form than includes:
  – Long term goal
  – Short term goal
  – Strategies use to attain short term goal
  – Target dates where you will reevaluate the short term goals.

• Have the athlete keep a log of their rehab session
  – Track their progress of skills completed
  – Track their progress of goals attained
Goal Setting System

- Begin each session by reviewing with athlete their goals and the daily rehab session goal.
- Goals should be flexible.
- Goals need to be assessed regularly not just at the beginning and end.
- The goal setting system demonstrates progress and motivates the athlete.
Mental Skills (Chapter 12)

- Positive Self-talk
- Relaxation
- Coping with the fear of reinjury
- Modeling
- Healing Imagery
Self-Talk

Where the mind goes so does the body!

Usually mind will fail you before the body!

The key to controlling the mind is self-talk!
Self-talk and Injured Athlete

More self-critical thoughts than positive talk. Negative thoughts were associate with ability to return to competition. Injured athlete exhibited little change in their thought patter unless taught
How does positive self-talk help?

• It helps the injured athlete to:
  – Stay appropriately focused on their rehab
  – Foster positive expectations
Common Uses of Self-Talk

- Skill acquisition
- Changing bad habits
- Attention control (being in present)
- Creating mood
- Controlling one’s effort
- Building self-confidence
- Injury rehabilitation
- Exercise Adherence
What type of self-talk do you use?

• Positive or Negative?
  – What do you say to yourself after the injury?
  – What thoughts appear during rehab?
  – When do you use self-talk?
  – Common themes that appear across the rehab?
  – What cue words do you use in self-talk?
Cognitive Techniques to Control the Mind

- Thought stoppage
- Changing negative thought to positive thought!
- Rational thought
- Designing coping and mastery self-talk tapes
- Parking
Thought Stoppage

• Negative thought come into your mind….you stop it!
• Cue or trigger word that snaps you back to positive thought
  – Snapping your finger
  – Hitting your hand against your thigh
Changing Negative Thought to Positive Thought

List all the types of self-talk that you associate with the injury.

Try to substitute a positive statement for each negative statement.

Create a chart with negative thoughts in one column and your corresponding positive self-talk in another.
Negative Self-talk to positive Self-Talk

- You idiot—how could you get injured
- I’ll never recover from this injury
- I can’t do my rehab
- Everyone gets injured—just concentrate on rehab
- Healing takes time.
- Just take one day at a time and make rehab fun
Rational Thought

• Irrational thought
  – I am never going to play again.
  – I am not good injured, so what is the point!
  – My season is lost, so what is the point.

• Rational thought
  – The trainers and physical therapist told me that I will recover from the injury quicker if I complete the rehab exercises correctly.
Master Self-Talk Tape

With pleasant or motivational music
With positive cue words or statements
Positive Self-affirmation statements
  - You can do it!
  - Just do it!
  - Feel it! See it! Perform it!
  - No pain, no gain!

Psychology of the Injured: Part II
Parking

While performing and negative though intrudes your thought. “Park it” and then deal with it after the performance is over!

One of the distinguishing factors between a good athlete and poor athlete is:
- good athlete are able to deal with set backs while poor athlete cannot. “Park it”
Anxiety
Trait and State Anxiety Relationship

- **State anxiety**: “Right now” feelings that change from moment to moment.

- **Trait anxiety**: A personality disposition that is stable over time.

- High trait individuals experience more anxiety in rehab if they perceive the injury as serious and threaten their sense of self.
Who usually are high anxiety clients?

- Very young
- Inexperienced athlete
- People who have never been injured.
Anxiety and Rehab

Anxiety interpreted as unpleasant inhibits rehab. Anxiety interpreted as pleasant promotes rehab.

- Injured should view anxiety as a facilitator not inhibitor.

Bottom line: Athlete’s interpretation of anxiety determines it’s affect on rehab.
What can the AT or PT do?

• Change the athlete *perception of severity* and importance of the injury

• Reduce *uncertainty* about the injury
Anxiety Reduction Interventions

• Matching Hypothesis
  – Somatic anxiety
  – Cognitive anxiety
Anxiety Symptoms Due to Injury

- Cold, clammy hands
- Constant need to urinate
- Profuse sweating
- Negative self-talk
- Dazed look in eyes

(continued)
Symptoms of Anxiety (Continued)

- Feel ill
- Headache
- Cotton (dry) mouth
- Constantly sick
- Difficulties sleeping

(continued)
Anxiety–Reduction Techniques

Somatic Anxiety Reduction

Learn to control your breathing in stressful situations.

- When calm, confident, and in control your breathing is smooth, deep, and rhythmic.
- When under pressure and tense your breathing is short, shallow, and irregular.
Anxiety–Reduction Techniques

Somatic Anxiety Reduction

Progressive relaxation

Learn to feel the tension in your muscles and then to let go of this tension.
Anxiety–Reduction Techniques

Somatic Anxiety Reduction

Biofeedback

Become more aware of your autonomic nervous system and learn to control your physiological and autonomic responses by receiving physiological feedback not normally available.
Cognitive Anxiety Reduction

Teaches individuals to quiet the mind, concentrate, and reduce muscle tension by applying the basic elements of meditation.
Anxiety–Reduction Techniques

Cognitive Anxiety Reduction

Autogenic training

A series of exercises designed to produce two physical sensations—warmth and heaviness—and, in turn, produce a relaxed state.
Coping with the fear of re-injury

*Athletic courage* to return after an injury is “the ability to accept the discipline necessary to become well…Coakley(1998)
Coping with fear of being re-injured

SIT (Stress Inoculation Training)
Cognitive-affective stress management Training (SMT)
Systematic Desensitization
Goal-Setting strategies
Self-talk strategies
Visualization
Stay physically active
Coping Techniques

Stress–inoculation training (SIT)

An individual is exposed to and learns to cope with stress (via productive thoughts, mental images, and self-statements) in increasing amounts, thereby enhancing his or her immunity to stress.
Stress Inoculation Training

Kerr & Gross found that SIT was effective in helping athletes cope with the stress of injury.

SIT teaches skills for coping with psychological stressors.
Three Phases of SIT

Conceptualized stage.
- Awareness of the effects of positive and negative self-talk

Rehearsal stage
- Injured athlete learns to use healing imagery and positive self-talk

Application stage
- Athlete practice imagery and positive self-talk in low stressful situations
- Gradually progress to applying positive imagery and self-talk in more stressful situations
Cognitive Affective Stress Management Training (SMT)

Most comprehensive stress management approach

SMT involves

- coping response using relaxation and cognitive components to control emotional arousal.

- Injured athlete are an ideal population for SMT because they face stressful rehab and return to competition problems
SMT Phases

Pretreatment Assessment
Treatment rationale
Skill acquisition
Skill rehearsal
Pretreatment Assessment Phase

Conduct personal interviews to assess the injured athletes stress:
- circumstances that produces stress
- Their responses to stress
- How their responses affect their behaviors
Treatment Rationale Phase

Focus is on helping the injured athlete:
- Educate the athlete
- Help them understand their stress response
- Increase self-control

The emphasis is education, not psychotherapy
Skill Acquisition Phase

Develop coping responses by:
- Relaxation training
- Cognitive intervention skill training

Cognitive intervention skill training involves:
- irrational to rational self-talk
- reconstruct self-statements
  “I won’t be worth anything” to “I’ll be good person no matter whether I win or lose”
Skill Rehearsal

Use the coping skills of relaxation and cognitive strategies:

- during early training when one just returns to activity or sport
- Gradually increase the intensity of training (stress) and have the athlete use the coping skills.
Coping Techniques

• Systematic Desensitization
  – Ask the athlete to identify the fear(s)
  – Have the athlete relax then,
  – Have the athlete visualize the situation that they are fearful of.
Coping Strategies

Goal Setting Strategies

Set a date to return to competition
Number of drills in practice
Specific skill required in develop fully
Coping Strategies

Self-Talking Strategies
Counteract lowered confidence
Thought Stopping
Coping Strategies

Visualization

Visualize the game situations
Visualize his or her return to competition
Stress Prognosis Integration
Kinematic Expectancy

Commonly referred to as SPIKE

Psychology of the Injured: Part II
Modeling in a Therapeutic Context
(Chapter 13)
Modeling

• Through vicariously gained information patients, judgment criteria is established and new behavioral patterns are learned (Bandura, 1986)
Effective Models

• Physical Characteristics
  – Age, sex, and physique

• Model type
  – Mastery or coping

• Number of models
Effective Models

• The injured client or athlete needs to form a bond with the model through the identification of similarities, thus, the injured client will be move motivated to pay attention to the message the model is conveying (McCullagh el al., 1989).
Effective Models

• Model needs to similar
  – Same injury
  – Same sport
  – Same position

• Needs to be a coping model
  – Demonstrates the thoughts & strategies used during each stage of rehab to overcome the injury.
Modeling

- Informal & Formal Models
  - Lee-Gartner (1992) winter Olympic goal medalist after having 5 knee injuries.
  - Being exposed to newly hospitalized patients who demonstrate coping skills in order to reduce preoperative anxiety, postoperative ambulation, and decrease the number of days in hospital after surgery.
Modeling

• Formal and Informal Models
  – Six players were video taped who had ACL surgery.
  – Videotapes occurred immediately after surgery, at 2 mos post surgery and 4 mos.
  – Injured athlete with ACL injures watched the tapes.
    • Were more motivated in their rehab programs, had knowledge that helped them throughout rehab, and provided then with goals during each phase of their rehab.
Modeling Strategies

• Develop a vide tape delivered by a former injured athlete about the pertinent injury information.

• Have a former injured athlete provide information about the guidelines, exact nature of the injury, obstacles ahead, how to overcome the obstacles, and feelings the injured athlete may experience.
Modeling Strategies

• More the information is made preoperatively about what to expect, the better are the chances of recovery being facilitated.

• For first time injured athletes, vicarious learning from a similar other can accurately account for the road ahead (Kulik & Mahler, 1987).
“Now that I have seen that others can recover from serious injury, then so can I!”

David Pargram, 1999
Healing Imagery (Chapter 14)

“Imagination is more important than knowledge” – Albert Einstein
Mind-Body Integration

- Facilitates the healing process
  - Increased immune response between imagery and lymphocyte function.
  - Immune system is triggered by imagery
History

Ancient time the removal of pathogenic image was necessary for a cure.
- images led to pathology (Aristole)
- images were movement of the soul

Middle Ages
- Vital spirits traveled between the heart and brain
- Imagination became a predominate role in pathology
History

Pre modern times
- all illness were regarded as psychosomatic
- Blindness was a loss of sensation of reality
- Imagery was a key interventions
History

Imagery ended in 17th century as predominate intervention due to dualism (mind and body are separate)

- bleed became popular

In the 18th & 19th century, imagery was defined as the content of the mind and end product of sensation.

- Illness that had no explanation were imaginal
History

20th Century
- Link between imagination and pathology
- Edmund Jacobson work in relaxation
- Cancer research
Mental Imagery

Positive imagery are useful in enhancing one’s believe and mobilizing one’s own healing powers. Simonton, et al (1978) cancer patient study found relaxation and imagery showed 41% improved, 22.2% had total remission, and 19.1 tumor regression. Hull replicated Simonton study and found similar results.
Ievleva & Orlick Study

35 injured athletes used 3 types of imagery
- Healing imagery (see and feel the body part healing)
- Imagery during physiotherapy (imaged the treatment promoted recovery)
- Total recovery imagery (imaged total recovery)
Results

Injured athletes with knee and ankle injuries participated in the study.

Mental imagery was a focus of the study.

19% of these athletes had exceptionally fast recoveries that used any form of imagery. Recovery time was significantly shorter for those athletes that used imagery than athletes that did not.
Healing Imagery

Defined as visualizing and feeling the healing taking place to the injured area.

“Imagine the clot formation around the fracture, the change of the clot into fibrous tissue lattice, calcium crystallization on the latticework, and restructuring of new bone around the fracture.”
The uses of imagery during rehab

• Immediate following injury
  – Imagery should be devoted to developing an awareness.
    • Type of injury
    • What is expected during rehab
    • Be Positive imagery

• During rehab
  – Imagery should be devoted to creating a mind-set for recovery
    • Affirmation imagery used with goal setting
    • Coping with pain
    • Healing imagery
    • Self-confidence**
Healing Imagery

First relax then image.
Imagine the body being repaired
Internal imagery
Practice imagery daily
Involves all the senses not just vision
How Imagery Works

• Psychoneuromuscular Theory
  – Neuromuscular activity pattern activated during the imaginal process
  – Research with downhill skiers by Suinn monitored electric activity in leg muscles
    • Imagined the skill
    • Monitored the physical skill of skiing
  – Imagine of performance strengthens neuromuscular pattern
How Imagery Works

• Symbolic Learning Theory
  – Imagery may function as a coding system.
  – Feltz & Landers study found participants who use imagery performed consistently better on tasks that were primarily cognitive than those that were motoric.
Vividness

Use all the senses to make images as vivid and detailed as possible.

Exercise:
Imagine being at home, a positive outcome of rehab, and return to play.
Controllability

Learn to manipulate your images so they do what you want them to.

Exercise:
Imagine controlling the repair of one’s tissue, controlling your emotions, and performing in sport after the injury.
Tailor imagery programs to an athlete’s injury, needs (self-confidence), and interests.

The first step in developing an imagery program is evaluating the athlete’s imagery skills.

Imagery must be individualized and practiced. Hence, it should be built into the rehab or daily routine.
Types of Healing Imagery

Relaxation imagery
  - find a favorite place, peaceful scene

Sensation imagery
  - send healing messages to the body

Process imagery
  - using biologically correct healing process; seeing the fractured bone being repaired

End result imagery
  - See where you want to be, doing things you would normally do!
Final Note on Imagery

Winners see what they want to happen, losers see what they fear— Linda Bunker
Chapter 15

• Counseling Athletes with career ending injuries
Athlete & Permanent Injury

Athlete’s and clients who have problem are:

1) Those who has a heavy investment in the “sport identity” or “exercise identity”

2) Those who do not have a high level of self-worth and require frequent reinforcement.
General Reaction to Sport Injury

Denial
  ↓
Anger
  ↓
Grief
  ↓
Depression
  ↓
Reintegration
A MODEL OF HEALTHY ADJUSTMENT FOLLOWING A CAREER-ENDING ATHLETIC INJURY

MATT BROWN & JOHN HOGG
University of Alberta

INJURY

DOWN PERIOD

COPING RESOURCES

SOCIAL SUPPORT    INTERNAL COPING

FEELINGS OF COMPETENCE

AFFILIATION

PHYSICAL ACTIVITY

REDEFINING SATISFACTION

NEW PASSION OR CHALLENGE
“The Down Period”

Period of depression characterized by:

- low energy
- lack of motivation
- inactivity and
- withdrawal.

The implication of the injury can be slowly accepted. Period where the athlete is involved in “taking stock” in one’s life and all it have to give.
Social Support

Support from friend, relatives, coach, and trainer:

• “whose positive regard of the individual is unchanged by the injury.”

• Those that preserve the sense of belonging while reinforcing feelings of self-worth, independent of involvement in sport.
Internal Coping

Religious beliefs
Gaining perspective
Focusing on the present
Focusing on the positive
Refusal to focus on the past and the “what if”s.
Feelings of Competence

Sport was a primary source of competence. Loss of sport, individual must develop other aspects of personal competence. Of primary importance is developing a sense of worth that is not contingent upon performance in sport.
Affiliation

Athlete’s sense of belonging from the relationships with teammates and coaches.

Injured athlete must develop a new sense of belonging
- based on common goals, values, and experiences related to sport but not solely focused on athletic involvement.
Physical Activity

One fitness and high level of activity maintained by the athlete become a major component of self-image.

Loss of PA:
  Volume of participation
  Time & energy

Athlete needs new activities that challenge and fulfill them despite physical restrictions.
Redefining Satisfaction

New activities can match the intensity of their experiences as athletes. The discrepancy can become problematic for the athlete.

We see a shift in many athletes to:
- non-competitive sport
- becoming a coach, sport announcer, etc.
New Passion or Challenge

Athlete is driven toward high standards of achievement.
Preservation of positive self-image depends on individuals ability to pursue a personal vision or challenge.
Lack of direction potentially results in stagnation and preoccupation with the sport career that was terminated.
Structure of the Model

Perception of Loss (internal coping)

Social support is catalyst for positive action

Healthy transition include feeling of competence, affiliation, PA, and satisfaction.

Pursuing a passion or challenge was central for adjustment for all injured athletes.
Implications

- Normal to feel sadness
- Talk about it.
- Identify those people who can provide support.
- Focus on the future.
- Identify key interests or pursuits in which you have some ability or are willing to develop it.
- Surround your self with people with whom share common interests, values and qualities.
- Stay active.
- Be open to new pursuits and leisure activities.
- There’s a whole lot of living left to do…let’s get on with living.
Psychological Intervention
Summary

• Be flexible in your attitude and approach about the athlete path to recovery
• Mention that learning relaxation techniques help.
• Mention self-talk promotes the time of rehab
• Emphasize the positive aspects of recovery
• Develop a physiotherapy plan that provides benchmarks that demonstrate progress in a short period of rehab.
What should the Coach do?

Foster coach-athlete contact & involvement
Demonstrate positive empathy and support
Don’t repeatedly mention injury in training
Sport Medicine Personnel

Education and inform the athlete about the injury
Demonstrate empathy and support
Have supportive personality
Foster positive interaction
Demonstrate competency
Foster athlete confidence