# Understanding The Psychology of Sport Injury: A Grief Process Model

BY JOHN HEIL, D.A.

To the athlete, injury results in the loss of the opportunity to participate in a high valued activity and is a threat to continued success at sports. This is most problematic where injury is severe, or the process of rehabilitation is long or complicated. Serious injury can mean instant death to an athletic career cultivated by years of hard work. Even relatively mild injury may have a significant impact on the athlete when its timing is such that is undermines competitive success, for example, if it occurs immediately prior to a key competition. The terribly unfortunate and highly publicized injury of figure skater, Nancy Kerrigan, exemplifies this.

## A STAGE THEORY OF EMOTIONAL RESPONSE TO INJURY

Personal reaction to the experience of trauma including athletic injury may be viewed as a grief loss process. Kubler-Ross (1969) in **On Death and Dying** provided seminal thinking on this process of adaptation to loss. Drawing on her work with terminally ill patients, she described a series of stages that patients typically face: disbelief, denial, and isolation; anger; bargaining; depression; and acceptance and resignation. Her model provides a simple yet intuitively meaningful strategy for conceptualizing a complex set of emotional responses without the assumption of underlying pathology. The model constitutes a strong statement for the dynamic nature of affective response and is sensitive to the sometimes puzzling concurrent existence of contradictory emotions and to the transformation of emotional experience.

Given the obvious and important differences between terminally ill patients and injured athletes, work on understanding emotional response to injury needs continued development.

## THE AFFECTIVE CYCLE OF INJURY

An alternative to a stage theory is the affective cycle of injury; the fundamental assumption of which is that movement through stages is not a one-time linear process but is a cycle that may repeat itself. This model retains three important ideans from the initial work of Kubler-Ross (1969), the dynamic transformational nature of emotional experience, the patient's active "work of recovery", and the importance of denial. The affective cycle of injury includes three elements, distress, denial, and determined coping.

Distress recognizes the inherently disrupting and disorganizing impact of injury on emotional equilibrium. It includes shock, anger, bargaining, anxiety, depression, isolation, guilt, humiliation, preoccupation, and helplessness. The psychologists (or other member of the sports medicine team) should assess the magnitude of this distress and how appropriate it is relative to the severity of the injury. Denial includes a sense of disbelief (as well as varying degrees) of outright failure to accept the severity of injury. Denial may be reflected in the athlete's rather transparent assurances to health providers, teammates, and others about plans to quickly return to top form. It can range on a continuum from mild to profound and vary across time or circumstances. Given the specifics of its manifestation, it may serve an adaptive purpose or may interfere with rehabilitation progress. Determined coping implies acceptance (to varying degrees) of the severity of injury and its impact on the athlete's short-term and long-term goals. It is characterized by the purposeful use of coping resources in working through the process of recovery.

In the early stages of injury, distress and denial will tend to be at their peak. There is a general trend toward determined coping as rehabilitation proceeds. However, shifts in emotional response from denial to distress to determined coping can occur at any time. This is not a random process but is tied to specific experiences or events. One element will tend to dominate at a given stage in the rehabilitation process; however, any given element will seldom dominate 24 hours a day. Even during a period primarily characterized by determined coping, denial or distress may resurface for varying periods of time and with varying degrees of impact. Something as simple as a review of game films that show any injury can elicit this. Setbacks during the treatment process and pain flare-ups are the most likely triggers of a shift from determined coping to distress or denial. To the extent that these situations make the athlete feel that he or she is making no progress, they will tend to be a problem. Difficulties may also occur at natural transitions in the rehabilitation process. Generally, an athlete's emotional well-being will vary predictably with her or his subjective sense of progress through rehabilitation.

## CHRONOLOGY OF INJURY

Orthopaedic surgeon and sports medicine specialist, Richard Steadman, has described the medical process of injury and rehabilitation as a series of stages. Each stage presents a challenge to the athlete which elicits a distinct and intense psychological demand. These are listed below:

1. Preinjury
2. Immediate postinjury
3. Treatment decision and implementation
4. Early postoperative/rehabilitation
5. Late postoperative/rehabilitation
6. Specificity
7. Return to play

## THE AFFECTIVE CYCLE AND THE CHRONOLOGY OF INJURY INTEGRATED

The immediate postinjury period is one of maximum emotional disorganization. In conjunction with injury, there may be a shock-like response. The athlete may make unrealistic statements about speed of recovery and return to play, and specific fears and generalized anxiety may be evident. Denial is most adaptive during this phase of injury and need not be challenged as long as it does not jeopardize the athlete's safety. This is also a time of uncertainty, especially if surgery is to follow. Establishing rapport and moving the athlete toward realistic expectations regarding recovery will prompt determined coping.

The treatment decision and implementation period is a direct extension of the immediate postinjury period and is marked by a similar emotional profile. Because time has allowed the athlete to emotionally reorganize somewhat, reactive anxiety to injury may begin to resolve, but anticipatory anxiety regarding surgery may replace this. Determined coping rests on the athlete's ability to shift from an emotionally reactive mind-set to one of careful, calculated decision making. It is important that denial not interfere with

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this process.

At the beginning of the early postoperative/rehabilitative period, the athlete is severely limited physically, which with a related sense of helplessness, can set up accute depression. The athlete may focus upon surgery as a quick cure, re-eliciting denial. Treatment complications following surgery may lead to renewed anxiety as well as questions of trust in treatment providers. The athlete will be prone to loneliness and isolation during this period, especially if away from his or her home environment. Presenting the athlete with achievable short-term goals will guide determined coping and facilitate emotional reorganization around productive activity.

The late postoperative/rehabilitative period is an extension of the early postoperative/rehabilitative period. Well on the road to recovery, the athlete may feel an enhanced sense of self control or may struggle to maintain emotional equilibrium. Treatment setbacks may elicit transitory anxiety or depression during this period as well as throughout the remainder of rehabilitation. The drudgery of rehabilitation may begin to take its toll, sapping motivation and setting up irritability and anger. If acting out behavior results in significant guilt or alienation from others, it may contribute to depression. Continued consistent support and encouragement are essential.

By the time the athlete reaches the specificity period, success at rehabilitation should diminish depression, and an improving level of fitness should enhance vitality. As the athlete anticipates return to play, fear of failure or reinjury may arise, and self confidence may be further threatened if confidence in the athlete is not expressed by significant others (e.g., the coach). A continuing goal orientation and emphasis on treatment gains cue determined coping.

Return to play is a natural extension of the specificity period; participation replaces anticipation. Heightened anxiety and fear will resolve with success, but problems with return to play can re-elicit anxiety, depression, and irritability. If denial is still present, it will be challenged directly by the sport environment itself. By reinforcing success and by developing specific problem-solving strategies for difficulties that are encountered, treatment providers can guide the athlete in developing effective coping strategies.

## CONCLUSION

The advantage of a grief process model of injury is that it helps the athlete and practitioner understand the process of change and the challenge of coping, without presuming psychopathology. This model normalizes emotional response and offers a rationale for intervention to reduce suffering, and facilitate speedy psychological recovery and readiness for return to play.◆

This article has been excerpted from the **Psychology of Sport Injury,** a comprehensive guide for psychologists, psychiatrists, sports medicine physicians, athletic trainers, and sports physical therapists. It is available from Human Kinetion Publishers, Champaign, IL, 1-800-747-4457.

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## *Charles Shagass, M.D. A Professor, in the Best Sense of The Word continued from page 8*

Philadelphia and founded the Temple University Psychiatric Electrophysiological Laboratory at Eastern Pennsylvania Psychiatric Institute. Here he continued his work on electrophysiological predictors of mental illness by conducting large studies which evaluated evoked potentials in psychiatric patients. These studies documented and confirmed systematic differences in the electrical brain activity of psychiatric patients. The program is still ongoing today. During this time, his major collaborators were Drs. Marco Amadeo, Richard Josiassen, Donald Overton, Richard Roemer, and John Straumanis.

In Philadelphia, Shagass held academic and administrative positions as Chief of Temple Clinical Services (1966-81) and Acting Dirctor (1977-80) at Eastern Pennsylvania Psychiatric Institute. At Temple University he was Professor (1966-90), Acting Chairman of Psychiatry (1986-90), and then Professor Emeritus. In 1991, he became Professor of Psychiatry at the Medical College of Pennsylvania and continued his research program in psychiatric electrophysiology by establishing a Clinical Research Center at

Dr. Shagass earned a well-deserved reputation as an excellent clinician and teacher. He always devoted at least half of his time to these activities. His clinical orientation can best be described as a comprehensive and problem-solving approach, adhering to a broadly conceived medical model. This approach attempted to evaluate fully the intrapsychic, biological, interpersonal, social and situational aspects of the patient's difficulties. Shagass viewed psychiatry as a medical specialty. He thought that the biological approach should regain a dominant position in psychiatry because it was concordant with medicine's emphasis on pragmatic relevance. For him, the main functions of medicine were those of relieving suffering, ameliorating disability, and saving life, all this without doing more harm than good.

Dr. Shagass always viewed that his primary public service functions were performed through his work. In addition to his research, teaching, and clinical services, he served for 18 years on review committees for the National Institute of Mental Health.

Perhaps the most moving and accurate description of Dr. Shagass was given by Dr. Donald Overton at Dr. Shagass' funeral. "Charles Shagass, along with a few dozen colleagues around the country changed the face

small band of like minded psychiatrists who had formed a new society (Soc Biol Psychiatry) in order to have a place to present and compare their work. Now biological psychiatry is mainstream, and everyone does it. The whole field decided that those men were right, and joined them. And Psychiatry is better, and offers more hope to those who are mentally ill, as a result of that change.

So Charles Shagass had a vision of the direction in which psychiatry should develop to become a better field. When he accepted an office in a society, or made a decision as an officer; when he worked to create a scientific society; when he nominated individuals to leadership positions; when he advised on the expenditure of federal funds; those efforts and his advice were always generated with reference to an internal image of what psychiatry should become and how it could best get there.

So those are his accomplishments – what he did – scientist, teacher, physician, public servant, visionary."

He was truly a professor, in the best sense of the word. His wife Clara, his children Carla, Kathryn and Thomas and his grandchildren will greatly miss him. So will we here at Temple.◆