The Challenge of the Physically Challenged: Delivering Sport Psychology Services to Physically Disabled Athletes

Michael J. Asken
Polyclinic Medical Center, Harrisburg, PA

This paper discusses the delivery of sport psychology services to physically challenged (disabled) athletes. It begins with a description of the current status of athletic competition for physically disabled individuals. Commonalities in the sports experience of able-bodied and physically disabled athletes are addressed. Unique issues that must be considered for effective sport psychology consultations with disabled athletes are discussed. These include the background of physical and psychological trauma, altered physiological responses and medical problems, complexities in motivation to compete, unique performance problems, and the structure and organization of disabled sports. The article concludes with the effects of the social environment of disabled sports on the consultation process.

Consider the following:

- A Boston Marathon finishing time of 1 hr, 45.34 min
- The mile completed in 3.59 min
- A bench press of 585 lbs
- A high jump of 6 ft, 1.75 in.

Certainly these represent respectable athletic performances. They take on even more meaning, however, when it is realized that they were produced by physically disabled athletes (paraplegic George Murray for road racing, paraplegic John Brown for the bench press, and one-legged high jumper Arnie Boldt). The performances also reflect the status of competitive disabled sport in contemporary athletics, a pursuit that requires the same elements of speed, strength, skill, endurance, dedication to training, and competitive desire as able-bodied sports (Shearer, 1977).

This paper will address the challenge and process of providing sport psychology services to "physically challenged" athletes. Although rehabilitative, recreational, and health oriented sport and exercise are also essential for disabled individuals (Abramson, 1978; Goodling & Asken, 1987; Halpern, 1978) and in-

Michael J. Asken is with the Dept. of Physical Medicine and Rehabilitation at the Polyclinic Medical Center, 2601 North 3rd St., Harrisburg, PA 17110.
corporate important aspects of sport psychology, the current focus will be on the competitive physically disabled athlete. The comments will be drawn predominantly from motorically affected individuals (spinal cord injury, amputation, cerebral palsy), and especially wheelchair athletes.

The paper will describe the current context of disabled sport in which sport psychology services are likely to be delivered. It will then address some similarities between disabled and able-bodied sport. Finally, it will describe some unique issues in competitive disabled sport, the awareness of which can result in either the successful or the unsuccessful implementation of sport psychology services in the arena of disabled sport competition.

**Physically Disabled Sport Competition and Sport Psychology**

The current context of disabled sport competition requires a brief discussion of its historical development. Many years ago competitive disabled sport might have been defined by a few special or curious situations such as Pete Gray, a right-arm amputee who played baseball for the St. Louis Browns, or Monty Straton of the Philadelphia Athletics and Bert Shepherd of the Washington Senators who played despite their prosthetic legs.

The landmark developments for broad competition for and among disabled individuals, however, was the formation of the Stoke-Mandeville Games Federation in 1948 and the first international sporting event for disabled competitors, which was held at the National Spinal Injury Center at Stoke-Mandeville Hospital in England in 1952 (Jackson & Fredrickson, 1979). Other significant developments have included Bob Hall's completion of the Boston Marathon in a wheelchair in 1975, the Olympiad For The Disabled in Toronto in 1976, and the U.S. Olympic Committee's formation of The Committee on Sports for the Disabled in 1979 (at that time called the Committee for Handicapped in Sports) (Goodling & Asken, 1987).

While the contemporary status of physically disabled sport competition is too developed and complex to describe in detail here, a sense of it can be gleaned from aspects of the VIII Pan American Wheelchair Games held in Puerto Rico in November 1986 (Pope, 1987). Over 400 athletes representing 17 countries competed. Opening ceremonies were estimated to have been attended by 20,000 spectators. In addition to extensive volunteer efforts, there was fiscal support from companies such as Pepsi, Mitsubishi, 3-M, Everest and Jennings, and the Digital Corporation. The IX Pan American Wheelchair Games hosted 2,000 athletes from 20 countries (Staff, 1991).

Sport for disabled individuals has certainly moved from merely rehabilitation, solely the spectator role, and the "balloon bounce and bean bag toss" to true competition. To put it in the vernacular of a disabled competitive athlete,

> From a bunch of convalescing cripples out for a little recreation, we'd become a bunch of muscled, highly fit gimps out for blood. (Brademeyer & McBee, 1986, p. 182)

The growth of competitive disabled sport opportunities was not mirrored in the available opportunities for sport psychology training, however. Goodling
and Asken (1987) noted that a literature review yielded only one article on sport psychology and the physically disabled athlete as of 1979, and only one additional reference was found on sport psychology training through 1986. The lack of emphasis on psychological preparation in disabled sports was also observed by other authors (Horvat, French, & Henschen, 1986). And despite the USOC’s committee formation, no formal sport psychology programs were available to disabled athletes from the USOC as recently as 1985 (K. Clarke, personal communication, March 21, 1985).

Whereas sport psychology was once called “an undeveloped discipline from among the sports sciences for disabled athletes” (Asken & Goodling, 1986a), it would be more appropriate to now describe it as a developing discipline in this area. Sports ‘N Spokes, a journal for wheelchair sport, sponsored a three-part series on sport psychology in 1986 (Asken & Goodling, 1986b). Palaestra: The Forum of Sport, Physical Education and Recreation for the Disabled, has placed Dr. Bruce Ogilvie on its editorial board to represent sport psychology and has published psychological research in the area. In 1989 The Sport Psychologist profiled a physically disabled athlete (Asken, 1989). And the USOC now provides facilities for physically disabled athletes for physical and sport psychology training (S. Murphy, personal communication, February 28, 1991).

Thus the role of sport psychology for the physically disabled athlete is being enlarged and more broadly implemented. With this development it becomes coincidentally important for sport psychology practitioners to be familiar with similarities as well as unique issues in providing such services to this population of athletes.

Even though this paper will focus on issues that are unique to effective sport psychology consultation with disabled athletes compared to able-bodied athletes, it is fair to say that the commonalities are as frequent and striking as the differences.

**Commonalities Between Able-Bodied and Disabled Athletes**

Certainly a key tenet of disabled competitive sport is to minimize differences with able-bodied sport as much as possible. Labanowich (1978) has indicated that disabled sports seek to maintain the structure of able-bodied sports to the greatest degree possible, and where feasible, equal and integrated competition is endorsed.

Psychological studies (Henschen, Horvat, & French, 1934; Horvat, French, & Henschen, 1986) are noteworthy in finding, perhaps not surprisingly, that the psychological profiles of competitive disabled athletes are similar to those of competitive able-bodied athletes. Disabled athletes differ from the general nonathlete population on parameters similar to those of able-bodied athletes as well.

Madorsky and Curtis (1984) have observed an analogy between the need for able-bodied athletes to seek medical care from sports medicine specialists rather than general physicians, and the need for disabled athletes to work with physiatrists or physicians who are aware of the unique physical and medical parameters of competitive disabled sports over and above general rehabilitation principles. The same authors also describe a less complimentary similarity, that some disabled athletes will feign weakness to obtain a more favorable class rating for competition just as able-bodied athletes may try to manipulate their competitive class in some instances.

Regarding sport psychology consultation to athletes, Orlick and Partington (1987) provided valuable information on perceived characteristics of successful
Physically Disabled Athletes 373

and unsuccessful consultants. Those characteristics, especially competence, applied focus, concrete suggestions, accessibility, rapport, and commitment, are all necessary requirements for successful sport psychology consultation to physically disabled athletes as well. In fact the typical sport psychology training program content for physically disabled athletes is so similar to that of able-bodied athletes that it will be described only briefly here.

Arousal control techniques are important for physically disabled athletes as well as able-bodied athletes and often form the core of a sport psychology training program. Concentration skills training is often also appreciated by physically disabled athletes as a performance enhancement technique. Goal setting, self-talk, negative thought stopping, and interpersonal and assertiveness skills are all important areas to be addressed.

Clinical experience suggests that a further area that may frequently be appropriate for physically disabled athletes is attention to general confidence enhancement. Descriptions of approaches to psychological performance enhancement, team dynamics, and lifestyle and counseling issues are well described in the sport psychology literature elsewhere (Harris & Harris, 1983; May & Asken, 1987; Nideffer, 1985; Orlick, 1980). Creative adaptations may be needed, however, as in the case of muscle relaxation for paralyzed athletes or imagery for blind athletes.

The focus now will be on the unique issues that must be incorporated for successful consultation to this population of athletes. Solid training in one’s professional discipline, competent ability, and valid approaches certainly form the basis for all sport psychology consultation. However, just as there are special considerations in various areas of able-bodied sports, for example given the level of athlete or type of sport, there are crucial considerations in working with disabled athletes that must be added to a solid infrastructure in sport psychology. Although many counterparts to the issues described for disabled athletes may be found in various areas of able-bodied sport, it may be that consultation to the physically disabled athlete brings together in one focus more of these diverse issues and professional requirements than any other area of sport psychology.

Unique Issues

Background of Trauma

Clearly the most compelling characteristic of the physically disabled athlete that separates him or her from the able-bodied athlete is the history of having encountered a physically or psychologically traumatic experience resulting in loss of function and the disability. This is the defining characteristic of the physically disabled athlete.

The impact of incurring a physical disability cannot be minimized. Much has been written about the psychological difficulties experienced by able-bodied athletes as a response to injuries, most of which are not permanent. And it is not clear that even a career-ending injury, as hard as that may be for an athlete to accept, carries the impact of one that results in permanent, complete, and profound loss of function. The stages of psychologic response to athletic injury in able-bodied athletes such as denial, anger, bargaining, depression, and acceptance (Lynch, 1988) must be reemphasized as coming from the literature on death and dying (Kubler-Ross, 1969) and, indeed, physical disability.
One athlete reflected on his psychological response to becoming disabled in these words:

Like most people, I went through a series of feelings from disbelief to depression. . . . I believe a person's personality before injury plays a major role in how they adapt. Also crucial is family support and access to knowledge, competent and superb rehab professionals. (Asken, 1989, p. 168)

An interesting footnote to the difficulties in dealing with the negative aspects of disability is that, in competitive disabled competition, athletes were classified until recently according to the level of disability (to provide equal competition). This is in contrast to traditional classification by ability, as in able-bodied sports.

Thus the first area of specialized knowledge required for working with disabled athletes is that of the psychology of physical disability. It is not possible here to address all the areas of knowledge that this subsumes, for it includes familiarity with areas ranging from posttraumatic stress to the psychology of rehabilitation to cognitive/neuropsychological effects of injury. Yet, to relate to the athlete and to successfully intervene, a firm grounding in these areas must be established.

**Altered Physical Responses and Medical Problems**

The second area of specialized knowledge related to disability is that of the physiology and medical considerations unique to this population. The analogy of the unique aspects of sports medicine for the competing able-bodied individual has already been alluded to. In disabled sports, the term wheelchair sports medicine is becoming more common to denote the specialized area of athletic performance versus functional (daily living) performance (Madorsky & Curtis, 1984). This is superimposed on a requirement of understanding some of the unique physiological and medical sequelae of disability in general.

For example, Curtis (1981) has pointed out that due to paralysis, wheelchair athletes will physically condition via arm exercises. However, upper body exercise produces a higher heart rate and blood pressure than leg exercises at the same intensity. Further, depending on the level of injury, the heart and circulatory system may no longer receive direct sympathetic nervous system input to speed up during exercise, resulting in lower maximal heart rates.

Other authors (Madorsky & Curtis, 1984) have described unique injuries such as decubitus (skin) ulcers which result from sweat and moisture combining with shearing forces from sitting in the wheelchair during competition. A common concern is temperature disregulation problems from an inability to respond to changes in heat and cold and a lack of perspiration below the level of injury. A final example is the fact that a unilateral below-the-knee or above-the-knee amputee requires 10-33% and 38-55% more energy, respectively, to move 3.5 miles an hour compared to an able-bodied individual (Molnar, 1981).

**Complexities in Motivation to Compete**

Examples of the ramifications of the past history of trauma are the level of adaptation in a disabled athlete and motivations for participating in competitive sport. These can be quite complicated but very important in fully understanding the psychology of the physically disabled athlete.
Many reasons for participating in sport may be recognizable, expected, and similar to those of able-bodied athletes. Sherrill (1986) has listed the following as motivations for sports participation by disabled athletes: challenge of competition, fun and enjoyment, love of sport, fitness and health, knowledge and sport skill development, contribution to the team, and involvement in a team atmosphere.

Ideally, the decision to participate in competitive sports should represent the extension of the goals of rehabilitation and signify a return to a more normalized lifestyle. Given the hurdles in adapting to a situation of physical disability, however, this may not always be the case. There may be a variety of reasons for sport participation that reflect different motivations and even a less than optimal adjustment (Goodling & Asken, 1987).

Several authors (Goodling & Asken, 1987; Montelione & Davis, 1986; Sherrill, 1988) have suggested that, among disabled athletes, almost all see sport as a means of affirming competence. Further, sport is an attempt to reify a focus on ability rather than disability. Therefore there may be several layers of motives in participation.

Elite competitor and wheelchair athlete Michael Goodling has observed that there is a potential for even more problematic motivation in sport participation, however:

In rare instances, sport seems to be a way for disabled individuals to avoid dealing with their disability, to deny its existence, rather than incorporating sport in a new and healthy sense of self. . . . My concern here is what happens to these athletes when, for any of several reasons, they can no longer compete. (Asken, 1989, p. 169)

Thus, while the pursuit of competitive sport can be an indication of adaptation, it may also be symptomatic of a failure to adequately adjust. Individuals may engage in sport as a form of denial or counterphobic response to their medical situation and its emotional concomitants. Participation may be an attempt to show how uninhibited or how unencumbered they are: how wrong everyone, including the physician, was in their cautious estimations of a return of ability. Such a motivational situation should be considered when participation is undertaken with unremitting zeal or with an intensity that stretches good personal, common, medical, and sport training judgment.

Another potential problem in adjustment concerns the sports participant who has unrealistic expectations of the results of competing, either for physical improvement effects or personal gain. Even though there may be a rational approach to training and participation, exaggerated expectations can lead to disappointment, if not to psychological devastation. A variation of this problem concerns the individual who uses sport or exercise as the only way to adjust psychologically to the disability. Such a circumscribed approach becomes a significant problem if sports participation must be terminated for any reason. Using sport in these ways can delay working through and accepting the physical, psychological, and emotional consequences of disability.

The affirmation of competence may be a goal felt socially as well as individually. Consider the comments of elite disabled competitor Sharon Hedrick after her exhibition performance in the 800- and 1,500-meter wheelchair races at the 1984 Summer Olympic Games in Los Angeles:
I hope to make a lot of people aware that this is an exciting, competitive sport. We are trying to reach the general sports fan—able bodied people who don’t know what we can do. And we are trying to reach disabled people to show them to focus on their ability—not disabilities. (McBee, 1984, p. 10)

Thus there may be even more felt responsibility than just that to oneself in competition.

While the ability to recognize, understand, and work with such potential adjustment issues is important, it is also essential not to overdiagnose adjustment problems or questionable motivations. Once again, referring to comments from elite athlete Michael Goodling, “I compete to challenge my archery skills, not because I am disabled, but because I am an archer” (Goodling & Asken, 1987, p. 22).

Unique Performance Problems

A final effect of competing with a physical disability can be the development of some performance problems that are less likely to be seen in able-bodied athletes. One example is the case of L., a cerebral palsy athlete in her mid-30s who pursued competitive swimming. Shortly into her season she developed anxiety attacks during training, probably due to her spasticity and other competitive concerns. This was expressed by her becoming anxious when she would enter the deep water portion of the pool or leave the proximity of the pool edge. This became even more pronounced and problematic if she was likely to be placed in a swimming lane away from the pool deck during competition. When this occurred, her spasticity and her panic increased and she would cease swimming, swallow water, and grope for the nearest rope or pool edge. Working with the coach and the athlete, a program of visual imagery, positive self-talk, and the use of a distracting cadence was developed to allow her to overcome her problem and compete successfully.

The implication of these unique aspects is that competent sport psychology delivery to physically disabled athletes requires a level of medical and psychological knowledge beyond that typically found in training programs. Gaining that knowledge on a postgraduate or continuing education basis may also be problematic. Such training is not readily available. Information is scattered throughout disparate and often obscure journals, and clinical experiences may be limited.

The most direct means of gaining experience with physically disabled athletes is through the U.S. Olympic Committee. The USOC’s Committee on Sports for the Disabled can provide information on currently available activities. Another approach would be to contact the administrative or governing bodies for a particular disabled sport. (A list of administrative organizations is provided in the March/April 1991 issue of Sports 'N Spokes, p. 96).

Organization of Wheelchair and Competitive Disabled Sports

Competitive disabled sports has shown dramatic growth since its beginnings after World War II. It must also be recognized that, as a result, the organization of disabled sports is quite complex, variable, and somewhat splintered. Corporate support funds are much more available than ever before, but they are still re-
stricted when compared to able-bodied sports or even the Special Olympics. Elite wheelchair athletes have even had to raise travel funds for international competitions through candy and bake sales! Financial rewards are ultimately less for disabled athletes, and even the opportunity to focus solely on training for competition, by having a sponsor, is still uncommon in disabled sport. Michael Goodling’s comments once again seem poignant:

A lack of job opportunities and marketable skills may be even more pronounced for the disabled ex-athlete, and during his [her] sport career he or she will not have the financial potential of the elite able-bodied athlete. (Asken, 1989, p. 169)

The complicated and variable organization of disabled sports has some significant implications for the delivery of sport psychology services as well. First, most individuals involved in disabled sports are volunteers. With regard to athletes, this means many of them will have mixed priorities, needing to maintain a regular job as well as training for competition. Many coaches are in the same situation and also may have limited coaching knowledge or experience. Coaches may be rehabilitation professionals rather than individuals with specific sports or coaching expertise.

In addition to limited training times, there may be limited facilities for practice and for physical training. Opportunities are often “secondhand”—facilities made available after a high school or other sports program has prioritized its needs. Thus the sport psychologist needs flexibility and availability in working in a less refined system. It is also likely that services will be provided gratis.

The second issue related to the organization of disabled sports is dealing with a combination of sports at one time. The more typical able-bodied sport psychology experience is that of working with a single team or a single sport per consultation situation. A recent issue of *The Sport Psychologist* (Vol. 4, December 1990) provided some excellent descriptions of sport-specific programs and approaches. However, in disabled sports, due to its grass-roots organization and limited number of athletes, a “team” may comprise athletes in various sports, for example swimmers, track athletes, archers, and marathoners. Creativity is required for effective presentation to such a diverse group.

Not only are sports mixed in representation, but age levels and level of competition may not be homogenous for the same reasons as described above. Young athletes as well as older ones are often on the same team. More serious and competitive athletes may be on the same team as those who are less intense in their goals. Well-defined ascending levels of competition, as found in able-bodied youth leagues which lead to college and more elite levels, do not exist for young disabled athletes.

Finally, many disabled athletes change sports after their injury. A typical experience is that a disabled athlete tends to choose a new sport for competition after becoming disabled rather than pursuing one he or she engaged in prior to injury. Therefore the athlete is learning new techniques, skills, and approaches at a basic level while possibly pursuing high levels of competition. Hence, sport psychology in the area of a disabled sport competition may be part of a system and environment quite different from that to which many sport psychology professionals are accustomed.
The Social Environment of Competitive Disabled Sports

Individuals with physical disabilities do not exist in isolation but must deal with social communities that react to them. While support and encouragement would be ideal for an individual who is struggling to adapt to a disability or even to extend limits by engaging in sport, this is not always the case. In fact physical disabilities often bring a negative reaction from the community. The physical and social barriers encountered by disabled individuals are too complex to be more than noted here. And despite the recent landmark legislation of the Americans With Disabilities Act, sociologist Erving Goffman's (1963) use of the term stigma to describe the status of the disabled is still appropriate.

Sherrill (1986) has remarked that there is a hierarchy of stigmatization among the disabilities. The sensory disabilities are least stigmatized; those that impair mobility and physical attractiveness are more so. The most stigmatized are the mental disabilities which affect rationality or self-control. This bias exists among able-bodied and disabled individuals alike. Disabled athletes are not exempt from such attitudes even though they may be functioning at much higher levels (Sherrill, 1986). For example, Brandmeyer and McBee (1986) have observed that when wheelchair road racers sought (unofficial) entry into many competitions, their applications were not viewed seriously or positively by officials but rather as a "dramaturgic display."

The attitudes often begin with childhood and can lead to segregation that not only affects life in general but also access to sports opportunities. Despite legislation supporting the contrary, reasons are often found for excusing youngsters with disabilities from physical education and sports experiences.

One set of authors (Sherrill, Rainbolt, Montelione, & Pope, 1986) have reported that most ambulatory cerebral palsy students received physical education training in a mainstream class. Most wheelchair cerebral palsy students were placed in a separate adapted physical education class. However, 25.8% of wheelchair and 18.4% of ambulatory cerebral palsy students were reported to be excused from any physical education instruction.

An illustrative case was that of J. At the time of the occurrence he was a 12-year-old with osteogenesis imperfecta, using either crutches or a wheelchair for mobility. The fact that his mother was constantly engaged with the school over issues related to normalizing his general educational and social experiences was also representative of his physical education program. During physical education activities, J. was always assigned (or relegated) to being the scorer or helper. The school raised concerns for his safety and the safety of other students, such as the wheelchair running over a student’s toe during competition. Desiring an athletic experience, J. went outside the school system to join a local wheelchair athletic team. This previous sideline scorekeeper soon was regularly selected as a competitor to the Junior National Wheelchair Games, has won over 22 medals, and is indeed an elite junior wheelchair athlete.

The community may not be the only inhibiting force to athletic participation for disabled individuals. At times those closest to them may exhibit an over-protective and demotivating attitude. Sherrill (1986) reported the results of a survey of disabled athletes from 18 countries which showed a unique pattern of socialization into sport. Unlike able-bodied sports wherein the impetus for participa-
tion often comes from the family, only 9% of the disabled athletes indicated family influence in their motivation to participate. Internal motivation and support from both disabled and able-bodied friends were the primary sources of influence. Although working with parents is a central issue in all youth sport, it may provide different dimensions for the disabled youth sports participant.

Also significant is the finding that only 8% of the disabled athletes reported that their physicians had influenced them to participate. Given the intimate role that physicians play in the lives of most disabled individuals, this also suggests an attitude of overprotectiveness or a lack of awareness of what would seem to be a natural extension of medical rehabilitation—participation in sport. Kegel, Webster, and Burgess (1980) surveyed amputees and found that while overprotection was not reported, 47% did believe that family and friends underestimated their abilities.

Interestingly, public attitudes toward disabled sport competition may not be as negative as the foregoing would project. Sherrill (1986) did raise concerns over the paucity of spectators at the 1984 International Games for the Disabled and the fact that most of them were either family members or other athletes waiting for their competition. However, a preliminary study by Asken and Goodling (1987) found that, in general, able-bodied individuals reported a positive and supportive attitude toward competitive disabled sports. There was an absence of negative attitudes, and disabled athletes were seen as legitimate competitors.

A correlative but important finding from this study was that able-bodied individuals indicated a lack of awareness of the occurrence of disabled sports competitions. They said there were no resources informing them of ongoing events or reporting the results of such competitions. The lack of "profile" may not only be a barrier to the growth and acceptance of disabled sports but may also represent a subtle form of sports media bias. It has been observed that when disabled sports events are covered, they tend to be reported on the social pages rather than the sports section of the print media.

Hurst and Lykins (1990) extended the findings of this previous study. They surveyed sports editors of U.S. newspapers with circulations over 200,000 as to perceptions of disabled sports. It was found that the editors perceived wheelchair and able-bodied athletes to be similar in traits required for success. However, coverage of wheelchair sports was significantly less (no greater than 10% of the sports pages) due to a perception of the lack of reader interest and newsworthiness. The majority of respondents (83%) were acquainted with disabled persons; however, only 39% had attended a wheelchair sport event and only 29% personally knew a disabled athlete.

Therefore the sport psychology consultant will find the social context of disabled sport to be quite different from the typical high school, college, or other sport experience. Certainly it is an endeavor that has a much lower public profile and lacks much of the glamour of being associated with a highly esteemed able-bodied sports team or program (a questionable motive for involvement anyway!).

Finally, the social environment and nature of disabled individuals and sports argues for the sport psychology consultant who wishes to be involved in this area to have a clear understanding of his/her own attitudes and motivations. This must begin with an awareness of personally held attitudes about disability and the disabled in general. Working with the disabled athlete means working with a disabled person and encountering areas of potential sensitivity such as the appearance
of prosthetics, amputated stumps, spastic movements, or adapted self-care related to bowel and bladder incontinence.

Difficulties in developing a sincere appreciation of disabled sport must be acknowledged if they exist. Certainly, many akinetic movements may seem to be the antithesis of the grace of athletic ability with which one may be more accustomed. Just as a true appreciation of a given sport is required for successful consultation with an able-bodied athlete in that sport, there must be a true appreciation of the value and beauty of disabled sport competition. Finally, involvement motivated by pity is not only inappropriate and condescending but underscores a misunderstanding of the dignity and pride of the physically disabled athlete and physically disabled sport in general.

The delivery of sport psychology services to the physically challenged therefore does provide an exciting professional challenge, one that calls for knowledge and skills required in the areas of physical medicine and rehabilitation, the psychology of physical disability, and the psychology of sport. There is the challenge of implementing services in an underdeveloped, underserved, and essentially uncharted area. There is the challenge of functioning in a social environment different from the traditional sports environment. Meeting these challenges is particularly gratifying in this area where sport and performance not only provide appreciation, pleasure, and entertainment but also contribute substantially to the quality of life.

References


While some advocate the use of the term "physically challenged" or "athletes with a physical disability" rather than the term "physically disabled athlete," the latter will be used in this paper based on precedent and economics of space and communication. Also, it has been my experience that physically disabled athletes are not offended by the use of this term.

Dr. Wayne Harris of Mankato State University in Minnesota has been instrumental in developing as well as being a frequent provider of sport psychology training for disabled athletes at the USOC site.