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Abstract

In this chapter, we present the case of “Andrew”, an elite male professional rugby union player in his early 20s, who suffered a series of severe knee injuries and experienced a number of negative psychological reactions, including heightened stress and anxiety, as a consequence. Humanistic counseling and REBT, specifically the ABCDE and “badness scale” techniques, were used to change Andrew’s beliefs regarding his injury, from his pre-intervention perceptions – that the injury he had was a catastrophe – to more rational beliefs, emphasizing that it might be bad but it was not “the end of the world”, post-intervention. The second part of the chapter reflects upon the use of REBT in supporting the recovery of injured athletes more generally and how the practitioners’ experience has influenced subsequent delivery of REBT techniques. Specific topics discussed in the chapter include: factors influencing psychological recovery from injury, the methods used in the REBT sessions, and the specific outcomes that resulted from the use of the intervention with Andrew. The practitioners’ reflections on the use of REBT techniques, such as the way they may be used as part of broader injury rehabilitation programs, are also discussed.

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“It’s the end of the world as we know it (and I feel fine)”

The use of Rational Emotive Behavior Therapy (REBT) to increase function and reduce irrational beliefs of an injured athlete

Robert Morris, David Tod, and Martin Eubank

Context and presenting issue

I (first author) was first approached to work with Andrew when he was in his early 20s and competing as a professional rugby player. Andrew approached me directly via links that I had with his professional rugby club and the University I worked at. In the initial instance, Andrew asked if I would help him with his performance, including how to control his anxiety levels when competing, as he had become overawed in major games. He also reported some personal issues he wanted assistance with, specifically in how to overcome challenges in his personal relationships with his girlfriend and young family. In addition to being a professional rugby player, Andrew was also studying for an undergraduate degree in Law. We also worked together on Andrew’s lifestyle, to ensure he was able to manage and balance his life demands, which were varied and plentiful. I worked with Andrew for an initial period of 9-months, with the focus of our sessions together aiming to ensure that Andrew was in peak mental condition when competing in matches and that he had high levels of psychological wellbeing.

We had developed a strong relationship over the 9-months we had been working together. One day, I had four missed phone calls from Andrew, with a voicemail message that insisted I call him back

as soon as possible. I phoned him back as soon as I could, and heard in his voice almost immediately that something was wrong – Andrew had suffered a major knee injury while competing and was going to require knee surgery. He was going to be out for a minimum of 7-months and he was clearly highly distressed. Despite being considered one of the best players in the team by teammates and coaches, during this phone call Andrew outlined that he had quickly become uncertain about everything he had accomplished as a professional athlete and viewed the injury as “the worst thing that could happen” to him. Due to the severity of the injury and the way Andrew was responding emotionally and cognitively, we quickly agreed to meet up to speak in more detail and outline his likely recovery path. We also identified how we could work together to ensure that he was psychologically prepared for, firstly, what he was about to undergo during rehab, and secondly, what he may have to overcome to become a successful professional rugby player again.

It was clear from the first time that Andrew and I met after his injury that he was experiencing several strong negative psychological reactions, and these were also having an impact upon his personal life. He continually talked about how rugby was the “most important part” of his life, how he felt useless because he could not do much prior to having surgery due to the pain he was in, and that he was continually “falling out” with his partner because she “didn’t understand” what he was going through. In essence, Andrew was experiencing heightened anxiety and stress as a result of his injury and was unable to cope effectively with the challenges this presented. From a humanistic perspective (this was the framework I had always adopted with Andrew) I helped him to understand how he perceived the event and how it may influence his capability to achieve self-fulfillment and satisfaction in life (Rogers, 1959). As a model of practice, the approach draws on optimism and outlines that humans have the capacity to overcome hardship, pain, and despair (Rogers, 1959), something with which Andrew and I were both congruent. Working with Andrew within this framework, I was able to

help him to better manage the psychological distress he was experiencing prior to his operation, which was one of the immediate issues with which he presented. The plan was that Andrew would have his operation, after which we would work together with staff at the club to determine a rehabilitation strategy, incorporating physiotherapy, medical support, and psychological assistance.

Having put this plan in place, the physiological and psychological recovery subsequently appeared to be progressing well. Two months post-operation, I received a phone call from the physiotherapist at the club. Andrew had just been reinjured in training and was about to head to hospital. I was informed that it was likely that his first operation had been unsuccessful and Andrew may require more extensive surgery to find out the root cause of his re-injury. At that time, I was uncertain how to react – Andrew had been progressing well psychologically, but I knew from the fact that the job of phoning me had been given to the physiotherapist that he did not want to talk, and that he would see the re-injury as a major blow.

Andrew required a second major operation on his knee, which this time involved major reconstructive work. Andrew felt devastated, was highly anxious and worried about what was to come – he thought he had been progressing well with his recovery and now he was being told that his knee was so severely damaged that he would be out for a year and could potentially never play again. To Andrew, it was, as he put it, the “end of the world”. I continued to work with Andrew using the same humanistic approach before and after his second operation. I expected that, after a period of working with Andrew from a humanistic perspective, he would start to show signs of improved mental wellbeing. However, there was no clear sign of progress, with Andrew still showing signs of being highly anxious and worried about his situation. To contextualize, Andrew still believed that the injury was devastating and the worst thing that could have happened to him. At this point, I started to challenge whether my humanistic model of practice, while previously helpful to Andrew, was enough.

The approach I used did not help to contextualize to Andrew the importance of his injury and his recovery when compared to other aspects of his life. Consequently, I started to consider other methods I may use to support Andrew in his recovery.

Needs analysis

During my training as a sport and exercise psychologist and in my subsequent readings on interventions to support athletes who were experiencing injury, I often wondered how I would choose to work with athletes who had deeply rooted issues because of their injury. Acknowledging my own doubts about the lack of progress I had made using my humanistic approach with Andrew, I knew I needed to return to the literature to consider other models of approach and congruent interventions that had empirical support for their effectiveness that could be applicable in helping Andrew. It was during this period that I came across the work of [Turner and Barker \(2014\)](#), who were writing about the application of REBT as a way of increasing athletes’ functioning and reducing irrational beliefs. Although not focused on injury, [Turner and Barker \(2014\)](#) outlined the principle of irrational beliefs and how this could negatively impact an athlete’s mental health and wellbeing. I started to read more of the literature associated with REBT, including some of the original works by [Ellis \(1957\)](#) and some of the more recent works where REBT was applied to sport (e.g., [Turner & Barker, 2013](#)), and attending workshops around its application in sport. It became clear to me that the thoughts and feelings Andrew had could be categorized as irrational, especially when he was outlining to me that the injury he was experiencing was the “end of the world” and the “worst thing that could have happened”. Previous literature (e.g., [Tripp, et al., 2007](#)) has highlighted that a fear of re-injury, negative affect, and catastrophizing were all significantly correlated with athletes’ confidence in their ability to return to their sport. It is, therefore, important that there is a conscious reduction in catastrophizing in order that

athletes who are injured may be able to confidently recuperate and perform to an optimal level post-recovery. As a consequence of Andrew’s current needs, the REBT evidence base, and the literature associated with sports injury rehabilitation, my case formulation led me to incorporate REBT into my support for Andrew as he moved through his recovery period, drawing on the framework of [Turner and Barker \(2014\)](#).

The REBT intervention

My needs analysis with Andrew had identified that he was experiencing a significant emotional reaction to his second injury that needed to be overcome to increase his functioning as a human and athlete. To increase and improve his functioning and mental wellbeing would take a lengthy period of time. Initially, and in the shorter term, there was also a need to start getting Andrew to think more rationally about his injury and how important this was in the broader spectrum of his life.

Education phase

When I was working with Andrew, the main focus of the education phase was to, firstly, outline the ABC process of REBT (e.g., [Dryden, 2009](#); [Turner, et al., 2014](#)) and, secondly, explain what ABC meant in the context of his situation ([Turner & Barker, 2014](#)). Outlining that when facing the adversity (A), it was his belief (B) that determined his emotional and behavioural responses (C), and not the injury itself, was the first step in helping Andrew recover. This outline involved me explaining to Andrew, via a presentation on these concepts, what he could and could not control in this process – he could not control his injury, but he could control his belief that it was the “end of the world” and consequently his emotional and behavioural responses to this belief. The ABC assessment table below

(Figure 15.1) provides a summary of the main activating event, irrational beliefs, and unhelpful consequences and highlights more clearly why REBT was an appropriate intervention to help Andrew with his situation.

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Figure 15.1 ABC assessment table for Andrew

<p>Activating Event (A)</p> <p>Situation: Second stage long-term knee injury, which required reconstructive surgery, with an anticipated 12-month period out of rugby</p> <p>Adversity: Rugby is all Andrew bases his worth upon and having a long-term period out of the game is something he would find very difficult to overcome. From Andrew’s point of view, rugby is everything</p>
<p style="text-align: center;">Irrational Beliefs (iB)</p> <p>Demand: “I must recover as I absolutely must play rugby again”</p> <p>Awfulizing: “If I cannot play again, it is the end of the world and this is the worst thing that could have happened to me”</p> <p>Depreciation: “If I cannot play again, I am no use”</p>
<p style="text-align: center;">Unhelpful Consequences (C)</p> <p>Emotional Consequences: Increased anxiety and anger about the recovery process and subsequent performances after the recovery</p> <p>Behavioural Consequences:</p> <ul style="list-style-type: none"> Avoidance coping Withdrawal

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Emotional and behavioural responses (C)

In order to advance the intervention, I started to identify the main emotional and behavioural reactions Andrew had in response to the injury. To identify these, I first asked Andrew how he felt and what actions he carried out when he found out about the severity of his injury. Andrew identified that he immediately felt anxious and angry when he knew he was injured.

Finding the adversity (A)

The next stage of the REBT framework was to identify with Andrew the critical adversity that had triggered the irrational beliefs he was experiencing. In this instance, I used “inference chaining” (Ellis, et al., 1997), a technique in which Andrew was continually asked why his experience was a problem, in order to establish whether or not the injury itself was the underpinning adversity or merely the trigger point for other, more central inferences about it. Inference chaining enabled me to identify that it was not the injury itself that was the adversity, but the potential outcomes and consequences of not being able to recover and play rugby again, including self-depreciation and questioning of worth.

Irrational beliefs (B)

After establishing the critical adversity, I explored with Andrew the main irrational beliefs he held, primarily through the use of questions such as “What are you saying to yourself about the adversity that is causing the emotional and behavioural response?” When I asked this question, Andrew took some time to consider his response, before identifying that, to him, rugby was his “life” and that he had to recover because playing it “is an absolute must”, otherwise he is “no use”. Andrew also continually

“awfulized” throughout our conversations – “If I cannot play again, it is the end of the world and this is the worst thing that could have happened to me”. He did not consider that there was anything maladaptive with any of these beliefs, but after I reflected them back to him, he started to understand why such beliefs might be unrealistic and unhealthy. He also started to identify that it could be these thoughts that had resulted in him experiencing increased anxiety and anger about the recovery process.

Disputation (D)

Within this phase, the main area of focus during the work I carried out with Andrew was around understanding the pragmatics of his beliefs and how they were contributing to his actions and behaviours. Initially, to dispute Andrew’s beliefs, I used the “badness scale” technique, outlined by [Ellis et al. \(1997\)](#). I gave Andrew a range of adversities that he may encounter throughout his life, both within his sport and outside of it. I initially asked him to rate on a scale of 0% (not bad at all) to 100% (the worst thing that could ever happen) where he would rate his current injury situation. Andrew initially identified his injury situation as one of the worst things that could ever happen at “85% bad”. Subsequent to this phase, I then asked Andrew to identify on the scale where he would put aspects such as stubbing his toe, being paralyzed, contracting an incurable disease, never playing rugby again, losing a loved one, losing an important match, or being relegated.

Andrew started to appreciate two things. Firstly, he started to realize that, regardless of how bad any situation may become, it was never awful or insurmountable. Andrew had identified that losing a loved one, in particular his girlfriend, was the worst thing that could happen to him, but that he could recover from even that situation. He rated this event at “95% bad”, which was below awful, or “101% bad” ([Ellis et al., 1997](#)). Andrew also started to understand that the situation he was in with his injuries was not as bad as he had considered it to be when he was first asked to put this on the scale. When we

were working through the other events that may be considered adverse in a person’s life, Andrew asked whether or not he could move events he had already put on the scale to accommodate his changing thoughts and opinions. When I asked what he meant, he responded by outlining that there are a number of much worse events that could happen in his life, and losing some playing time or his rugby career to injury was not as terrible as he had thought. I asked him where he would now put his injury on the scale and he moved it to “50% bad”. Although he still believed that it was a bad situation, he acknowledged that he could experience worse events, including being paralyzed (“90% bad”), contracting an incurable disease (“85% bad”), and never playing rugby at any level again (“60% bad”). In essence, Andrew had gone from believing his injury situation was one of the worst aspects of his life (“85% bad”) to having a more rational understanding of the circumstances he was experiencing (“50% bad”).

Effective rational belief (E) phase

Within this phase, I worked with Andrew to promote a new, more adaptive rational belief. This change only occurred once he understood that the current beliefs he held were irrational and illogical in relation to other potential adversities he might experience in his life. I firstly asked Andrew if he could outline to me how he would change his belief that the injury was the worst thing that could happen to him to a more rational belief. Andrew struggled with this, as he had never considered an alternative way to think about these beliefs he held. Consequently, I worked with him by suggesting he could consider softening the tone of language used and using preferences as alternatives (Turner & Barker, 2013). Due to the directive nature of REBT, I suggested that Andrew might wish to consider a more rational belief like, “I really, really want to play rugby again, and . . . if I am not able to it will not be the end of the world and it will not reduce my worth as a person. It will be hard to bear but it will not be unbearable”. Andrew acknowledged that this belief was perhaps more rational, but he also thought

that this was underselling what he had achieved and what he could offer if he recovered from injury. Instead, he suggested the alternative belief could be, “Being injured is bad, but it is not the end of the world, and I know I can give everything to recover and try 100% to become a professional rugby player, and it may still not happen. I would like to recover and play again but I will be able to do other things with my life if I can’t”. When I asked Andrew to comment on why he wanted to include the aspect about giving everything to recover, he said it was because he felt it was something he could control. He now acknowledged that there were aspects of his situation, such as the injury itself, he could not control, but there were other aspects such as his motivation and determination throughout his recovery he could control and he wanted to be reminded of this in his rational belief. This new belief was one that Andrew now aligned himself to and kept reminding himself of throughout his recovery period.

Reinforcement

In this period, I worked with Andrew to reinforce the ABCDE and badness scale procedures we had used to challenge his beliefs and consequential behaviours by asking him what he felt he had learned from the process. Andrew outlined that he believed he was more knowledgeable about his current situation and the way his beliefs drive his behaviours, while also acknowledging his new beliefs around the injury process. The reinforcement session of the REBT process with Andrew took place 1-month after the final effective rational belief (E) phase had taken place. This timescale was chosen because it allowed Andrew to have some experience of reminding himself of his rational belief, while at the same time identifying instances during his recovery process where he had gone back to more irrational thinking. Although Andrew acknowledged the benefits of the process he had gone through, he identified that he had gone back to irrational thinking during particular events in his recovery period.

These were primarily during tough rehabilitation sessions, where he had either been pushed to the limits of his capabilities, or had been involved in conversations with other players and coaches in the team asking when he was going to be back playing with the team. Andrew was, however, able to manage and deal with this maladaptive thinking and restructure his thoughts to be more positive and facilitative to his mental health. In essence, Andrew was using ABCDE in situ, self-regulating his own thoughts and beliefs based upon the conversations we had previously. This understanding allowed me to reiterate to Andrew that he had the capabilities to change any irrational beliefs he may have had, regardless of whether it was during a recovery from injury or not.

Humanistic counseling

While I used REBT as a technique to help Andrew understand his thoughts and beliefs in relation to his injury, the continuation of humanistic-based counseling with Andrew helped him to determine his own direction in the recovery process. This approach took place before, during, and after the introduction of REBT and continued until Andrew had fully recovered from his injury a number of months later. To me, it was fundamental that Andrew continued to be an active participant in the psychological recovery process and that through the adoption of REBT I was not just imposing skills and techniques I had at my disposal on him. The combined approach of REBT techniques and humanistic conversations, as outlined previously, provided Andrew the ability to respond well to particular demands and gave, I think, the most complete, person-centered approach in this situation. Our humanistic conversations, prior to his second injury, were around his reactions to his initial injury and how he was feeling psychologically and physiologically. Driven by Andrew himself, after the introduction of REBT, our conversations centered on his decision-making regarding what else he could do with his life to achieve self-fulfillment and actualization should he not be successful in his recovery from injury. This change

in conversation by Andrew highlights the value that an integrative approach to practice can have for the client.

Outcome analysis

After Andrew had fully recovered from his injury, both psychologically and physically, and had started to train and compete with the team again, I asked him to reflect with me as to whether or not he believed his recovery process had been influenced by the work we had done. He offered the following reflection:

Absolutely it has! I think there are a couple of reasons for that to be honest. Firstly, it gave me a better understanding of why I was behaving the way I was. I was falling out with people and getting really frustrated. When we did the ABCDE, I started to understand just how bad things were. It put it all in perspective – nothing is as bad as it ever seems. At the end of the day, I still have a family, I’m still healthy overall. That was what it made me realize. And I think starting to work through alternatives as well – knowing rugby wasn’t everything or the only thing I could do. I just feel more relaxed about things. And even if I get injured again, I know it’s not the “end of the world” as I thought before! I felt control . . . control of my thoughts and behaviours.

Andrew also felt that the process had been easy to follow, commenting that “at times” sport psychology can become “deep” if the conversation is focusing on difficult issues. He had found that the approach taken in response to his injury “was easier” because, due to the structure of REBT, it was “easy to understand and made it clear what was going on”. He continued to come to the sessions we had arranged, owing to the fact that he felt they had value for his recovery.

As social validation, this form of evaluation is valuable in understanding, from Andrew’s perspective, the recovery process he had gone through and the impact of the integrative approach on his

injury rehabilitation and recovery. The work had helped Andrew understand that his irrational beliefs and consequential behaviours were controllable and gave him ways he could act in more adaptive ways. In my own reflections on this work, I believe that Andrew was helped in his recovery by this intervention. When I first spoke to Andrew after his injury, I knew that he was experiencing anxiety and anger due to his body language and the way he spoke to me. A usually forceful character, Andrew had become withdrawn from others and spoke in a more timid manner. When I reflect upon how his attitude and body language changed throughout his recovery process, after every session he would comment on how much he valued the work I was doing with him and he also became more forthright with his opinions again. As our work together unfolded, he proceeded to become the Andrew I knew prior to his injury.

Critical reflections

Overall, the integrative use of REBT within a humanistic framework of sport psychology support was, for Andrew, a success as it helped support his psychological recovery from injury and increase his functioning. That said, some reflections on the strengths and limitations of the use of REBT as part of an injury recovery rehabilitation strategy may help to inform future applied practice.

Firstly, practitioners may need to consider the type and severity of the injury and how long the athlete is likely to be unable to train when using REBT as part of a recovery programme. When I worked with Andrew it was clear that after a period of time (approximately 2-months) the beneficial impact of the badness scale in reducing awfulizing to which he was prone would gradually decrease, resulting in him becoming more irrational in his beliefs again. Repeated sessions of REBT throughout longer-term injuries could be beneficial for athletes, ensuring that this type of “drift” might not be as pronounced.

One of the major benefits of REBT in the current context was that Andrew found the intervention easy to follow. It was, therefore, much easier for me, as the practitioner, to implement REBT because I did not continually have to explain the process to him. Rather, I could focus on helping him to change his beliefs via the intervention. When I first outlined what we were going to do and started to implement the intervention, he immediately identified why doing such an intervention may be beneficial, and we were able to quickly progress through the stages of intervention without him being unsure what we were doing and why we were doing it. For practitioners who place importance on their clients being able to collaborate in the work being done to inform its intended outcomes, the experience of working with Andrew suggests that REBT, as a technique-driven intervention, can be accommodating in this regard. Indeed, collaboration is a key part of what the REBT model emphasizes, and clients need to be active in the process.

One final consideration for future practice is the underpinning philosophical approach practitioners take with their work. Having an underpinning humanistic orientation to my practice, REBT and other technique-based interventions are not tools I would usually consider when choosing an intervention in my sport psychology practice. Through this case study, however, and other work I have carried out over the subsequent period, I have come to acknowledge and understand the value of having a skill set which is not solely and over-narrowly defined by the philosophical approach I take to the exclusion of all others, but that is also flexible enough to be concerned with the specific issues athletes present. In the case of Andrew, I may have been effective in helping his recovery from injury using just a humanistic approach. I believe, however, this would have taken a much longer period of time, with Andrew having to go through a more prolonged period of distress. Through broadening my approach, I was able to consider other alternatives to practice and offer a support programme, which gave Andrew

short-term comfort and long-term benefit, helping him on his way to achieving self-actualization and recovery.

Conclusion

The current chapter outlined the case of Andrew, a professional rugby player who suffered significant knee injuries, and outlined how a combined integrative approach using REBT and humanistic counseling can be used to effectively support athletes with serious injuries (such as those Andrew encountered) and facilitate recovery. Although the process was successful in Andrew’s case, in deciding whether to use REBT in other cases there is a need to consider the length of time athletes are likely to be out injured, but perhaps more fundamentally whether or not REBT represents a useful intervention on its own, or is best used in combination with other approaches (as in this instance), to provide psychological support for athletes with serious injuries.

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Editors’ commentary on Chapter 15: “‘It’s the end of the world as we know it (and I feel fine)’: the use of Rational Emotive Behavior Therapy (REBT) to increase function and reduce irrational beliefs of an injured athlete”

Robert, David, and Martin address a really important issue in their chapter. Injury will affect every athlete in their careers, to lesser and greater extents, and REBT can be a very effective approach to helping athletes rehabilitate, or in the worst cases, transition out of athletic performance. As highlighted in the chapter, awfulizing can hinder an athlete’s efforts to successfully come through an injury. Research indicates that higher catastrophizing (a term often used instead of awfulizing) leads to

greater pain, more distress, greater disability, poorer quality of life in response to injury, and is generally negatively related to all pain outcomes investigated such as intensity, distress, and functioning, whereas decreased catastrophizing leads to decreased pain, disability, and depressive symptoms (see [Schnur, et al., 2010](#), for a review). Particularly relevant to athletes, catastrophizing is related to post-knee surgery pain ([Pavlin, et al., 2005](#)), and poorer pain adjustment and unrealistic thoughts about pain ([Dixon, et al., 2004](#)). Therefore, irrational beliefs may have an important part to play in the biopsychosocial understanding of pain.

The authors skillfully work with the athlete to dispute his “it is the end of the world” belief. Timing is vital here. We would not recommend disputing a client’s awfulizing too soon after an injury, particularly if the injury is severe. In disputation, you are challenging the athlete, and in some cases, you are having a difficult conversation. Being too active-directive and challenging too soon can damage rapport. Morris et al. collaborate with the athlete, developing rapport before disputation, therefore when beliefs are disputed, teamwork (athlete-practitioner) becomes a vital component. When taken at its most fundamental level, even if the injury is career-ending, helping the athlete to see that this is not truly awful will be a difficult conversation and process, but if done right, will help the athlete to move on.

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