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# DELIVERY OF PSYCHOLOGICAL SERVICES TO THE U.S. OLYMPIC TEAM AT THE 1992 SUMMER OLYMPIC GAMES: BARCELONA, SPAIN

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ABSTRACT: A description of the psychological services to the U.S. Olympic Team at the 1992 summer Olympic Games, Barcelona, Spain is provided. Services were based upon a crisis intervention model. Philosophy, preparation for games, criteria for psychologists selection, goals and objectives of psychological activities, range of services and intervention strategies are provided, as well as recommendations for the future. The U.S. Olympic team consisted of an excess of six hundred fifty male and female athletes representing thirty different sports. In addition, there were another two hundred plus olympic support delegation members. The U.S. Olympic Sports Medicine team included: one psychologist, eight physicians, twenty-five athletic trainers and one chiropractor.

RESUMEN: Se proporciona una descripción de los servicios psicológicos para el Equipo Olímpico de Estados Unidos en los Juegos Olímpicos de verano de 1992 en Barcelona, España. Los servicios estuvieron basados en un modelo de intervención de crisis. En el artículo se presentan la filosofía del trabajo, la preparación de los Juegos, los criterios para la selección de los psicólogos, las metas y objetivos de las actividades psicológicas, rango de los servicios y las estrategias de intervención, así como recomendaciones para el futuro. El Equipo Olímpico de Estados Unidos constaba de más de seiscientos cincuenta hombres y mujeres, representando treinta deportes diferentes. Además, había otros doscientos miembros más de la delegación de apoyo olímpico. El equipo de medicina del deporte de Estados Unidos incluía: un psicólogo, ocho médicos, veinticinco entrenadores y un fisioterapeuta.

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## Philosophy

The philosophy of the psychology program has envolved since its inception in 1977 at the U.S. Olympic Training Center in Squaw Valley, California. The basic philosophy is based upon a broad spectrum systems theory approach (May, 1987; May and Brown, 1989). Three factors are involved in this model: Factor one, the target population includes athletes, coaches, administration, families and any individual having impact on the athlete. Factor two, the format for delivery of service includes individual, didactic or group sessions. Factor three, the methods of services include clinical, educational, organizational or research data gathering.

At the Olympic Games a clinical crisis intervention model was the primary philosophical focus blended with educational and organizational issues playing a critical but secondary role. The criteria for the coordinating psychological services was to have a Ph. D. -level, licensed clinical or a counseling psychologist who was listed in the U.S. Olympic Sports Psychology Registry. Additionally, the psychologist at the Games was to act as an interface with other psychologists who were a part of specific National Governing Body games contingency.

As the U.S. official psychologist at the Barcelona 1992 Olympic, I worked closely with the head physician, head athletic trainer, and other members of the sports medicine team. In addition, I stayed in contact with the executive director of the U.S. Olympic Committee. The interface role with the other attending National Governing Body psychologists was critical as some sports bring their own psychologists. Unfortunately, this was inconsistent with some sports having almost no contact with sports psychology. Therefore, an individual representing the entire olympic delegation was needed which was my position.

The Olympic Games is a highly unique, competitive situation which brings with it unbelievable pressures upon the individual athlete from themselves, their country, their coaching staff, their sports organizations, family, and the media. It is frequently stated that the Olympic Games is simply another competitive sports event. Basically this is true. Fortunately or unfortunately, however, the Games take on a completely different and, sometimes exaggerated, emphasis to the world. For example, approximately 2.5 billion people were reported to have watched the opening ceremonies of the Barcelona Games. In the 1972 Munich, West Germany Games, ABC paid $7.5 million for the television rights whereas in 1992 during the Barcelona, Spain games NBC paid $401 million television rights. Corporate sponsorship and costs have risen dramatically. The Olympic is very important to international business.

Given that, there are many unique and unexpected situations that come up during Olympic games, the crisis intervention model was set forth. The type of problems and services provided at the Barcelona Games will be expanded on later in this article.

## Preparation for the Olympic Games

I have been fortunate to have been involved with the U.S. Olympic movement since 1977 in various capacities. I was the first Director of Sports Psychology at the U.S. Olympic Training Center in Squaw Valley, California, became a member and then chairman of the U.S. Olympic Sports Psychology Advisory Committee an have been a member of the U.S. Olympic Sports Medicine Council for several years. In addition to working with athletes from many different National Governing Bodies, for twelve years, I was the psychologist for the U.S. Alpine Ski Team traveling approximately six to eight weeks a year with them. This background was invaluable for understanding

elite athletes and high-level competition situations. It gave me the background to understand the sporting organizations, coaches, and the significance of the Olympic Games.

Specific to the Barcelona Games, I participated in the Second International Olympic Committee Sports Sciences Congress in Barcelona, Spain in October of 1991. In addition to presenting research, the visit allowed me to become acquainted with the city, venue sites, and to meet with the various people involved. In April of 1992, the U.S. Olympic Committee had a National Governing Body Team Leaders meeting in Barcelona, Spain. Each National Governing Body had, at least, two team leaders and/or an olympic coach. I was able to travel, participate and meet with each of the 30 National Governing Bodies sports representatives to discuss their potential psychological needs during the games. This meeting was important in that each representative was able to meet with me. Individuals meeting face to face with psychologists helped demystify psychology. It allowed us to discuss expectations and limitations of the potential psychological services to be provided. I also traveled with the head physician and trainer which helped us develop networking for the sports medicine team. Several key U.S. Olympic delegations officials and administrators also attended the meeting. This, organizationally, set things in place for the potential success of the overall team nature of the various sports governing bodies and the sports psychology program.

## Range of services provided

Since a crisis intervention model was the driving force, I arrived at the Olympic Games one week prior to competition and was available throughout the two weeks of the Olympics. The average day began at 7:00 a.m. and finished around 11:00 p.m. Nearly every day the majority of time was spent in the U.S. Olympic Sports Medicine Clinic housed in the Olympic Village. Appointments were scheduled for athletes and coaches and many times I saw unexpected "drop-ins" and dealt with crisis. A few days were spent at distant venue sites of Banyoles and Montanyà working with the rowing and equestrian athletes and coaches. There were occasions when I was asked to go to specific venue sites within Barcelona for sailing, diving, swimming, track and field, team handball, etc. Fortunately, I was provided a credential which had an "infinity" designation which allowed me access to any venue site within the Summer Olympic Games. This turned out to be an extremely important credential and made it possible for me to be available where and when I was needed by the athletes and coaches.

The Sports Medicine Clinic was in the Olympic Village. I stayed outside the village in a hotel with the official U.S. Olympic delegation. The strength of the living environment was that I had the opportunity to interact with many of the U.S. delegation. The weakness was the travel time to and from the Sports Medicine Clinic and the inability to go back and forth from my living quarters and the clinic. Once in the clinic, I usually stayed there all day and all evening. Another important detail was that I was provided a message pager so I could be reached 24 hours a day. This was essential.

I was very busy throughout the Games. I felt the psychological services provided were important to the ahtletes and coaches and were very rewarding. I worked with individual athletes and coaches as well as teams. Most of my time, however, was spent working with individuals. The following were the sports with which I had contact: rowing, team handball, track and field, swimming, diving, sailing, equestrian, cycling, taekwondo, gymnastics, roller hockey, the Sports Medicine Staff and the U.S. Olympic delegation. I worked with approximately 70 different individual athletes. I met with at least 20 coaches or team leaders. Some of these were single meetings but many were repeated meetings. With some sports I met with athletes every day. The type of problems were primarily crisis in nature with sports enhancement issues next in frequency. One fact that was clear was that it was not

predictable which issues would be more clinical in nature or educational. The involvement with coaches was primarily a consultation about an individual or team issue that the coach was trying to improve. Although coaches and team leaders also experienced many of the same stresses as the athletes.

The range of problems included are listed in Table 1.

Table 1. *Range of psychological problems and issues manifested at the 1992 Summer Olympic Games.*

-Stress of the competition and Olympics
-Stress with family issues
-Focusing and distraction problems
-Teamwork issues
-Career ending injuries to more minor injuries
-Relationship breakups
-Athletes not working well in a team
-Sexual identity issues
-Communication issues between athletes or athletes and coaches
-Death of a family member
-Acute crisis illness and life threatening problems of a family member back home
-Situational and sometime more chronic depression
-Anxiety
-Media concerns
-Loss of confidence in a coach
-Psychosomatic problems
-Lack of confidence in self
-Career counseling
-Team conflict
-Coaches' conflict
-Relationship difficulty, with some athletes and coaches who were having problems being gone from home so long without their primary relationship
-Olympic burnout
-Difficulty with perceived failure
-Anger
-Effects of overtraining
-Fear
-Goal setting
-Sleep disturbance
-Substance abuse problems

The variety of issues and problems and depth of severity varied considerably. The range of problems and diversity of services needed were not a surprise. I have previously outlined the importance of many of these in a previous publication (May, 1989).

## Intervention strategies

The intervention strategies consisted of providing enough time for the athlete or coach to relate what was goin on and making an appropriate assessment and treatment intervention plan. Obviously,

listening, support, and empathy as well as appropriate intervention to the system to improve communications, as needed, were important skills. The content of sessions was kept confidential except with permission where appropriate individuals within the system needed to be involved. Most of the time the goal was to assist the athlete to stay involved in competition and focus on their event. However, in some cases this was not possible. Many of the cognitive/behavioral techniques from clinical psychology were utilized in this crisis intervention model. These techniques, however, were not used to cover up the underlining issues of athletes' concerns as they needed to be tracked. A brochure entitled, "Staying Focused at the Olympic Games" was made available to athletes as well as relaxation and focusing audio tapes. I had athletes work on positive thoughts, mental rehearsal, and goal setting. Frequently, an athlete would become too result oriented and we would discuss the importance of paying attention to the task and process. A repeated theme dealt with the need for the athlete to take their event(s) "seriously" but themselves more "lightly". Having fun was a critical intervention. Sometimes the media evoked anxiety and fear and we discussed ways of getting the individual's message out to the public and having the athlete stay in control and provide realistic but positive statements.

I personally met with the print, radio, and television media on several occasions. I kept the U.S. Olympic media office and the head physician aware of those contacts. My message was on specific psychological topics of athletes as people, psychological factors of performance, injury, stress, mental skills, etc. I had a strict policy never to discuss individual athletes and, although at times I felt pressured to do so, the media respected my position and I think a positive message of the benefits of psychology was relayed to the public.

## Evaluation of services

I felt very well received by the athletes, coaches, sports medicine staff, and U.S. official delegations. My time and expertise was utilized very productively. Athletes and coaches at an olympic level are very unique and special people and seem to be very open to the options and assistance that psychology can give. It was disappointing that not more psychologists traveled with National Governing Bodies. The evaluations of the psychology services primarily were based on pieces of input: (1) demand of psychological services, (2) athlete and coach feedback, (3) U.S. Olympic Sports Medicine report, and (4) U.S. Olympic Committee feedback. The feedback to date has been very positive. I did not feel the evaluation was only of me, but the importance of psychology as it related to psychological crisis, sports performance, the organizations, and the individual athletes as human beings. The crisis intervention model particularly emphasized that athletes were people first and athletes second. Although their goal was to perform at their highest level and everything was done to help them achieve that goal, I was also providing care and support of them as people. I believe this message was relayed and well received.

There were a few somewhat negative aspects to the services provided. The demand greatly exceeded my availability. One psychologist was not sufficient. There were needs at outlying venue sites that could not be met because of the time it would take away from the clinic duties. A better proactive interface between National Governing Bodies which do have psychologist in attendance could be made. In addition, I was aware that within some National Governing Bodies, there were major problems either for an individual athlete, the team, the coaches, or system where no intervention was requested. In these situations, at best athletic performance was affected negatively; at worst, people were treated unprofessionally or inhumanely. Because of confidentiality, it is not appropriate to comment on which sports or situations these may have been, but the organizations of these sports need to take a more serious and global look at how they are treating people and what they are trying to accomplish.

## Recommendations

1. Psychologists present during major competitions is very valuable.

2. Although the crisis intervention clinical model was utilized for the Barcelona and Seoul, Korea (Murphy and Ferrante, 1989) olympic games. The Psychology team should be large enough to provide more educational sports enhancement training as well.

3. It is critical psychologists be part of the sports medicine team and work closely with the physicians and trainers.

4. Psychologists must look beyond that system and work with the various sports National Governing Bodies and athletes and meet their needs. Psychologists would be best used if they rotate between the clinic and venue sites. This woul allow psychologists to blend the venue site work with clinic work.

5. Psychologists must be given an “F” credential with an “infinity” designation, a message pager to be on call and officially identified as a psychologist.

6. The larger National Governing Bodies should be strongly encouraged to bring with them a psychological team. Each National Governing Body also should be encouraged to introduce sports psychology from psychology professionals at the beginning and throughout the quadrennium between olympics. This would better serve the athletes to learn the skills and be prepared for the Olympics. Even with this, however, it will be important to have a psychology team for crisis intervention at the Olympics.

7. The official U.S. Olympic team psychologists must be senior clinical/counseling psychologists who have had considerable experience in working with high level athletes at major competitions. These individuals should be listed in the U.S.O.C. Psychology Registry.

8. The development of the sports medicine team and the team leaders meeting that was conducted in Barcelona in April prior to the Olympic Games with the Sports Medicine team was highly successful and should be utilized again. Although the stigma of psychology has been reduced markedly over the last several years, this team meeting provided everyone the opportunity to interact and further identify what psychology has to offer athletes. I know within the U.S. Olympic movement, psychology has been given proper identification along with the other disciplines which help athletes perform at their best while maintaining mental and physical health.

The Spanish people and the country of Spain are to be congratulated for organizing and demonstrating to the world the purpose of the Olympics in such an outstanding fashion in the beautiful city of Barcelona. The world, we hope, truly will be “FRIENDS FOR LIFE” (“Amigos para siempre”) because of Spain’s success in hosting the 1992 Summer Olympic Games.

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