

Emotional Reflections of an Athlete Referral: The Practitioner Perspective

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A consistent component of psychological practice and lifelong continuous professional development is reflective practice. Through reflective practice, practitioners can increase their self-awareness of their personal beliefs and values whilst develop a deeper knowledge of self (Poczwardowski, Sherman, & Ravizza, 2004). The reflections from this case were initiated by moments of self-doubt and concern which can often lead to personal growth and development (Anderson, Knowles, & Gilbourne, 2004; Lindsay, Breckon, Thomas, & Maynard, 2006). This article aims to not only provide the author with an opportunity to engage in further personal reflections but to encourage readers to explore their own philosophies and beliefs in regard to the current case.

The method adopted for this article is that of autoethnography. As described by Sparkes (2000), autoethnographies are highly personalised accounts that draw upon the experiences of the author for the purposes of extending understanding. Therefore, this case study looks to extend the readers understanding and considerations of the referral process, whilst providing a resource for trainees to better understand the nuances when faced with an athlete with a mental health disorder. This autoethnography will hopefully highlight some of the challenges faced by the author in their early work as a trainee practitioner as well as stimulating further thought by current and future sport psychologists on the topic.

To respect issues of anonymity and confidentiality, the name of the athlete and those involved in the case have been changed.

The Primary Voice

I am a trainee sport psychologist with the British Psychological Society (BPS), currently employed by a higher education institution in the United Kingdom to provide sport psychology provision to their scholarship athletes. At the time of this case, I had just transitioned into the second year of my enrolment on the Qualification in Sport and Exercise

Psychology (QSEP) and was looking to increase my applied practice. The following case study was submitted as part of my second submission. At this stage in my career, I am still developing, refining and adjusting my personal philosophies and values. I believe my core beliefs align with the humanistic approach. In regard to consultancy, I look to support the holistic development of the individual as opposed to focusing exclusively on the athlete, which I feel is reflected in this case. Developing a strong professional bond with the client, built upon a foundation of rapport, trust and genuine understanding is an important element of my practice and philosophy. I believe that clients' are the experts on themselves (Rogers, 1957) and one of my roles is to understand what meaning the athlete has attributed to their situation.

Case Overview

Jack is aged 20 and competes for Great Britain in Swimming. Jack is also studying a post-graduate degree at a UK university in which he is excelling. As a recipient of a sports scholarship, Jack sought out the support of a sport psychologist through his university and was given the contact details of my QSEP supervisor, David. At the time, David provided sport psychology support at the university; however, due to time constraints he was looking to support me to take over this role.

The following account describes the first three consultations that took place with Jack followed by my personal reflections on the case.

Session 1: Intake Session

David had recently communicated to the university that he was looking to support me to take on some of the consultancy opportunities at the institution, which they were complicit in, once they had received proof of my enrolment on QSEP. As my supervisor, David is aware that I have somewhat been 'putting-off' engaging in consultancy due to feelings of self-doubt, which are common amongst trainees (Tonn & Harmison, 2004). In an attempt to

ease my concerns, David arranged that he would lead the first session with Jack, allowing me to observe and contribute when I felt it was appropriate. The supervision process is an integral component of training and practice in applied sport psychology (Holt & Strean, 2005) and this gave me the opportunity to engage in valuable supervised practice in which David had created a safe environment, which I perceived to be free from significant threat.

For the first session, David and I met at a café close to Jack's university approximately half an hour before the consultation to discuss our approach. Jack arrived at 14:00 and we began by introducing ourselves (e.g., qualifications, background, approach to applied practice etc). Following this, Jack introduced himself and began to discuss his reasons for seeking sport psychology support.

Jack described that his reason for wanting to meet with us was because he was not able to "switch his mind off and relax". Jack stated that this was impacting his day-to-day life, sport performance and physical health. David used the Sport-Clinical Intake Protocol (SCIP; Taylor & Schneider, 1992) to loosely guide his questioning. Jack described a need to always keep busy because his mind can wander which can end up being "destructive". Jack has experienced physical symptoms (e.g., vomiting, headaches, black-outs) which he perceives is induced by stress as his blood tests have come back clear of any physical illnesses. Strategies that Jack has tried to use to overcome this problem have included mindfulness and yoga, but this was unsuccessful because he was not able to quieten his mind and relax. Jack also shared that he does not get much sleep, approximately a few hours every night, and that this is because he struggles to fall asleep due to his racing mind and wakes up every few hours during the night.

Aside from the information gained during the consultation, the interaction at times was awkward and uncomfortable. Jack was very considered in his responses and would leave a number of seconds of silence while he considered his response to our questions or

reflections. Despite sharing his personal information, I still struggled to develop rapport with Jack at this stage of the relationship. However, at the end of the consultation, we all agreed that I would take over with this case and from now on consultations would be one-on-one, with David being available to support and mentor me if needed.

After the consultation, David and I stayed behind to debrief the session and share our thoughts. We both thought the case was interesting and unsure of the 'root of the problem'. We discussed potential ideas but both agreed that I needed to gather additional information and understand more about Jack and what he was experiencing.

Session 2: The Bigger Picture

Before the second session with Jack, I was slightly nervous after reflecting on some of the awkward silences from the first session while he pondered his responses. How would I cope with this now it was just the two of us? Would I be able to get him to open up to me?

Going into this session, I had planned to use the Five-Step Career Planning Strategy (5-SCP; Stambulova, 2010) as a tool for eliciting more information from Jack. The 5-SCP is a framework used to facilitate a dialogue between the consultant and the client with the aim to help the client (a) increase awareness of his/her past experiences, present situation, and future perspectives in sport and life, and (b) to be better prepared for the forthcoming transitions in sport and life. I saw the first three steps of the framework to be most important for this session, as it involved discussing Jack's past and present and would hopefully give me holistic information about the client and an opportunity to develop rapport.

Once Jack had arrived and we had gone through the usual formalities, I provided a reflection and review of the first session and my plan for the consultation. Prior to our session, I had drawn up a timeline on a sheet of A1 paper, as this reflected the first step of the 5-SCP. I asked Jack to consider step 2 which involved adding some of the most important events in his life to the timeline.

During the session, I saw a completely different side to Jack compared to when we first met a week prior. Jack was engaged and sharing stories with me, he was incredibly open and honest. Jack shared stories of how he began his career in swimming and the various clubs and teams he has swum for. Jack then began to discuss the problems he was experiencing in more detailed and the impact this was having on him. Jack described a number of competitions which were very traumatic for him and resulted in panic attacks, negative thoughts, delusions, “feeling hot in the head”, and blacking out. All of these responses seemed to be triggered by something external and out of Jack’s control (e.g., new wetsuit, broken air conditioning, hot weather). One example Jack gave occurred while he was sat in a car on the way from the airport to his hotel for a competition. Jack perceived that whilst in a traffic jam, the exhaust fumes from the stationary car in front of him, came into their car through the ventilator, poisoned him and made him ill. Jack said this created a downward spiral of panic and obsessive thoughts. Jack also described times where he would become really confused which caused him to walk to university at 2am for a 9am lecture and turn up to training at 11:45pm when training was scheduled for 6am. After further discussion and allowing Jack to complete his timeline up until the present day, we moved on to the third step of the framework.

The third step of the 5-SCP involved structuring the present. First, Jack identified the most important parts of his life and used three pie charts to represent the element on three different scales; (a) personal importance, (b) time spent, (c) perceived stress (see Figure 1.).From this step, what I found most interesting is that Jack attributes 75% of his stress to be caused by social interactions, despite being an elite athlete, chemistry student, and experiencing health problems. After probing a little further, Jack divulged that he does not like social situations, he does not like eating out in restaurants or receiving phone calls and often avoids social events.

[INSERT FIGURE 1 HERE]

Jack and I were so engrossed in the consultancy that we both lost track of time and realised 3 hours had passed since we met. I did not mind that the consultation had lasted so long because Jack and I had developed such a good rapport from this one session. I could see he trusted me which was reflected by the sensitive information he had shared. This was particularly important to me as developing trust and rapport are crucial elements of the person-centred approach I adopt for consultancy (Ravizza, 1990; Rogers, 1952). I concluded the session by asking Jack for his permission to share the information with my supervisor in order to receive some guidance on how to continue; Jack consented. I was concerned for Jack's mental health based on the stories he was telling me, especially because he referred to experiencing delusions (although by definition it was a hallucination). We concluded the session, where I had thanked him for sharing his experiences with me but expressed I needed additional guidance from David regarding some of the concerns I had developed. I could see Jacks mood was positive, which I believe was because he felt relieved to be able to share his experiences with someone. Jack and I arranged to meet up a few weeks later once he had returned from his competition in South Africa.

I informed David of the developments with the case and sent him my notes from the session via email. While Jack was away, I met up with David to discuss this further, coincidently this was when we were both attending a one-day Mental Health First Aid course. David suggested I should explore further what Jack meant when he spoke about his delusions, and whether they are in fact delusions. We also spoke about the referral process and David was able to guide me through the sensitive process of referral which is not always simple and straightforward (Andersen & Williams-Rice, 1996).

Session 3: Beginning the Referral Process

After Jack returned from his competition we arranged a third consultation. We started by debriefing his recent competition in South Africa, which had gone well but he had been ill in the build-up. At the time Jack believed this was because he was working with a certain chemical in the laboratory at university which had poisoned him. Jack said he now realises this could not have been the case because no one else in his laboratory group was ill at the time, despite them all handling the same chemicals. Jack said he overthinks and becomes fixated on things which cause him to become ill. During the consultation, it became apparent quite quickly that Jack had experienced a number of hallucinations which he can recall starting from the age of 8. Jack said that the hallucinations are happening more frequently and are very debilitating as it can take him many days to recover. One particular hallucination that Jack found terrifying was when he thought he was on a boat to Russia (he was actually in his bedroom) and his mum had drowned. I empathised with Jack that this must have been a very scary hallucination to have but equally explained that his symptoms were concerning. Jack expressed that he wanted to get help as these episodes have been going on for a long time and are becoming more frequent. At this point, I broached the topic of referral.

Raising the issue of referral

During this session, I explained to Jack that I recommend a clinical referral. Practitioners can often feel uncertain how an athlete will react to a referral suggestion and how to best approach the situation (Roberts, Faull, & Tod, 2016). Similarly, there are a number of barriers that an athlete might perceive to prevent them from seeking clinical support, including (a) public, perceived, personal and self-stigmatizing attitudes to help-seeking, (b) a lack of knowledge about mental health services on offer, and (c) a lack of knowledge about the symptoms of mental disorders (Gulliver, Griffiths, & Christensen, 2012). However, based on my interactions with Jack I believed that he would accept the referral as he wanted to get the appropriate help.

At this point, I explained to Jack the options he had available to him in regard to seeking a clinical referral. He could (a) see a clinical psychologist through the National Health Service (NHS), (b) pay to see a clinical psychologist in private practice, or (c) contact his university to see if they have access to a clinical psychologist or could cover the cost since he was on a scholarship. After I was sure Jack understood his options, we ended the session there to give Jack some time to consider the next steps. Later that day, I sent Jack a copy of the notes from the session via email and again reiterated his three options for seeking a clinical referral. Jack decided to seek a clinical referral through his university.

Confidentiality

Confidentiality may be one of the most important factors that fosters a trusting client-practitioner relationship (Andersen, 2005). After choosing to gain clinical support through the university, I perceived that this could have added an extra challenge. I believed that I might have a role to play in convincing the university to support Jack with clinical provision. Ethically what could I tell the university about my consultations with Jack? How could I express the need for a referral without offering a diagnosis or sharing any information the client might not want? In the end, the situation unfolded with little challenge, particularly because of how supportive the university were during the process. I conversed with the university and told them that David and I had assessed the case and it was in Jacks' best interest to be referred to see a clinical psychologist as a number of his symptoms suggest he needed clinical support. The university decided that part of Jacks scholarship includes psychology provision for which they do not discriminate between sport or clinical psychology and would pay for Jack to see a clinical psychologist based on our recommendation. Through his years of consultancy, David has developed a number of connections for eventualities like this one and was able to recommend a clinical psychologist for Jack to work with. The clinical psychologist had a number of years of experience but was

also recently undertaking their training to become a sport psychologist. Being referred to clinical psychologist with minimal sporting knowledge can potentially result in athletes being resistant to seeking such support for fear of not being understood and athletes can resent clinical psychologists' lack of insight into sport and the associated demands (Roberts et al., 2016; Sherman & Thompson, 2001), therefore Jack, David and I believed referring to someone with a knowledge of sport psychology would be beneficial.

Self-Reflection

In this case, a referral was absolutely necessary and in the best interest of the client, however, this did not stop me feeling a range of emotions. One of my overwhelming feelings was of concern for the athlete. Firstly, I was concerned about the outcome and I wanted to ensure that Jack would get the appropriate help. I was also concerned that Jack might feel rejected by me or that I could not help him because he was a lost cause. I was aware throughout our consultations that if not handled properly, the referral process may be viewed by Jack as rejection. Jack was brave to share this sensitive information with me, especially after the first session, we built up trusting relationships and I felt terrible to have to tell him needed to repeat this process and form that relationship with someone else (e.g., a clinical psychologist).

The BPS Code of Ethics and Conduct (British Psychological Society, 2019) states that psychologists should consider "The limits of their competence and the potential need to refer on to another professional" (p. 6). Current UK professional applied sport psychology training does not include clinical education or training. Therefore, addressing clinical disorders under the UK professional guidelines would fall outside of practitioners boundaries of competence, and would represent unethical practice and a breach of professional standards (Papathomas & Capicotto, 2017).

I recognise my limits within this case and the need to refer to a clinical psychologist, certainly when there is the potential need for medicinal treatment. However, after negotiating the referral process I still perceived I had a role to play in supporting the athlete. After reading an article by Papathomas and Capicotto (2017) the following statement resonated with me:

> To refer is not to retreat; you're not done yet and you should remain an integral cog in the treatment process. Your athlete is likely to have a more mature relationship with you than their clinical psychologist and so they may still see you as their primary contact for psychological issues (p.21).

Since going through the referral process, I have maintained regular contact with Jack and tried to be a source of support through this challenging time. Jack even asked me to attend his first consultation with him which gave me further reassurance of our trusting relationship. I believe that whilst the clinical psychologist looks to solve clinical problems, the sport psychologist can work in a 'middle-ground' by providing essential support through their capacity to listen and be empathic in an unconditional and non-judgment way (Eubank, 2016).

One of the main questions I asked myself after the consultation was, why do clinical and sport psychology appear to operate so distinctly from one another when clearly there is an overlap? The prevalence of mental disorders are as common in professional sport as they are in the general population (Markser, 2011; Yang et al., 2007). Having already developed a confidential, trusting, and empathic working relationship with the athlete, I wonder if there is room for more collaboration between the sport and clinical psychologist.

An example of this comes from Rotheram, Maynard, and Rogers (2016) who used an integrated clinical and sport psychology approach when working with an athlete with anxiety. This involved the clinical psychologist working collaboratively with the sport psychologist,

and the wider team (e.g., sport science, medical team and coaches) to formulate the problem and the approach to be used. The sport psychologist would then implement the intervention under close clinical supervision. Over the 5-month period, the athlete demonstrated a reduction in the bouts of anxiety from occurring every day to once a week, as well as performance improvements. In my opinion, the key to this case is that the athletes' psychological safety and wellbeing was put first, and this integrated approach was deemed to be in the client's best interests. Reflecting on Jack, an approach like this would not have been in his best interests and unethical considering the symptoms he is displaying, potential diagnosis and required treatment. Nevertheless, I believe sport psychologists' can offer crucial insight into the sporting environment and through collaboration with a clinical psychologist can provide the athlete with psychological support that is clinically informed as well as athlete sensitive (Papathomas & Capicotto, 2017). However, sport psychology as a profession is divided by two contrasting standpoints; one of which argues that sport psychologists should work with athletes to focus exclusively on performance enhancement (e.g., mental skills), whereas the other stance promotes a more holistic approach and considers the well-being of the athlete to be most important and connected to sport performance (Roberts et al., 2016). Sly, Mellalieu and Wagstaff (2020) discussed the recent diversification of applied sport psychology practices and reflected that sport psychologists are often required to support with non-performance problems, such as clinical issues. Eubank (2016) suggested that sport psychologists should look to develop and attain counselling competencies so that they are able to 'bridge-the-gap' and support the client with a number of skills (e.g., demonstrating empathy and effective listening). Whilst performance enhancement will always remain a central component of sport psychology practice, the development and delivery of psychotherapy, counselling and mental health related competencies is often up for contention (Sebbens et al., 2016; Sly et al., 2020). From my own reflections, I believe certain

cases may provide opportunities for sport and clinical psychologists to collaborate, as long as crucially it is in the best interest of the client. It may not always be the best option for the athlete where referrals are made to a clinical specialist and no sport psychologist involvement continues. Instead using both the clinical expertise of the clinical specialist and the sporting knowledge and already formed relationship of the sport psychologist may offer a more holistic and beneficial treatment (Rotheram et al., 2016).

Moreover, whilst going through the referral process, David asked if I would share my experiences with our supervisory group of trainees which provided me with another opportunity to reflect. I shared similar feelings to those described above but was given reassurance that I had acted professionally, ethically and should be encouraged by the relationship that I had developed with the athlete. These experiences have taught me many valuable lessons as I venture along the QSEP journey. I am confident in my ability to respond ethically and professionally to a referral situation and so far have been successful in developing a trusting relationship with my clients. For fellow trainees, it is important not to fear the referral process as encountering an athlete displaying clinical symptoms is likely, if not a certainty. For me, it was important to try and understand what the athlete was feeling and demonstrate genuine empathy while they are courageous enough to share their story. Importantly, if the athlete desires it, and it is in their best interests, I will remain a source of support for them throughout their referral and beyond. As emphasised in the current case study, supervisory support was, and is, crucial to my development as an applied sport psychologist. Trainees need to ensure that they have an effective support network to rely on and reflect with throughout their applied practice.

Moving forward, it may be necessary for a review of education and training of sport psychology, specifically, to ensure applied sport psychologists develop the knowledge of common mental-health disorders, as well as skills (e.g., counselling) to support those coping

with such challenges. As highlighted by Roberts et al. (2016), applied sport psychologists should be engaging in a lifelong professional development to ensure that they are able to respond the needs of the client. Finally, through these experiences and supervisory support I feel better prepared and more equipped to work professionally and ethically with clients experiencing non-performance related issues.

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Figure 1. Pie charts made in step 3 of the 5-SCP by Jack