Abstract

The current case reports the service delivery experiences of a trainee practitioner working within elite youth athletics, while discussing the experiences and challenges associated with encountering clinical issues and appropriate referral for the first time. Alongside ongoing clinical support, this case warranted ongoing sport psychology service delivery, during which the trainee adopted an Acceptance and Commitment Therapy approach. Interventions were focused towards the promotion of openness to experience and the identification of values-driven behaviours for sport. Service effectiveness was evaluated by using a multimodal method alongside other professionals in a multidisciplinary support team. Reflections on the service delivery highlight the potentially beneficial and maleficent impact that practitioner beliefs and values may have, as well as some issues regarding role clarity, education, and preparedness for sport psychology trainees encountering clinical issues for the first time.

Keywords: Acceptance and Commitment Therapy; Youth Sport, Athletics; Referral; Trainee.

Navigating sub-clinical sport psychology as a trainee: A case study of Acceptance and Commitment Therapy in elite youth athletics

Context

As a final year sport and exercise psychology trainee, I had been completing my supervised training at a multi-sport performance academy which caters to young athletes aged 12-18. Over the preceding two years, although I was not contracted to provide support to the track-and-field athletics programme, I had managed to establish a good working relationship with the head athletics coach due to shared office space. Accordingly, the coach approached me to explore 1-on-1 service delivery with one of his athletes, Mel (pseudonym); a 16-year-old female long jumper competing at national level. The coach was concerned about Mel's 'mindset' while performing, perceived her confidence to be low, and that she was reacting very negatively to constructive criticism. The coach also indicated that Mel wished to meet me individually, so I agreed to an intake meeting in one of the Academy's treatment rooms.

Ethics and Contracting

I explained to Mel what service delivery might involve and worked my way through an ethics agreement outlining the British Psychological Society (BPS; 2018) and Health and Care Professions Council (HCPC) standards of conduct, performance and ethics minimum requirements with regards to disclosure, avoidance of harm, record keeping, right to withdrawal, areas of competency, and trainee status (Keegan, 2015; Kerr, Stirling & MacPherson, 2018). After explaining to Mel the benefits of having her coaches scaffold and support the sport psychology service (Kerr et al., 2018), we agreed to partial confidentiality. This meant, with the exception of concerns regarding Mel's health or welfare (per disclosure requirements), that I could share confidential information with others in Mel's support team *if* given consent from Mel. Following this, I provided Mel with the opportunity to ask questions

and whether she felt able to provide informed and written consent. We agreed to meet every two weeks during her lunchbreak at the Academy. The service totalled nine face-to-face meetigs, with additional instances of brief contact time (e.g. between Mel's classes or training sessions).

Philosophy of Service Delivery

Functional contextualism is a truth criterion applied using an agnostic stance with respect to ontology (Codd, 2015), and forms the philosophy that permeated and informed all aspects of the service delivery process (Poczwardowski, Sherman & Ravizza, 2004). Specifically, functional contextualism postulates that the purpose of behaviour cannot be meaningfully separated from the context in which it occurs, and that the extent to which behaviour is considered functional (or 'true') depends on said context (Zettle, Hayes, Barnes-Holmes & Biglan, 2016). Therefore, in functional contextualism, truth is defined by what is considered effective and in the best interests of the client (also known as 'workability'), and emphasis is placed on the *function* and *context* of behaviour (Hayes, Strosahl & Wilson, 1999).

Functional contextualism is, in turn, applied to human learning and behaviour through Relational Frame Theory (RFT; Hayes, Barnes-Holmes & Roche, 2001). RFT is a theory of human learning referring to individuals' ability to symbolically relate stimuli and responses to one another through the process of behavioural reinforcement, even in the absence of direct experience (e.g. forming appetitive or aversive associations through language; Montoya-Rodríguez, Moline & McHugh, 2017; Ramnerö & Törneke, 2008). While this explains why different forms of behaviour can be considered functional, RFT also explains why direct 'experiental' learning may allow clients to inhibit the unhelpful 'symbolic' learning and thus transform the function of aversive and appetitive stimuli (Bennett & Oliver, 2019). In other words, rather than engaging in language-based discussions or attempts to

examine the validity of a thought or reaction; by contacting the present moment in a non-judgemental manner (e.g. examining the exprience of an anxiety-provoking situation), clients may experience new ways of responding to their internal events that allows them to pursue meaningful and valued behaviours (in spite of their internal events; Törneke, 2017).

Model of service delivery

My philosophy of service delivery was, in turn, operationalised using Acceptance and Commitment Therapy (ACT; Hayes et al., 1999). ACT is a third-wave cognitive and behavioural therapy which rests on the philosophy of functional contextualism (Harris, 2009). Specifically, because functional contextualism allows any form of behaviour to be considered functional in certain contexts (due to individuals' unique learning experiences as specified by RFT; Bennett & Oliver, 2019), ACT does not aim to change the frequency or form of private events (e.g. thoughts, feelings, sensations); but instead aims to change clients' *relationships* those private events (Hayes et al., 2011). In sport, ACT may allow for superior outcomes to emerge through the non-judgemental acceptance of private events, mindful present-moment awareness, and the identification and pursuit of value-driven behaviour (Bennett & Lindsey, 2016; Buhlmayer, Birrer, Rothlin, Faude & Donath, 2017; Gardner & Moore, 2012; Harris, 2009).

The stages of service delivery were based on the process model as outlined by Keegan (2015). However, because the ACT model affords practitioners with the flexibility to start and revisit therapeutic processes in an interactional manner (Hayes et al., 1999), the stages of service were non-linear in nature and dynamically revisited as and when needed.

The Case

Needs Analysis

I adopted a cyclical and multi-modal needs analysis. As such, I started conceptualising Mel's needs by conducting a semi-structured interview. In conjunction with

recommendations to triangulate evidence using a range of modalities (as opposed to relying on a single method; Anderson, Miles, Mahoney, & Robinson, 2002), the topics and concerns that were generated during interview warranted a more rigorous investigation and monitoring to be completed over a period of several weeks, and were thus used as the basis for a Thought Diary. Following this initial generation of Mel's needs, this guided my subsequent decision-making to use questionnaires, and then to finally interview significant others (using both structured and 'informal brief contact' interviews; Friesen & Orlick, 2010). Triangulating Mel's needs in this manner improved my contextual awareness, and the integrity of my subsequent case formulation and implementation plan (Weston, Greenlees & Thelwell, 2013; Beckmann & Kellmann, 2003).

Semi-structured interviews. My initial interview with Mel was guided with the 'Brief Case Conceptualisation' ACT-worksheet (see Table 1; Harris, 2013). Mel highlighted that she was often 'hooked' (fused) with thoughts around not performing 'well enough' compared to her team-mates, that she didn't feel confident participating in training, and that she struggled with feelings of anxiety. Mel said this made it 'impossible to jump', even causing her to occasionally cease participation midway through training.

Thought diary (see Appendix). I provided Mel with an adapted-ACT 'Getting Hooked' worksheet (Harris, 2009) which she completed after training and competitions. This Thought Diary provided me an opportunity to gather and examine instances of Mel's fusion with thoughts, struggling with feelings, and any associated behavioural costs (Faull & Cropley, 2009; Steptoe, 2013). The Thought Diary also served as a useful monitoring and evaluation tool for Mel's engagement with subsequent interventions (Anderson et al., 2002). As seen in the Appendix, Mel recorded persistent self-critical thoughts (e.g. commenting on her weight and self-worth), anxiety, panic, and low mood which persisted for longer than two weeks. These internal events were also stopping Mel from participating in training sessions

and caused sleeplessness due to rumination. This highlighted potentially clinical concerns to me based on my initial evaluations of the aforementioned content with reference to mental health first aid. With subsequent input from my wider clinical support and supervision network (two supervisors and a consultant clinical psychologist), there was collective agreement that this information was consistent with ICD-10 diagnostic indicators for mild to moderate depressive episodes.

Questionnaires (see Table 1). I then invited Mel to complete a general measure of psychological flexibility (Francis, Dawson & Golijani-Moghaddam, 2016) to measure and indicate Mel's baseline proficiency for the therapeutic ACT processes, and (in conjunction with the rest of the needs analysis) to inform subsequent case formulation and implementation planning. I also invited Mel to complete a mental health screening tool that is routinely used and referred to as part of National Health Service clinical referral procedures (the GAD-7 and PHQ-9; Kroenke, Spitzer & Williams, 2001; Spitzer, Kroenke, Williams & Löwe, 2006), which further suggested the existence of a possibly clinical condition (see Table 1).

CompACT scale (Francis et al., 2016). The CompACT scale was chosen as it is suggested to have applied utility for practitioners as a general process measure of psychological flexibility, and because it may help understand (and differentiate) the active components of ACT interventions. Mel's scores indicated that she scored low on Openness to Experience, suggesting a lack of willingness to experience thoughts and feelings as they are. Mel also scored relatively low on Behavioural Awareness, indicating that she may have poor present-moment behavioural awareness. Finally, Mel achieved a midway score on Valued Action, suggesting she may have some clarity and engagement in valued actions during performances.

Significant other interviews. I held semi-structured interviews with significant others in the form of Mel's coaches and the Academy co-ordinator to gather more examples and further validate the responses and information gathered in the preceding steps of needs analysis. They seemed to be unaware of any mental health-related concerns, but stated that Mel's 'mindset and confidence' was low during training and competition (however, I was cautious about attributing too much authority to these accounts and kept an open mind that it might not be either of these issues; Lindsay, Pitt & Thomas, 2014). When prompted to describe Mel's behaviours, her coaches said this was characterised by Mel's 'head dropping' when receiving constructive feedback, and that she may occasionally stop training mid-session. This was validated through her coaches showing me recent competition and training video footage.

(Lack of) observation. It would have been contextually 'out of place' for me to start observing training sessions in the athletics programme, and I did not want to risk having Mel's teammates ask and/or identify why I was there. Mel and I therefore decided that observation would have been potentially maleficent given the context. In this case, the behavioural accounts and video footage provided by Mel and her coaches sufficed to 'fill the gap' of observation.

Preliminary Decision Making and Clinical Referral

Given the concerns raised in Mel's Thought Diary, in conjunction with her scoring and responses on the mental health screen (e.g. answering '*How often have you been feeling bad about yourself - or that you are a failure or have let yourself or your family down?'* with '*Nearly every day'*, item 6; PHQ-9); I felt Mel's non-performance issues were outside my scope of competence and I was ill-prepared to safely case formulate any performance-related issues. As such, I delayed subsequent case formulation and planning in service of prioritising appropriate clinical referral. In the first instance, I discussed my needs analysis and planned

actions with my professional support network. They advised that clinical referral and evaluation would be safer, but that it might also cause harm if I ceased supporting Mel's performance at this time (Moesch et al., 2018).

I discussed the reasons and procedure for clinical referral with Mel and sought her consent before proceeding and sharing information with others (respecting our confidentiality agreement; Harris, Blom & Visek, 2018; HCPC, 2016). I adhered to the performance academy's procedure of reporting clinical suspicions to the performance director and Mel's coach. I also wrote a referral letter (see supporting evidence) to the Academy's pastoral care team and Mel's medical doctor, requesting a referral to the Child and Adolescent Mental Health Service (CAMHS). Only after I had received professional input from the Academy's pastoral support team and a mental health nurse did the multidisciplinary support team discuss whether (and subsequently agree that) continued sport psychology support may be beneficial. First, this decision was based on the mental health nurse's observation that the severity of Mel's symptoms may not meet the diagnostic criteria required for urgent clinical treatment, and second, due to my sport and clinical supervisors highlighting that ongoing sport psychology may offer preventative benefits for Mel's 'sub-clinical' needs while also mitigating harm by preventing the loss of my existing support (Bär & Markser, 2013).

I explained to Mel and others in her support network the benefits of engaging with CAMHS as an adjunct to continued sport psychology support (e.g. by providing transitory support and offering Mel's mental health nurse with sport-specific insights; Harris et al., 2018; Kerr et al., 2018). However, I was aware that the scope ACT as a therapeutic framework aims to enhance overall psychosocial functioning and wellbeing across various life domains (e.g. sport and school; Gross et al., 2018) and – considering the presence of potentially clinical issues in Mel's case – I was worried about creating role confusion and the blurring of boundaries with those directly treating Mel's mental health. To prevent

maleficence and role confusion, I reclarified expectations regarding my role responsibilities and boundaries with Mel and others in her support network (Sharp, Hodge & Danish, 2015) – namely, that I would only be working to support Mel's continued performance and participation in her sport (although it is debatable whether practitioners can actually 'separate' service delivery that is oriented towards sport performance from athletes' wellbeing and mental health; Morton & Roberts, 2013; Roberts, Faull & Tod, 2016). Following agreement from the wider multidisciplinary support team, and after checking Mel's understanding and comfort with the suggested service plan, I then proceeded with creating a case formulation.

Case Formulation

In line with functional contextualism and RFT, the information gathered during needs analysis can be organised into a set of contributing mechanisms using Functional Analytic Psychotherapy based on the appetitive and/or aversive functions served by the various forms of behaviour noted (Kohlenberg & Tsai, 1991). This underpinning case formulation can, in turn, be structured within ACT and augment the delivery of subsequent interventions by deductively fitting the client's presenting experiences into a descriptive template such as the ACT Hexaflex or Matrix (discussed below; Harris, 2009).

The content generated during needs analysis suggested that Mel was frequently engaging in various forms of behaviour that was under aversive control, with the function of reducing the frequency of her unpleasant internal events (e.g. anxiety, self-critical thoughts) and her exposure to the situations that prompted them (e.g. training and competition settings). Specifically, discussions with the mental health nurse indicated that the state of Mel's mental health may have prompted a tendency for critical self-evaluations (e.g. by engaging in social comparisons with team-mates) and anxiety to emerge. Mel's semi-structured interview and Thought Diary corroborated this, and was indicative of the first therapeutic point; that Mel

would ruminate over these thoughts during and following certain situations (in ACT, this is known as 'cognitive fusion' or being 'fused with one's thoughts'; Hayes et al., 1999). For example, following constructive coach-feedback, failure to achieve performance targets, or being out-performed by team-mates, Mel would fuse with thoughts such as "*Why do I even bother, what's the point?*" The second therapeutic point was that feelings of disappointment and unpleasant cognitive and somatic anxiety would often accompany these thoughts, which worsened as Mel engaged in experientally avoidant behaviour (e.g. as noted in her CompACT sub-scale scores, Thought Diary and semi-structured interview; by attempting to ignore or eliminate her internal experiences through keeping occupied). The third therapeutic point was that Mel's unsuccessful attempts at regulating these feelings contributed to further fusion with critical thoughts (e.g. equating a lack of emotional regulation with being and feeling like a failure). The interactional nature of the ACT model hypothesises that its core processes (e.g. cognitive fusion and struggling with feelings) can create a synergy that compounds with other processes (Hayes et al., 1999). As such, the fourth therapeutic point was that fusion with self-critical thoughts, struggling with feelings, and experientially avoidant behaviour may collectively have contributed towards reduced present moment awareness (e.g. Mel's Thought Diary noted a struggle to focus due to 'listening' to her thoughts, and she scored relatively low on the CompACT behavioural awareness sub-scale). The final (and fifth) therapeutic point was that this 'unworkable action' (i.e. attempts at controlling or eliminating internal events) led to aversive behavioural changes as noted in the video footage and views gathered from significant others (e.g. losing assertiveness in her body language, reducing effort during training sets, etc.) that ultimately reduced Mel's ability to engage in meaningful activity, such as performing to her capability and/or attending training sessions (she occasionally ceased participation altogether).

Implementation Plan

Mel indicated a desire to eliminate these unpleasant internal experiences so that she could fully perform and participate in her sport. However, Mel's needs analyses and case formulation suggested the five therapeutic points above were prompted by experiental avoidance (i.e. points one and two), as she was generally unwilling to experience internal events and frequently engaged in avoidance behaviours. Considering the above, researchers have suggested that targeting experiental avoidance and emotional dysregulation has the potential to improve sport performance and support clinical antecedents to mental health concerns (although addressing mental health concerns was not the focus of this service; Gross et al., 2018; Moghadam, Sayadi, Samimifar & Moharer, 2013). However, I was concerned whether using an acceptance-based model would 'clash' with the support Mel may be receiving from CAMHS, as different therapeutic modalities may contain fundamentally incompatible underpinning assumptions (e.g. rational emotive behavioural therapy may directly contradict with ACT principles in terms of whether one's thoughts and beliefs can or cannot be modified; McCormick, Coyle & Gibbs-Nicholls, 2018). As such, I remained in contact with Mel's mental health nurse and sought ongoing advice from my supervisors and a clinical psychologist to ensure the work I was doing would be non-maleficent nor overlap with boundaries (Kerr et al., 2018; Moesch et al., 2018). These concerns and cautious steps were taken to protect the interests of the client responsibly and to manage risk (BPS, 2018; HCPC, 2016).

Together, Mel and I completed an ACT matrix to create a shared case formulation and agree upon the goals of service delivery (this act in itself may also promote behaviour change; Polk & Schoendorff, 2014). In line with Points 1-4 outlined above, our goals were to teach Mel 'ways of managing thoughts and feelings so that she could feel confident to perform, and that she could more compassionately and functionally evaluate her performances.' It should be noted that, at this stage, Mel's choice of wording (e.g. '*to feel*

more confident to perform') was indicative of her desire to manipulate her perceived lack of confidence (as noted in her case formulation), which further suggested that it may beneficial to start by addressing her experiental avoidance (e.g. through promoting the defusion and acceptance of internal events; Harris, 2009). I encouraged Mel to agree on several observable behavioural goals that we could use as barometers for evaluating progress (Lindsay & Bawden, 2018) for Point 5 (e.g. by asking her '*How would someone see your behaviour change if they were watching you on TV?*'). Mel's observable behaviour-goals were to resume regular training, to participate fully during sessions, and to perform with assertiveness (e.g. displaying effort and having a 'taller posture').

Mel felt that it would be beneficial for me to keep her coaches, parents, and pastoral care team updated about service delivery progress. I agreed that doing this through ongoing discussions to monitor and adjust the service delivery would allow me to better use the wider support team to help scaffold any progress made (Gilbourne & Richardson, 2005; Pain & Harwood, 2004), while also regularly checking-in with Mel and my supervisor to manage confidentiality (BPS, 2018; HCPC, 2016). In this way, working as part of the wider multidisciplinary team allowed me to judiciously use this information to facilitate supportive channels of communication between Mel and other members of her support team (e.g. if they felt unsure about how best to support her; Lorimer & Jowett, 2009). I could also support Mel's coaches in implementing relevant information and interventions into the training environment (Henrikksen, Storm & Larsen, 2018).

Intervention

To principally address the third therapeutic point identified above (i.e. Mel's experientially avoidant behaviour), I initially focused on introducing and facilitating openness to experience, a core ACT process and the opposite of experiental avoidance (which may also serve to indirectly influence therapeutic points one to four; Hayes et al.,

1999). In ACT, this can be achieved through the use of metaphor and experiential exercises, which (as specified by RFT) are theorised to inhibit symbolically learned relations between stimuli (e.g. challenging performance situations) and responses (e.g. fusing with self-critical thoughts) by offering new ways of relating to the same stimuli (e.g. by simply acknowledging the presence of self-critical thoughts; Bennett & Oliver, 2019; Törneke, 2017). As such, I used the ACT 'Sailing Boat' metaphor, which introduces the hopelessness of engaging in attempts at 'bailing rainwater' from a boat (i.e. being preoccupied with controlling or eliminating unpleasant internal experiences) when no one is steering the boat towards the target destination (i.e. that controlling or eliminating internal events may provide temporary relief in the short term, yet have noticeable costs in the long term by preventing valued action). The use of metaphors may also be effective due to being memorable and tangible (Anderson, Lau, Segal & Bishop, 2007; Lindsay, Thomas & Douglas, 2010) – indeed, Mel indicated that they were 'easy to grasp' (perhaps a relevant consideration given her age; Knight, Harwood & Gould, 2018).

To progress Mel's initial learning around openness to experience, Mel and I then explored alternative ways in which she could respond to thoughts and feelings. This served to explicitly address therapeutic points one and two, by providing Mel with ways of allowing her thoughts and feelings to exist as they are (i.e. by not ruminating about them or attempting to eliminate unpleasant feelings). As per RFT, a range of experiental exercises can be used to promote new ways of relating and responding to internal stimuli. For example, the cognitive defusion exercise 'Hands as Thoughts' involves metaphorically equating the act of placing one's hands over one's eyes to fusing with thoughts, and noticing how relating to thoughts from a different perspective (i.e. by moving one's hands to an arm's length away) may positively impact upon the ability to function. Similarly, an actual 'Tug of War' was conducted to metaphorically demonstrate how 'struggling against' one's feelings may cause

fatigue and reduce one's ability to do other tasks, whereas alternatively 'dropping the rope' could be equated to accepting the presence of such feelings (Bennett & Oliver, 2019; Harris, 2009). Initially, I modelled these interventions by encouraging Mel and I to notice thoughts and feelings as they occurred during meetings to promote mindful opportunities for practising defusion and acceptance 'in vivo' (which also served to facilitate present moment behavioural awareness, as per the fourth therapeutic point above; Hayes et al., 2011).

To support Mel's learning around openness to experience and to progress her implementation of the above intervention techniques into day-to-day practice, Mel's tasks in between meetings were to: (1) Practice brief mindfulness tasks to facilitate her awareness of being experientally avoidant (e.g. encouraging her to use the App HeadSpace, trying to 'notice three things mindfully', and engaging in informal mindfulness while completing daily chores; Harris, 2009); (2) relate differently to thoughts by defusing from them (e.g. by using compassionate self-talk such as 'Thanking her Mind' to acknowledge and defuse from distracting and/or unpleasant thoughts), and to; (3) notice her behavioural choices in response to the occurrence of thoughts and feelings (Bennett & Oliver, 2019). To support her progression with these tasks, I provided Mel with ACT-based resources which were adapted to be relevant to her case where possible (e.g. worksheets and links to psychoeducational videos; Harris, 2009), along with explaining their intended relevance and method of use.

After five weeks of service delivery (including three face-to-face meetings) had been completed, Mel appeared less willing to engage in defusion and acceptance techniques. This observation was based on Mel's use of language, which suggested that she was not convinced of the need nor importance of openness to experience (e.g. asking '*why would I want to just let a feeling of anxiety sit there?'*). Further questioning also revealed that Mel had poor awareness of the behavioural costs associated with experiental avoidance, and how this impacted upon her ability to do meaningful things in sport. For example, despite Mel being

aware of experiencing anxiety and low mood, she indicated having little awareness of how these internal events were impacting upon her ability to communicate with her teammates and/or coaches during training sessions. In ACT, clients' use of 'control oriented' language (e.g. expressing a desire to eliminate unpleasant internal experiences) in conjunction with a lack of appreciation for the behavioural consequences thereof may be indicative of poor awareness and/or remoteness from their values (the desired qualities of ongoing action; Harris 2009).

To capture this new information as it was being generated, Mel and I revisited the ACT Matrix to monitor and reformulate her case collectively. Specifically, this reformulation demonstrated that poor awareness and/or remoteness from her values may have been compounding Mel's aforementioned experiential avoidance. As such, we agreed that working towards identifying Mel's values and operationalising them behaviourally would build upon and progress the work completed previously (as defusion and acceptance are more easily pursued in service of valued action; Bennett & Oliver, 2019).

In ACT, values are the desired global qualities of ongoing action, and are distinct from goals in so far as they are not achievable 'targets' or 'summative end states' that can be conclusively reached (Hayes, Bond, Barnes-Holmes & Austin, 2006). To introduce what values were, I explained to Mel that we would focus on clarifying the kinds of behaviours that she *does* want to express in sport, as well disclosing what my own values were and describing the behaviours that characterise them. To prompt an exploration of Mel's own values, I then used 'ACT Conversation Cards' as the basis for discussion (i.e. playing cards which provide examples of values or hypothetical scenarios that may elicit the discovery of valued action; Hayes, 2019). Mel indicated this conversational exercise to be insightful and enjoyable, as she had never previously explored her values and enjoyed articulating what

mattered to her in sport. Mel identified three values of significance to her (I supported her choice of wording to ensure they were ACT-consistent):

- Value 1: 'Bravery' (being open to experience and doing things in spite of anxiety)
- Value 2: 'Authenticity' (choosing to engage in valued behaviour and performing to her capability)
- Value 3: 'Taking in the moment' (having present moment awareness)

Finally, in order to address therapeutic Point 5 (above), Mel and I created valued-action plans (Bennett & Lindsay, 2016). In line with goal setting principles, these plans operationalised how Mel could engage in values-congruent behaviours. For example, the 'Bravery Plan' outlined several processes Mel could use to participate in training despite unpleasant feelings, such as: 'thanking her mind', accepting discomfort that arose during training, and making brave choices by participating in small parts of training sessions (e.g. the warm-up and completing one training set as opposed to the whole session).

Monitoring and Reformulation

Consistent with the agreed implementation plan, I remained in contact with Mel's mental health nurse and sought ongoing advice from my supervisors and a clinical psychologist to maintain clear service boundaries with that of CAMHS, and to monitor and manage the impact of the service delivery. Mel documented her adherence to committed action through 'choice point' encounters in daily training (i.e. opportunities where she could choose to engage in value-driven behaviour or not; Harris, 2009). We revisited these choice-points during subsequent meetings and explored how it felt when Mel engaged in values-congruent and values-incongruent action (e.g. noticing how empowering it was to accept socially-comparative emotions and to instead choose to perform assertively). For example, Mel was pleased to report small triumphs, where she made the choice to participate in training (Point 5) despite having socially-comparative thoughts and anxious feelings (Point

1). However, Mel indicated that during some choice points, she 'knew' to engage in defusion and acceptance techniques in pursuit of value-driven behaviour, but struggled when she had poor present moment awareness (Point 4; Thienot et al., 2014).

As this new information was generated, I revisited the ACT Matrix with Mel again to monitor and reformulate her case. Research suggests that mindfulness practice over longer periods of time may be more effective, but that athletes may need additional support to learn and apply these techniques (Thompson, Kaufman, De Petrillo, Glass & Arnkoff, 2011). We therefore decided to prioritise the content of future meetings towards formal and guided mindfulness practice, where I could support Mel to focus on the present moment and to examine internal experiences from the perspective of the observing-self (thereby scaffolding her use of defusion and acceptance techniques). I encouraged Mel to continue practising daily mindfulness tasks as introduced previously, and to continue using the reflective diary with the addition of noting how and when she managed to defuse from thoughts and raise her present moment awareness. Mel indicated that guided mindfulness considerably facilitated acceptance, suggesting I could therefore have incorporated guided mindfulness practice earlier in the intervention delivery (e.g. by using 'Brief Centering Exercises'; Harris, 2009).

Evaluation

Through ongoing discussions with Mel and significant others, the service delivery was evaluated by triangulating the following sources of information (Keegan, 2015).

Questionnaires. Mel's pre- and post-intervention scores on the CompACT are shown in Table 1, which indicated an overall improvement in psychological flexibility across all three subscales.

Social validation questions. Based on assessor feedback, I also gathered evidence of Mel's evaluation of service effectiveness through bespoke social validation questions:

(1) ***What progress do you think you've made since we started working together?*** Mel felt that she had "learnt to identify and understand the performance issue", and that she was becoming increasingly proficient at utilising the ACT processes. Her performance outcomes had also improved, as Mel was regularly participating in most parts of training sessions and had even resumed competing.

(2) ***Is there anything I could be doing more of to support your performance?*** Mel felt there was "nothing we could be doing more of", saying the interventions "worked well and I enjoyed using them". In particular, she appreciated the discovery of the 'Bravery' action plan due to its importance to her.

(3) ***To what extent have we achieved the sport psychology service goals?*** Mel felt the service delivery goals 'moved away' from managing thoughts and feelings to improve her confidence, and 'reoriented' towards her observable behaviours and performances (i.e. indicative of greater psychological flexibility; Hayes et al., 1999). This was due to becoming more accepting of her internal experiences. Mel felt that she was now progressing with her physical performances despite the presence of unpleasant internal events.

Perceived ratings of progress. At intake, Mel's baseline score was 6/10, due to acknowledging that she needed to voice her needs and seek support from her support team. However, Mel also rated her post-intervention score as 6/10, explaining that this was due to initially "taking a step backwards before taking a step forwards". More specifically, this was because the process of clinical referral was experienced as initially distressing due to lengthy referral procedures and waiting times (e.g. for an initial clinical appointment). In this regard, it is possible that through the course of intervention clients' perceptions and expectations with regards to service progress may change, and they may (with hindsight) decide their baseline scores were overly generous (Hassmén, Keegan & Piggott, 2016). Nonetheless, Mel

indicated this experience allowed her to better identify and understand her performance issue, and her perceived effectiveness of the ACT-based interventions were "constantly improving".

Significant-others. Through ongoing discussions with Mel's coaches and her mental health nurse, I received positive feedback about the service delivery. Her coaches indicated Mel's mood and behaviour appeared 'changed' during training; she was now being more sociable by talking with her team-mates again, generally displaying a 'taller' posture, exerting effort and partaking in training sessions fully (they were even impressed with her jump-distances). Mel's mental health nurse also indicated that Mel found the sport psychology support "very helpful and she should continue receiving the sport psychology support".

Service Conclusion

After the ninth meeting, Mel chose not to attend two 'optional drop-in meetings' at the performance academy. Considering the summative evaluation above, I felt comfortable at this point to inform Mel (and others in the support network) that we could leave an 'open-door' to the sport psychology service, which could then be revisited if Mel felt she needed additional support.

Reflections

First, reflecting on the theoretical approach taken in this work, there were some challenges associated with implementing ACT in the sport context. Specifically, it initially appeared that the ideologies associated with the medical model and traditional second-wave cognitive and behavioural therapies might have been stumbling blocks to the ACT processes. Indeed, Mel initially indicated a desire to 'eliminate' her unpleasant internal events, suggesting she would be unable to perform in her sport unless I changed and/or removed them. However, as symptom reduction is not a focus of the ACT model, I was challenged to help Mel understand that our work would require a fundamentally different approach (e.g. by

willingly opening-up to internal events as they arose in service of valued-action). This notion of '*feeling better*' versus '*being better at feeling*' might be particularly alien and discomforting for clients who may be 'habitual experts' (e.g. athletes) at identifying and eliminating so-called problems when they arise (e.g. performance-related weaknesses). In this regard, the norms and ideologies associated with the sport context itself may contribute towards initial therapeutic resistance in ACT. For example, the social identities associated with particular group memberships in sport (e.g. a norm of '*persistence and resilience*') may cause coaches and athletes to adopt common and particular approaches to support one another (e.g. by '*eliminating or ignoring symptoms of early distress*'; Hartley, Haslam, Coffee & Rees, in press). As such, practitioners are advised to consider how these wider ecological and social processes may influence clients' readiness towards using acceptance-based approaches for service delivery. For example, practitioners are advised to be patient, creative, and flexible when working in environments where the medical model predominates (e.g. where ideologies of symptom reduction may be enforced) and where there may be low receptivity towards acceptance-based approaches (Bennet & Oliver, 2019).

Second, the similarity of Mel's chosen values to my own were somewhat jarring – as my own values are that of compassion, authenticity, and bravery. Specifically, it is important to me that the desired qualities of my own actions are enacted with compassion (i.e. for the client), authenticity (i.e. while being true to myself), and bravery (i.e. by committing to valued action in spite of discomfort). In this context, however, my values seemed to have an impact on the service delivery process, as is evident by the similarity noted between Mel's chosen values and my own. This may have been due to modelling the ACT processes for Mel (e.g. disclosing my own values and experiences of using them in sport; Harris, 2009). While this served to scaffold her understanding of and engagement with her own values, it is worth considering if doing so may prompt clients (and particularly younger athletes; Knight et al.,

2018) to simply 'copy' the practitioner's behaviour, and thus whether the use of modelling is always appropriate. Consider, for example, contexts where modelling the operationalisation of a 'bravery' value could be harmful – a poignant consideration indeed for clients whose mental health may be languishing (e.g. choosing to attend a competition in spite of heightened generalised anxiety). In line with functional contextualism, there are likely to be contexts where disclosing and modelling one's own personal and professional values may be harmful, and practitioners are advised to use self-disclosure judiciously to ensure doing so remains non-maleficent (Bennett & Oliver, 2019). If (as in Mel's case), practitioners notice a curious degree of similarity between their own values and those espoused by their clients, it may be helpful to gently and transparently encourage the exploration of alternatives.

Finally, this case warrants a discussion regarding role clarity. Peak performance may be conceptualised as existing on a continuum from wellbeing to mental illness (Gulliver, Griffiths & Christensen, 2012), and athletes may be unlikely to seek clinical support from within their own team due to a range of factors. For example, due to the experience of identity-based support threat, stigma, and/or approach-avoidance dilemmas (Butler, Mckimmie & Haslam, 2018; Tarrant & Campbell, 2007). As such, sport psychologists may (perhaps unintentionally) be the first neutral point of call regarding mental health concerns (Harris et al., 2018; Moesch et al., 2018; Schinke, Stambulova, Si & Moore, 2017), and may thus have proactive and preventative roles to play in supporting mental health and wellbeing. For example, improving an athlete's proficiency in using ACT processes for sport may be considerably facilitated by encouraging their application into daily life. As an adjunct, while clients learn to respond to issues in daily life with increasing proficiency in the ACT processes, this may allow for superior performances to emerge while simultaneously enhancing their overall psychosocial wellbeing (Gardner & Moore, 2012). However, while this may have protective functions for mental health and result in desirable performance-

related changes, this may have ethical implications regarding role clarity in cases where clinical issues are of concern (e.g. *"Is the practitioner here to support performance or functioning outside of sport*?").

Considering the above, I was nervous about causing confusion due to crossing a perceived role boundary with those supporting Mel's mental health, despite using an appropriate referral procedure and maintaining that the foci of my service delivery was on Mel's sport performance and participation. As mentioned previously, however, it is debatable as to whether practitioners can conceptualise performance-related services as being entirely separable from athletes' wellbeing and mental health (e.g. Morton & Roberts, 2013). Indeed, an effective approach to sport psychology service should strike a balance between completing both performance enhancement and therapeutic work with athletes (Keegan, 2015; Roberts et al., 2016), and activating a 'knee-jerk' clinical referral without further consideration of my role in supporting Mel's wellbeing and mental health may have done more harm than good in this case (Knight et al., 2018).

As such, although the above evaluations of this service delivery might have been (overly) positive, my concerns over crossing role boundaries may have decreased the effectiveness of this service delivery (e.g. by maintaining a somewhat superficial and rigid stance that this service delivery was *entirely* focused on Mel's 'performance and participation'). Indeed, Mel may have experienced this as somewhat confusing and contradicting, as the ACT interventions likely extended beyond her perception of what was considered 'performance related' and into what was considered 'wellbeing and mental health' related. Previous authors have stressed the importance of professional training and development that adequately that prepares trainee practitioners to competently strike a balance between performance and therapeutic work with athletes (e.g. Aoyagi et al., 2012; Tod & Lavallee, 2011). In a similar vein, practitioners (and sport psychology trainees in

particular) are advised to be mindful of the risks associated with rigidly maintaining views that the scope of their service pertains only to 'sport performance', when it may be clear that (in some contexts) the scope of their work likely extends beyond this. Relatedly, this point also stresses to importance of having and using an effective multidisciplinary support network – consisting of both sport and clinical colleagues – who can inform ethical decision making and support transparent role clarity throughout service delivery (Moesch et al., 2018; Schinke et al., 2017).

References

Anderson, A., Miles, A., Mahoney, C., & Robinson, P. (2002). Evaluating the effectiveness of applied sport psychology practice: Making the case for a case study approach. *The Sport Psychologist, 16,* 432-453.

Anderson, N.D., Lau, M.A., Segal, Z.V., & Bishop, S.R. (2007). Mindfulness-based stress reduction and attentional control. *Clinical Psychology & Psychotherapy, 14,* 449-463.

Aoyagi, M.W., Portenga, S.T., Poczwardowski, A., Cohen, A.B., & Statler, T. (2012). Reflections and directions: the profession of sport psychology past, present and future. *Professional Psychology Research and Practice, 43,* 32-38.

Bär, K.-J., & Markser, V.Z. (2013). Sport specificity of mental disorders: The issue of sport psychiatry. *European Archives of Psychiatry and Clinical Neuroscience, 263*(2), S205-S210.

Beckmann, J., & Kellmann, M. (2003). Procedures and principles of sport psychological assessment. *The Sport Psychologist, 17,* 338-350.

Bennett, J., & Lindsay, P. (2016). Case Study 3: An acceptance commitment and mindfulness based intervention for a female hockey player experiencing post injury performance anxiety. *Sport & Exercise Psychology Review, 12*(2), 36-45.

Bennett, R., & Oliver, J. (2019). *Acceptance and Commitment Therapy: 100 Key Points and Techniques.* Routledge: London.

British Psychological Society (2018). *Code of Ethics and Conduct*. Leicester: British Psychological Society.

Buhlmayer, L., Birrer, D., Rothlin, P., Faude, O., & Donath, L. (2017). Effects of mindfulness practice on performance-relevant parameters and performance outcomes in sports: a meta-analytical review. *Sports Medicine, 47,* 2309-2321.

Butler, T.L., Mckimmie, B.M., & Haslam, S.A. (2018). The approach-avoidance dilemma at the heart of group-based support: Evidence that group identification increases willingness to seek support at the same time that identity-based support threat reduces it. *European Journal of Social Psychology, 49,* 31-46.

Codd, R.T. (2015). The functional contextual a-ontological stance and Bas C. van Fraassen's constructive empiricism. *Journal of Contextual Behavioral Science, 4*(4), 215-219.

Faull, A., & Cropley, B. (2009). Reflective learning in sport: A case study of a senior level triathlete. *Reflective Practice, 10,* 325-339.

Francis, A.W., Dawson, D.L., & Golijani-Moghaddam, N. (2016). The development and validation of the Comprehensive assessment of Acceptance and Commitment Therapy processes (CompACT). *Journal of Contextual Behavioral Science, 5*(3), 134-145.

Friesen, A., & Orlick, T. (2010). A qualitative analysis of holistic sport psychology consultants' professional philosophies. *The Sport Psychologist, 24,* 227-244.

Gardner, F.L., & Moore, Z.E. (2012). Mindfulness and acceptance models in sport psychology: a decade of basic and applied scientific advancements. *Canadian Psychology, 53,* 309-318.

585 Gilbourne, D., & Richardson, D. (2005). A practitioner-focused approach to the provision of
586 psychological support in soccer: Adopting action research themes and processes.
587 *Journal of Sports Sciences, 23*(6), 651-658.

588 Gross, M., Moore, Z.E., Gardner, F.L., Wolanin, A.T., Pess, R., & Marks, D.R. (2018). An
589 empirical examination comparing the Mindfulness-Acceptance-Commitment
590 approach and Psychological Skills Training for the mental health and sport
591 performance of female student athletes. *International Journal of Sport and Exercise*
592 *Psychology, 16*(4), 431-451.

593 Gulliver, A., Griffiths, K.M., & Christensen, H. (2012). Barriers and facilitators to mental
594 health help-seeking for young elite athletes: A qualitative study. *BMC Psychiatry, 12,*
595 S35.

596 Harris, B.M., Blom, L.C., & Visek, A.J. (2018). Key considerations for applied services with
597 young athletes. In C.J. Knight, C.G. Harwood & D. Gould (Eds.), *Sport psychology*
598 *for young athletes* (pp. 231-242). Oxon: Routledge.

599 Harris, R. (2009). *ACT made simple.* Oakland: New Harbinger Publications Inc.

600 Harris, R. (2013). *Getting Unstuck in ACT: A Clinician's Guide to Overcoming Common*
601 *Obstacles in Acceptance and Commitment Therapy*. Harbinger: London.

602 Hartley, C., Haslam, S. A., Coffee, P., & Rees, T. (in press). Social Support. In S. A. Haslam,
603 K. Fransen, & F. Boen (Eds.), *The New Psychology of Sport and Exercise: The Social*
604 *Identity Approach*. Thousand Oaks: SAGE Publications.

605 Hassmén, P., Keegan, R. & Piggott, D. (2013). *Rethinking Sport and Exercise Psychology*
606 *Research*. London: Palgrave Macmillan.

607 Hayes, L. (2019). *ACT Values Cards*. Retrieved from https://contextualconsulting.co.uk/act-
608 values-conversation-cards [Accessed 01/01/2019]

Hayes, S.C., Barnes-Holmes, D., & Roche, B. (2001). *Relational Frame Theory: A Post-Skinnerian account of human language and cognition*. New York: Plenum Press.

Hayes, S.C., Bond, F.W., Barnes-Holmes, D., & Austin, J. (2006). *Acceptance and mindfulness at work: Applying acceptance and commitment therapy and relational frame theory to organizational behavior management.* Binghamton: The Haworth Press.

Hayes, S.C., Strosahl, K.D., & Wilson, K.G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford Press.

Hayes, S.C. Strosahl, K.D., & Wilson, K.G. (2011). *Acceptance and commitment therapy: The process and practice of mindful change.* New York: Guilford Press.

Health & Care Professions Council (HCPC; 2016). *Standards of conduct, performance and ethics*. HCPC Publications.

Henrikksen, K., Storm, L.K., & Larsen, C.H. (2018). Organisational culture and influence on developing athletes. In C.J. Knight, C.G. Harwood & D. Gould (Eds.), *Sport psychology for young athletes* (pp. 216-227). Oxon: Routledge.

Keegan, R. (2015). *Being a sport psychologist*. Basingstoke: Palgrave Macmillan.

Kerr, G., Stirling, A., & MacPherson, E. (2018). The role of sport psychology consultants in protecting young athletes from harm: Shifting from safeguarding to an ethic of care. In C.J. Knight, C.G. Harwood & D. Gould (Eds.), *Sport psychology for young athletes* (pp. 243-254). Oxon: Routledge.

Knight, C.J., Harwood, C.G., & Gould., D. (2018). *Sport Psychology for Young Athletes.* Oxon: Routledge.

631 Kohlenberg, R.J., & Tsai, M. (1991). *Functional Analytic Psychotherapy: A guide for*
632 *creating intense and curative therapeutic relationships*. New York: Plenum.

633 Kroenke, K., Spitzer, R.L., & Williams, J.B. (2001). The PHQ-9. *Journal of General Internal*
634 *Medicine, 16*(9), 606-613.

635 Lindsay, P., Pitt, T., & Thomas, O. (2014). Bewitched by our words: Wittgenstein, language-
636 games, and the pictures that hold sport psychology captive. *Sport & Exercise*
637 *Psychology Review, 10*(1), 41-54.

638 Lindsay, P., Thomas, O., & Douglas, G. (2010). Exploring and transforming client generated
639 metaphors in applied sport psychology. *The Sport Psychologist, 24*, 97-112.
640 Lindsey, P., & Bawden, M. (2018). *Pig Wrestling: The brilliantly simple way to solve any*
641 *problem… and create the change you need*. London: Ebury Digital.
642 Lorimer, R., & Jowett, S. (2009). Empathic Accuracy, Meta-Perspective, and Satisfaction in
643 the Coach-Athlete Relationship. Journal of Applied Sport Psychology, 21(2), 201-
644 212.
645 McCormick, A., Coyle, M., & Gibbs-Nicholls, S. (2018). Sharing good practice in sport and
646 exercise psychology. *Sport & Exercise Psychology Review, 14*(1), 47-64.
647 Moesch, K., Kenttä, G., Kleinert, J., Quignon-Fleuret, C., Cecil, S., & Bertollo, M. (2018).
648 FEPSAC position statement: Mental health disorders in elite athletes and models of
649 service provision. *Psychology of Sport and Exercise, 38*, 61-71.
650 Moghadam, M.S., Sayadi, E., Samimifar, M., & Moharer, A. (2013). Impact assessment of
651 mindfulness techniques education on anxiety and sports performance in badminton
652 players in Isfahan. *International Research Journal of Applied and Basic Sciences, 4*,
653 1170-1175.

Montoya-Rodríguez, M.M., Moline, F.J., & McHugh, L. (2017). A review of relational frame theory research into deictic relational responding. *The Psychological Record, 67*(4), 569-579.

Morton, J., & Roberts, C.M. (2013). The hurt business: The harsh realities of high-performance sport. *The Sport and Exercise Scientist, 38,* 28-29.

Pain, M.A., & Harwood, C.G. (2004). Knowledge and perceptions of sport psychology within English soccer. *Journal of Sports Sciences, 22*(9), 813-826.

Poczwardowski, A., Sherman, C.P., & Ravizza, K. (2004). Professional philosophy in the sport psychology service delivery: Building on theory and practice. *The Sport Psychologist, 18,* 445-463.

Polk, K.L., & Schoendorff, B. (2014). *The ACT matrix: A new approach to building psychological flexibility across settings and populations*. Oakland: Content Press.

Ramnerö, J., & Törneke, N. (2008). *The ABCs of human behavior: An introduction to behavioural psychology.* Oakland: New Harbinger.

Roberts, C.M., Faull, A.L., & Tod, D. (2016). Blurred lines: Performance enhancement, common mental disorders and referral in the U.K. athletic population. *Frontiers in Psychology, 7,* 1067.

Schinke, R.J., Stambulova, N.B., Si, G., & Moore, Z. (2017). International society of sport psychology position stand: Athletes' mental health, performance, and development. *International Journal of Sport and Exercise Psychology*, 1-18.

Sharp, L.A., Hodge, K., & Danish, S. (2015). Ultimately it comes down to the relationship: Experienced consultants' views of effective sport psychology consulting. *The Sport Psychologist, 29*(4), 358-370.

677 Spitzer, R.L., Kroenke, K., Williams, J.B., & Löwe, B. (2006). A brief measure for assessing
678 generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine, 166*(10),
679 1092-1097.

680 Steptoe, K. (2013). Case study 2: Provision of sport psychology services to an International
681 High Performance Tennis Centre: Models of practice as a function of primary and
682 secondary client needs. *Sport & Exercise Psychology Review, 9*(1), 24-36.

683 Tarrant, M., & Campbell, E. (2007). Responses to within-group criticism: Does past
684 adherence to group norms matter? *European Journal of Social Psychology, 37,* 1187-
685 1202.

686 Thienot, E., Jackson, B., Dimmock, J., Grove, J.R., Bernier, M., & Fournier, J.F. (2014).
687 Development and preliminary validation of the mindfulness inventory for sport.
688 *Psychology of Sport and Exercise, 15,* 72-80.

689 Thompson, R.W., Kaufman, K.A., De Petrillo, L.A., Glass, C.R., & Arnkoff, D.B. (2011).
690 One year follow-up of mindful sport performance enhancement (MSPE) with archers,
691 golfers, and runners. *Journal of Clinical Sport Psychology, 5*(2), 99-116.

692 Tod, D., & Lavallee, D. (2011). Taming the wild west: Training and supervision in applied
693 sport psychology. In D. Gilbourne & M.B. Andersen (Eds.) *Critical Essays in Applied*
694 *Sport Psychology* (pp. 193-215). Champaign: Human Kinetics.

695 Törneke, N. (2017). *Metaphor in practice: A professional's guide to using the science of*
696 *language in psychotherapy*. Oakland: New Harbinger.

Weston, N., Greenlees, I., & Thelwell, R. (2013). A review of Butler and Hardy's (1992) performance profiling procedure within sport. *International Review of Sport and Exercise Psychology, 6*(1), 1-21.

Zettle, R.D., Hayes, S.C., Barnes-Holmes, D., & Biglan, A. (2016). *The Wiley handbook of contextual behavioural science*. Chichester: Wiley-Blackwell.

Table 1

Semi-structured interview extracts as guided by the Brief Case Conceptualisation, mental health screen, and CompACT scoring changes representing part of the service delivery needs analysis and summative evaluation.

Brief Case Conceptualisation questions	Semi-structured interview extracts	
Fusion: *Is the client getting stuck with thoughts about the past/future, self-description, reasons, rules, or judgements?*	Mel indicated often 'getting stuck' with self-descriptive rules and judgements about herself in comparison to teammates, such as 'not being good enough', 'not knowing what she is doing', and/or not being able to complete tasks 'well enough' in sport and general life.	
Experiental avoidance: *What private experiences is the client trying to avoid, get rid of, or is unwilling to have?*	Mel reported disliking the experience of self-critical thoughts about her ability and self-worth, and the low mood, anxiety and experience of panic that would accompany these thoughts. Mel reported wanting to eliminate her lack of self-confidence and to not feel ashamed of her performances.	
Valued and committed action: *What domains of life, values, and activities seem most important to the client?*	Mel indicated that her sport is very important to her and jumping is her 'main motivation' and activity of enjoyment in life at the moment. Otherwise, not much clarity about valued behaviours.	
Unworkable action: *What is the client doing that makes their performance worse, keeps them stuck, or worsens their problems?*	Mel reported engaging in rumination and further negative examination of fused thoughts (e.g. while trying to sleep), which she felt made them worse (e.g. potentially catastrophising); Mel would react to private experiences with a loss of assertiveness in her performance, her conduct would become overly negative and/or catatonic (e.g. a notable change in body language, she may stop speaking with others), and she may stop participation or avoid attendance altogether (i.e. of sport and classroom activities).	
Mental health screen	Pre-intervention score	Post-intervention score
Generalised Anxiety Disorder Assessment-7	13/21 (Moderate anxiety)	N/A
Patient Health Questionnaire-9	16/27 (Moderately severe depression)	N/A
CompACT		
Openness to experience	15/60	40/60
Behavioural awareness	10/30	22/30
Valued action	28/48	40/48
Global psychological flexibility (total)	53/138	102/138

Appendix

Mel's Thought Diary

Hi Chris, this is [Mel] from [Performance Academy], I wanted to send you these at this time because I've had two competitions over the past two weeks and I wanted to get the most examples I could. There's a few days missing, those days I wasn't training. I've put the dates of when it happens, hope it's detailed enough:

18/12/18. In weights, comparing myself to other people, that I wasn't as skinny and small as them, made me panic and feel like I wasn't good enough. Performance and behaviour; I took a minute to just breathe and then went and did my weights like normal. I had the power to choose to ignore it at this point. Going to bed and head is at 100mph, can't sleep because of it. Thoughts: what's my purpose, why can't I get things right, what's the point anymore. I can't control this, it happens every night, I don't have the power to stop it from happening.

19/12/18. In training doing on/offs, negative thoughts, not good enough. Not a good day, negative thoughts took over my session, "not good enough" "can't do this", had another panic attack after a circuit, not able to control it, shaky, not able to focus in the rest of the session. Really low mood, tired, head at 100mph, not able to control thoughts, cant slow heart rate down, not able to just relax.

20/12/18. Not a bad day, but was just okay, a little anxious, had a first aid course, not much happened today, no panic attacks, just feeling low, feels like there is no energy left.

21/12/18. Negative thoughts during training, "don't deserve to be there", "not good enough compared to everyone else", held everything in but felt worse after the session.

04/01/19. During comp "just quit", I didn't have a choice to listen to these thoughts, but I held back, jumped, then broke down after the comp. Head going 100mph, couldn't stop it, had break down, avoiding people best as I can, not talking, just thinking.

06/01/19. Travelling to training, head is saying don't go. Feeling really anxious and nervous to go, as it's first time after the comp, don't feel good enough to go, feel let down had no choice but to listen to the thoughts.

10/01/19. I'm training, just isolating myself from everyone, not wanting to speak to anyone or do anything, just mentally drained.

12/01/19. Had a comp "don't feel good enough", "not good enough to be here" "what's the point". Didn't have a choice to accept these thoughts, felt like I let myself down along with my coach and family, avoided everyone then spoke to people and just felt like everyone was avoiding me because I done badly, felt like I didn't want to compete anymore, felt like nothing was going well, felt like everything was out of my control. Felt like I was the only person my coaches didn't want to speak to in case they said something wrong.

I just wanted to add in that a lot of the time at night I can't sleep because my thoughts in my head have decided to all just come to me at once. Examples of these are "why do you even try", "what's the point in training", "you're not good enough", "you need to just quit".

Thanks, [Mel]