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**“But I am a Runner”: Trying to be a Rogerian Person-Centred Practitioner
with an Injured Athlete**

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26 **“But I am a Runner”: Trying to be a Rogerian Person-Centred Practitioner with an Injured Athlete**

27 **Abstract**

28 This reflective case study presents the experience of a trainee Sport and Exercise Psychologist during
29 a period of applied consultancy with an injured runner. This was the trainee’s first consultancy
30 experience attempting to practice from a Rogerian/classic person-centred perspective. As a trainee,
31 the sport psychology delivery process followed academic and professional training models. After
32 identifying an incongruence relating to the client’s identity as a runner, Rogers’ rejection of
33 formulation and intervention, led to tensions. Drawing on sport and counselling psychology
34 literature to guide reflection and approach, maintaining a relationship between client and
35 practitioner consistent with Roger’s necessary conditions of change was the intervention. The
36 trainee’s reflections consider being challenged by conflicts between philosophy and training
37 requirements, their limited practice experience and responding to the client during sessions which
38 sometimes felt inconsistent with person-centred principles. Ultimately, the client reported moving
39 towards being a more authentic self by contextualising running as only one aspect of their life.

40

41 **Keywords:** identity, injury, person-centred therapy, sport psychology

42

43 **Context**

44 This case study describes my (first author) experiences as a trainee sport and exercise
45 psychologist working with an injured runner during the first year of supervised practice. At the time I
46 was a typical trainee feeling anxious about whether my knowledge and skills were adequate to
47 support the athletes with whom I was working (Tod & Bond, 2010) whilst also keen to apply theory
48 acquired during my university education. I would consider myself an atypical trainee, being 51 years
49 old at this time meant I had accumulated life experiences and was aware of my core beliefs and
50 values, the stable underpinning components for developing one's philosophy of practice
51 (Poczwadowski et al., 2004). As a first-year trainee with no experience of using humanistic
52 approaches to counselling, I felt adopting Rogerian/classic person-centred therapy (PCT; Rogers,
53 1951) aligned with my perception of these. Specifically, my beliefs matched the principle that
54 individuals are able to alter self-perceptions, attitudes, and behaviours when their own "resources
55 can be tapped if a definable climate of facilitative psychological attitudes can be provided" (Rogers,
56 1980; p.115). In addition to the congruence of my values and beliefs with PCT, I perceived that being
57 person-centred (that is, placing the client at the centre of the relationship) is sometimes confused
58 with adopting a Rogerian philosophy and thought it important to adopt PCT fully.

59 PCT aligned with my personal characteristics of empathy and warmth, and ability to develop
60 good working relationships, which have been shown to correlate more highly than interventions
61 deployed during therapy in achieving client outcomes (Lambert & Barley, 2001). This importance has
62 been similarly recognised in applied sport psychology, Nesti (2010) suggested that it would be
63 difficult "to do useful and meaningful work together without developing trust and a strong working
64 relationship" (p. 40). There have been multiple studies exploring components required to build a
65 successful relationship in sport psychology contexts, examples include counselling principles
66 (Longstaff & Gervais, 2016), connecting to create change and building relationships that meet
67 athlete needs (Sharp & Hodge, 2011) as well as being friendly but not a friend, athlete-centred,
68 flexible, open, honest, and respectful in a bi-directional relationship (Sharp & Hodge, 2014). In

69 addition, Friesen and Orlick (2010) advocated the most effective way to provide support was by
70 viewing an athlete holistically and that this was influenced by humanist practitioners such as Rogers.

71 Rogers (1957) prescribes six core conditions which enable change to occur. These are (1)
72 there is psychological contact between practitioner and client, (2) the client is in a state of
73 incongruence, (3) the practitioner is congruent in the relationship, (4) the practitioner experiences
74 unconditional positive regard towards the client, (5) the practitioner experiences empathic
75 understanding of the client's internal frame of reference and communicates this to the client and,
76 (6) the client perceives empathic understanding and unconditional positive regard. A state of
77 incongruence occurs when individuals experience feelings which are different from their perceived
78 conditions of worth, that is differences between their ideal and actual self (Rogers, 1959). It is
79 important to note that Rogers goes on to explain that when the individual is unaware of their state
80 of incongruence they can become "vulnerable to anxiety, threat and disorganisation" (p.204). For
81 example, an athlete who views their ideal self as a national representative may be experiencing
82 anxiety when a period of illness means they are unlikely to meet the qualification standard in an
83 upcoming trial (actual self). The athlete can experience congruence by recognising and being content
84 to live their values, of say doing their best performance on the day (for a detailed explanation of PCT
85 in the sporting context see Gupta and Duncan, 2023). Congruence is key to enable an individual to
86 self-actualise, which Rogers describes as developing "capacities in ways which serve to maintain or
87 enhance" (p. 196). In relation to the consultancy relationship, Rogers (1957) highlights how through
88 congruence, unconditional positive regard, and empathy the consultant aims to create a non-
89 judgemental environment to facilitate constructive client change.

90 To date there are limited examples of PCT use in applied practice within sport, recent examples
91 include supporting a basketball player (Black & McCarthy, 2020), a runner (Davis & McCarthy, 2022)
92 and a footballer (Gupta & Duncan, 2023). The present case study aims to add to this literature by
93 explaining how I tried to adopt PCT, the challenges encountered, reflections on the process and
94 perceived issues with congruence to philosophy.

95 **The Case**

96 **Client**

97 Sarah (pseudonym) was a 35-year-old amateur runner, participating on and off-road in races
98 up to ultra-marathon. She had recently moved to the area (returning 'home' from a major city) and
99 was in the process of establishing her own coaching and outdoor adventure business as well as
100 working part-time. Primarily competing for recreational purposes, she had a running coach, raced
101 competitively, and held an age-group London Marathon Championship qualification. Sarah had
102 suffered with mental ill-health since her teenage years and a pre-existing depression-related mental
103 health condition was diagnosed eight years previously. The condition was controlled and
104 pharmacologically managed by her general practitioner (GP). At the time of referral Sarah had a
105 long-term lower limb injury, which the physiotherapist thought was a hamstring/abductor issue.
106 Further tests to confirm this were required and therefore potential recovery time was unclear. She
107 was able to train, though volume and intensity of running was minimised, had been advised to cross-
108 train and not to race. Sarah was frustrated and the physiotherapist suggested a discussion with a
109 sport psychology professional would help her to understand and cope.

110 **Overview**

111 Sessions were delivered on a one-to-one in person basis and paid for by the client. In
112 keeping with PCT, there was no pre-agreed contract duration. The client decided session frequency
113 and led each one. The consultancy ultimately consisted of an initial informal meeting which led to
114 five sessions over a 16-week period. Throughout the consultancy I kept detailed notes, which were
115 shared with Sarah by email after each session. Post consultancy feedback was provided, as well as
116 Sarah referencing our work together in a blog. Table 1 provides a summary of the process.

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121 **Table 1**122 *Overview of the consultancy process*

Contact	Day	Location	Duration (min)	Summary
Informal	0	Coffee shop	45	Intake. Introductions and background discussion. Explained boundaries around scope of practice regarding mental health.
Session 1	11	Clinic	90	Contract/consent. Sarah's story (Needs analysis).
Session 2	18	Clinic	75	Reviewed the week and feelings. Discussion about identity, struggle to accept being injured, and sadness associated with not being able to run.
Session 3	38	Clinic	90	Catch-up, discussion about desire to challenge self and coping whilst waiting for scan.
Session 4	74	Coffee shop	110	Scan inconclusive. Focus on frustrations and the need to not run. Decided to try resting.
Session 5	109	Coffee shop	90	No running and frustrated that no change. Reflection about coping and plans moving forward.

Note: following session 5 the client provided an evaluation of the consultancy.

123 **Introductions/Intake**

124 I contacted Sarah to arrange an initial session, offering to meet at the clinic or informally. I
 125 explained the purpose was to gain a brief overview of the situation from Sarah's perspective and
 126 explain my approach to consultancy. From this meeting I hoped to ascertain whether we both felt
 127 that developing a working relationship seemed feasible. We met at a local coffee shop, therefore
 128 bearing in mind confidentiality we located ourselves in a private corner and I checked Sarah was
 129 happy with the privacy. My intention was to avoid creating a power imbalance and aimed to be non-
 130 directive by actively listening and being empathetic. To ensure service delivery is effective, rapport
 131 and trust are necessary (Tod et al., 2019), we started to develop this through informal introductions
 132 and background discussion. I explained PCT and how it involved using her inherent resources to
 133 change. Sarah talked about the history of her injury, how frustrated she was and that she hoped
 134 working together would help her to be more accepting of the situation. This led to Sarah describing
 135 her mental health and how running was a key part in managing this. I explained that scope of
 136 practice was limited for sport and exercise psychology as standards of proficiency are different from
 137 clinical care and we needed to recognise limits of my competence (British Psychological Society,

138 2021; Health and Care Professions Council, 2016). Sarah was comfortable with this as clinical
139 management was with her GP and we agreed to consider implications throughout the consultancy.

140 Following the meeting, I sent a contract and consent form to Sarah, providing her with
141 sufficient time to review prior to our next session. As well as contractual terms, this document
142 included information relating to British Psychological Society Code of Ethics and Conduct,
143 confidentiality, and data protection. I began to populate a template with information from Sarah, as
144 it would support the needs analysis phase of the consultancy. In response to my message, Sarah sent
145 potential goals for our work together.

146 **Initial Reflections**

147 I made two key reflections following the referral and initial session. First, at face value
148 Sarah's case related to coping with injury, however, there were additional layers of complexity when
149 considering the whole person, such as the role running plays in Sarah's management of her mental
150 health and impact on career changes. I felt comfortable that ethical considerations relating to
151 boundaries for scope of practice were clear and understood, and the work I was expected to engage
152 in fell within the sport and exercise psychology remit. I was apprehensive given my lack of
153 experience working with clients who also had recognised mental health needs. To develop my
154 knowledge of the condition I explored general information from the National Health Service and
155 Mind as well as specific literature in relation to sport (examples: Currie et al., 2018; Moesch et al.,
156 2019) and discussed in supervision. Support was available through various means, as well as my
157 supervisory team I was part of a peer supervision group, and through university was able to access
158 clinical psychology support. My supervisor and I discussed boundaries of practice and concluded that
159 I should remain vigilant for comments which could indicate clinical support was required, for
160 example 'I have been feeling down this week, what can I do?' and to pro-actively check with Sarah. If
161 I felt her needs were drifting towards practice boundaries, I would seek support.

162 Second, Sarah confirmed she was happy to adopt PCT as it would be different from her
163 clinical cognitive behavioural therapy experiences. Though I was experiencing conflicting feelings

164 about adopting my preferred philosophy and meeting the training requirements. Throughout Stage
165 1 training at University, Keegan's (2015) sport psychology process had been prescribed as the
166 structure to adopt during consultancy. Being in my first year of applied practice I lacked experience
167 to flex the approach and was therefore attempting to follow the stages. The third stage would be
168 Case Formulation which is also a required element of the Standards of Proficiency (Health and Care
169 Professions Council, 2015). My conflict arose from Rogers (1951) rejection of the formulation
170 process in relation to PCT, as it implied power on the part of the practitioner which could lead to the
171 client not taking responsibility for themselves. Simms (2011) suggested changing the way
172 formulation is viewed in PCT from directing the therapeutic process to facilitating "the client's
173 therapeutic experience, insight and understanding" (p. 30). Therefore, in supervision I explored how
174 to ensure that I was authentic and able to demonstrate required professional process. This led to
175 adopting an approach where I collected information from Sarah telling her story (like needs
176 analysis), documenting it and summarising to identify key issues (in lieu of formulation).

177 Aoyagi et al. (2017) developed the Performance Interview Guide (PIInG) to provide a person-
178 centred semi-structured approach to support collection of data at the beginning of a consultancy.
179 Whilst I recognised using an instrument was not consistent with PCT, it provided structure for
180 recording data which would enable me to demonstrate appropriate documentation for assessment.
181 It was important to ensure I did not generate structure to our discussions based on the PIInG which I
182 then imposed upon Sarah, to ensure formation of our relationship was genuine (Simms, 2011). Thus,
183 ensuring I remained able to serve her needs and not my own. This led me to reflect more deeply, a
184 meta-reflection regarding how I was feeling conflicted between client needs and trying to practice
185 using PCT. I recognised that PCT was not originally developed for use in sport and my knowledge was
186 evolving. My thinking was being typified by the early phases of practitioner development, driven by
187 a desire to achieve perfection (Rønnestad & Skovholt, 2003). In effect creating my own incongruence
188 of attempting to fix perceived issues associated with approach, rather than simply working
189 authentically with Sarah.

190 Sarah's Story

191 Practitioner literature describes the second phase in a consultancy process where
192 practitioner's gather information to assess and understand client needs (Keegan, 2015). In this stage
193 I sought to identify Sarah's presenting problems, goals, and contributory factors to her current
194 situation (Simms, 2011). I populated the PInG retrospectively from our naturally evolving
195 conversations. The second session took place in a private room at the rehabilitation clinic. Sarah
196 confirmed there were no issues with contract or consent and signed the document. We began with a
197 short discussion about the injury and what this meant for her training. Being mindful of the core
198 principles of PCT I listened, summarised, and reflected back to Sarah. Throughout I was empathetic
199 and demonstrated unconditional positive regard by creating a safe space from which Sarah could
200 explore her thoughts and emotions whilst feeling accepted and valued. I did this by listening without
201 interrupting, paying attention to Sarah's non-verbal communication, and adopting a non-
202 judgemental attitude to the feelings, experiences and emotions being described.

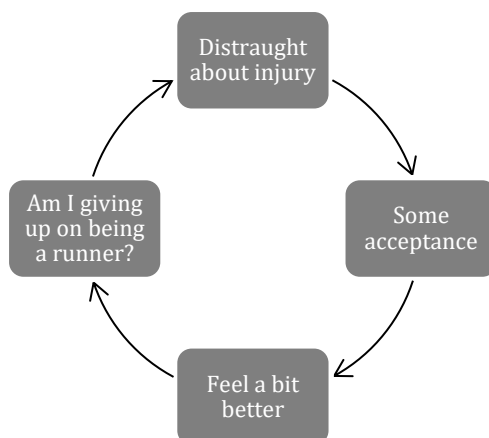
203 In overall terms Sarah reported that she was following the principles of day-on/day-off style
204 training, describing how she was trying to ascertain coping levels of volume and intensity. She was
205 frustrated and explained that it felt like treading water waiting for a change in injury status. We
206 explored running in a wider context to get a clearer picture of her history and support mechanisms.
207 Through this it became clear that running was interlinked with positive changes in life circumstances
208 following Sarah's mental health diagnosis. Participation began as part of day-to-day management of
209 mental and physical health, found enjoyment and over time participation and level of competition
210 grew. Associated feelings and emotions were that she "loves running", felt "calm and peaceful" as
211 well as experiencing "emotional freedom" when running (especially off road). I asked Sarah to
212 explain her goals in the context of this conversation. In summary these were to a) work on positive
213 self-talk, b) accepting goals that are not the ones that I want, c) how I define myself if it is not by
214 competition, success, etc, and d) self-view in relation to others. For self-talk and self-view, Sarah
215 described being self-critical at having to train at lower level and blaming herself in relation to the

216 injury as well as worrying about what others thought about her. It also appeared that objectives
217 relating to goals and self-definition could be linked to underlying feelings about identity. Figure 1
218 shows a cycle of thinking described by Sarah where she gained a level of acceptance in relation to
219 the injury, but this led to questioning herself about commitment to running. Sarah described not
220 being able to “find a balance whereby I accept the current situation but also recognise it doesn’t
221 define me and that acceptance isn’t the same as giving up”.

222 Finally, Sarah explained that she liked structure and usually adopted the principles of SMART
223 goal setting, though she found this was difficult in the absence of a diagnosis and likely rehabilitation
224 time. I explained to Sarah that what she had described reflected elements of the affective cycle of
225 injury (Heil, 1993). This is where, in the early stages of being injured, athletes can enter a state of
226 denial (experiencing a sense of disbelief) and/or distress (the impact on emotional state) which can
227 lead to multiple feelings including anger or helplessness. This led into a short discussion about
228 different types of goals, as Sarah was not familiar with the concept of open goals, I shared a link to
229 an article¹ which provided her with information we could revisit in future if needed.

230 **Figure 1**

231 *Cycle of thinking in relation to injury acceptance and identity*



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¹ <https://theconversation.com/want-to-exercise-more-try-setting-an-open-goal-for-your-new-years-resolution-149172>

269 In addition, I reflected whether in establishing this relationship the six necessary conditions were in
270 place (Rogers, 1957): (1) Psychological contact had been established, (2) The client was in a state of
271 incongruence, (3) I had demonstrated congruence by acting genuinely and authentically, (4)
272 Unconditional positive regard was demonstrated through facilitated open discussion without making
273 judgement about Sarah's thoughts or actions, (5) Empathy was being demonstrated through
274 understanding what Sarah was feeling and reflecting this back to her, and (6) Whilst I did not ask
275 whether Sarah perceived empathy and unconditional positive regard, her actions to engage during
276 our sessions indicated she considered me as being genuine in my endeavours to help her. In respect
277 of the incongruence, through Sarah's goals and our discussions, I perceived that her running identity
278 appeared to underpin the emotions and feelings being experienced. There was a clear link to her
279 objectives regarding goal setting, self-definition, and self-view, whilst changing self-talk appeared to
280 arise in response to the incongruence. From this assessment my plan involved maintaining regular
281 dialogue with Sarah, for her to set the frequency of sessions and generate discussion relating to her
282 aims during each. Practically, I needed to continue to engage empathetically and genuinely as well as
283 trusting in Sarah's capacity for growth. By working in this way, our relationship would enable Sarah
284 to move towards being a more authentic self through the process of actualisation.

285 **Interim Reflection 1**

286 Following the intake and assessment process, whilst I was comfortable that development of
287 our relationship was consistent with Rogerian principles, I had nagging doubts regarding my
288 competence to practice in this way. My early practice experiences had begun in a person-centred
289 way but in many cases had reverted to me having to be more practitioner led, often adopting a focus
290 on mental skills to overcome specific short-term issues. Therefore, I was asking myself can I do this?
291 and as Sarah was paying per session I had several worries, what if our work does not make a
292 difference? what if our progress does not match rehabilitation requirements? what if I start to mix
293 applied practice approaches? Compounded by thoughts about discussing the affective cycle of injury
294 and open goals that I had again strayed from the best practice approach to PCT. As I reflected that

295 like many trainees, I was experiencing imposter syndrome by doubting my applied practice abilities
296 and realised these feelings were normal. Through meta-reflection, though I still questioned myself
297 about process, I observed a shift towards questions of competence. I was on a journey to increase
298 my knowledge and skills, and that it was acceptable to recognise I had gaps in experience (Hings et
299 al., 2020) and negotiating fit between my approach preferences and the practice environment
300 (McEwan et al., 2019). Additionally, I recognised potential irony by reflecting on whether I felt the
301 necessary conditions of change were in place. I approached the next phase of consultancy mindful of
302 my concerns, to seek Sarah's feedback and to focus on being present, genuine, and empathetic.

303 **The Process of Change – Part 1**

304 For each of the four subsequent sessions, Sarah set the frequency of each and led
305 discussions. Sessions started informally with some small talk. Usually this led into a discussion about
306 what had happened since we last met, which served as a mechanism for me to understand Sarah's
307 perceptions of actions, awareness, and progress. If this discussion did not evolve into Sarah taking
308 the lead about a specific area related to her goals, I would ask what she wanted to talk about.

309 We met at the rehabilitation clinic for the next two sessions (2 and 3 in Table 1). At the first,
310 there had been little progress with the injury and a scan had been booked. We talked about a long
311 easy run Sarah had completed with a friend, slow pace eventually stopping as pain was building.
312 Sarah described reflecting on how she had been enjoying the social run on a beautiful day, but that
313 sitting down triggered a change in her feelings about it, becoming annoyed and frustrated that she
314 had to stop. Immediately afterwards, reflecting microsystem sociocultural norms (Wiese-Bjornstal,
315 2019) of running, comments made on Strava such as "great run" led to frustration as she perceived
316 the pace was slow and therefore not great. I asked Sarah to explain these frustrations, hoping this
317 would enable her to reflect and enhance awareness, and naturally she began to discuss identity.
318 Sarah referenced a comment I had made previously about running only being part of her identity.
319 During our intake session, when I described understanding clients holistically, I had used myself as
320 an example, self-disclosing how my personal, work, academic and sporting identities combine to be

321 the whole me. Sarah wondered how to view the injury and running in the context of her whole self,
322 and to try to gain pride and satisfaction from being a good but injured athlete. By reconceptualising
323 her thinking Sarah wanted to recognise where she was and “that it won’t be less shit, but [I] want to
324 make it less hard” whilst ensuring she did become falsely positive about her journey. We explored
325 what this meant for her and what she might do practically. Sarah described feeling sad that she was
326 not able to do what she loved and was struggling to accept the situation through the visible
327 reminder of reduced training targets. I reminded Sarah about the open goals concept we mentioned
328 previously and perhaps trying to see whether there were options other than setting times, volumes,
329 and intensity. Summarising things to work on, Sarah concluded she would focus on recognising her
330 ‘runner’ thinking and contextualise this around her whole self and trying to use open goals to ‘see
331 how...’ training activities go, rather than setting targets.

332 It was three weeks until Session 3, there had been little improvement in the injury and the
333 scan was not for another 3 weeks. Sarah described feeling in a state of limbo, though she continued
334 to follow a rehabilitation plan on an assumed diagnosis. On a day-to-day basis, she had mainly been
335 managing thoughts and frustrations a little more easily. She had also disengaged from Strava,
336 meaning that not getting feedback on activities removed a source of frustration. Sarah described
337 sometimes overthinking the situation, which had led to a spiral in terms of being an injured athlete
338 who left the sport because of the injury and did not want this to happen. I explained that
339 experiencing these feelings was not unusual, hoping to convey an empathetic response which would
340 be reassuring. A discussion followed about struggling to accept the injury which I referenced back to
341 the affective cycle of injury (Heil, 1993). I proposed that we could recognise there is an injury to
342 situate the thinking as part of a rehabilitation journey, which Sarah thought might help.

343 Our conversation returned to training and rehabilitation. The open goal approach worked in
344 circumstances where Sarah was relatively pain free, such as cycling. When running or completing
345 strength training, where pain was experienced, she felt an urge to find the coping limit but got
346 frustrated as the rehabilitation plan was to stay ‘within green’ for a pain score. Sarah recognised this

347 was a trait, describing how she regularly strives for the next level in all aspects of life, meaning that
348 through her actions she wants to show what she is capable of. She went on to describe how outsider
349 perception of her and her performances provide affirmation of success, though she was aware this
350 was not helpful in terms of self-perception. I suggested we could explore how she might cope in the
351 interim. The ensuing discussion concluded with Sarah deciding that she needed time to think
352 through what a longer-term training programme might look like and whether it would help cope
353 with her frustrations. A caveat emerged in relation to a feeling she had that the physiotherapist
354 wanted her to stop running but was afraid to suggest this because of concerns about impact on her
355 mental health. I asked Sarah about her feelings in relation to this. She thought that it would be
356 difficult but wondered whether a managed period away from running might ultimately be better for
357 her wellbeing if it meant running injury-free again in the long-term, rather than the injury leading to
358 not being able to run. At this stage Sarah was not keen, indeed the thought was upsetting to her. We
359 left it as something for Sarah to reflect upon and potentially discuss further with the physiotherapist
360 and GP if necessary.

361 I was aware that I had not found an opportunity to seek Sarah's feedback. Therefore, at the
362 end of this session, I checked how she felt about our sessions and progress to date. Sarah reflected
363 on the benefits of having space talk through issues, and how she appreciated that I listened and
364 "played back" what I had heard. This process enabled her to reflect on whether what she had said
365 was what she meant. We agreed to meet after the scan, though Sarah could contact me if needed.

366 **Interim Reflection 2**

367 There were three areas of reflection worthy of note. First, arising from Sarah discussing her
368 desire to challenge self, I remembered previously reading that high-risk behaviour was associated
369 with her mental health condition. Therefore, I decided to explore the clinical literature in more detail
370 finding that risk-taking (Nitzburg et al., 2016) rumination, self-blame and catastrophising (Rowland
371 et al., 2013) were all typical actions associated with her mental health condition. Sarah had openly
372 discussed her treatment and the separation of our work from clinical care, and I was not concerned

373 that we had drifted into a boundary of practice issue. I felt that being aware of these tendencies
374 provided information to consider if a break from running might occur and would need to discuss at
375 that time.

376 Second, I recognised my time management of sessions appeared poor, on average our
377 sessions had lasted 85minutes. During this period being flexible around duration of sessions was not
378 an issue for me, and I felt that by allowing the discussion to conclude naturally meant that Sarah did
379 not feel under pressure. How I managed this going forward required some consideration, though I
380 decided not to change my approach and would let sessions follow their course. In counselling, Bond
381 et al. (2012) explain that generally a therapeutic hour lasts around 50minutes, however person-
382 centred counsellors may be more relaxed about this. Mearns et al. (2013) go on to explain that
383 whilst sessions may last more than 2 hours, it is the counsellor's responsibility to ensure they are
384 open about the expectations relating to duration. These issues were discussed in supervision and my
385 supervisor reminded me not to be self-critical, but to consider in context of my professional
386 development, such as how I will set boundaries in relation to session times at the beginning of a
387 consultancy and adhering to that agreement.

388 The third reflection related to feedback. I was relieved that the relationship appeared to
389 reflect PCT principles, though wondered if on occasion, such as suggesting Sarah should be
390 "recognising the injury", that I had effectively led the conversation. I realised I was not actively trying
391 to lead but had been responsive in the moment, trying to support Sarah to process her thoughts and
392 emotions. My meta-reflection about this reminded me of previous observations regarding adaption
393 of PCT for these circumstances. I was not attempting to randomly integrate PCT with another
394 approach but began to consider whether elements of my practice were more akin to experiential
395 person-centred principles. Baker (2012) explains that experiential person-centred practitioners
396 provide more assistance to clients to enable them to "access their inner wisdom in a proactive way"
397 (p. 97), rather than through self-discovery. I remained cognisant of this variation in approach as we
398 entered the final phase of our relationship.

399 The Process of Change – Part 2

400 When Sarah contacted me to arrange the next session some 5 weeks after our previous
401 meeting, she suggested meeting at a local coffee shop. We sat in a quiet corner and Sarah confirmed
402 she was comfortable with the privacy. There had been little change as the scan had not confirmed a
403 diagnosis, meaning rehabilitation continued to reflect previous assumptions. This had left Sarah
404 frustrated and upset, and indeed during our session she was emotional. When this happened, I
405 remained quiet to allow her time to compose herself and did not fill the silence. We discussed the
406 rehabilitation process and relationship with her physiotherapist. Sarah explained that perhaps she
407 had been expecting too much and had reached a point where it felt like a “bit of a standoff” in
408 respect of whether a break from running was required. I asked Sarah to explain her concerns in
409 relation to resting, receiving an immediate response related to measurables, such as potential
410 impact on weight, pace, and form as well as feeling that her body had messed up the life plan
411 associated with moving and new business. I recognised these elements of rumination and self-blame
412 from the clinical papers I had read. Before I could explore further, Sarah added that this reasoning
413 typified her self-thinking that she “can’t see the wood for the trees” and being unable to focus on
414 the bigger picture regarding how recovery would lead to being “healthy, fit and able to again.” I
415 reflected by explaining, perhaps more strongly than intended, that she did describe having a focus
416 on specific details and appeared to struggle to position the idea of resting because of potential
417 impact on her runner identity. Sarah agreed and went on to explain how much more difficult it was
418 to deal with this type of injury, than say a fracture, where rest is mandated. Sarah repeatedly
419 returned to discussing whether she needed to take a break from running. At one point saying she
420 “always takes the hardest path,” I enquired what she thought the hardest path would be in respect
421 of the injury? Sarah said it would be to rest. Therefore, I asked whether she felt her actions were
422 consistent with this? Sarah was unable to answer this question directly and reflected. Something
423 which seemed to trigger a change in her perceptions was when she described watching an interview
424 with an Olympian who had a long-term, initially undetermined, injury but was able to come back

425 after a long break. Sarah went on to link this to the concept of Kintsugi (Japanese art of repairing
426 broken pottery with gold which emphasises the breakage) and how in a way this represents how she
427 needed to think about fixing herself. Eventually, as she was going on holiday for 2 weeks, she
428 decided in principle to try and rest while away. Mindful of the benefit from running for her mental
429 wellbeing in general we discussed being aware of her feelings and to run if needed.

430 We met for the final time, again at Sarah's request in a private corner at a coffee shop. Sarah
431 had taken a break from running whilst on holiday and continued to rest since returning, though the
432 break had made little difference to her pain. Further, the physiotherapy relationship had broken
433 down, Sarah had transferred to another practitioner and was engaging with NHS services for
434 additional support. Sarah spent time explaining feelings about the situation and why this might have
435 happened, which included questioning her own actions and how/what she may have contributed to
436 it. Sarah valued the expertise of her physiotherapist and described seeking enhanced psychosocial
437 support in relation to her injury, an action previously found in athlete populations (Arvinen-Barrow
438 et al., 2014). She recognised her actions, for example emailing regularly between consultations, may
439 have pushed boundaries of engagement which necessary for maintaining positive physiotherapy
440 relationships (Miciak, et al. 2018). This discussion felt like Sarah was using the environment created
441 through our relationship as a safe space for her reflection. She described having feelings related to
442 Sarah the runner, being sad about not being able to run, questioned what if a longer period not
443 running does not work and the potential consequences. Though describing she was "feeling lost in
444 the recovery journey", it was interesting to observe that Sarah's reaction to the situation had been
445 pragmatic both in terms of actions regarding her self-care, but also not immediately returning to
446 running. Sarah appeared to show changes in her cognitive appraisal (Wiese-Bjornstal et al., 1998),
447 the context was more about her whole self, describing work, social activities as well as running.
448 There was a change in her thinking about the injury, saying "all runners get injured" and "once
449 sorted, it is possible to retrain." Going further, Sarah described not being able to plan for the next
450 season yet, though was (kind of) relaxed and would focus/commit to the rehabilitation goals whilst

451 working through the process with new professionals. Sarah felt her frustrations and perspective had
452 changed during our time working together and saw a shift in how she now thought about running as
453 part of her identity but recognised there was still further to go. Sarah felt she was able to cope with
454 the next stage of her rehabilitation.

455 **Evaluation**

456 After our final session, I considered how we had addressed the aims Sarah provided at the
457 onset. In the context of coping whilst injured, most of our discussions related to addressing her
458 underlying incongruence of identifying primarily as a runner. By working through this, the aims
459 relating to accepting different types of goals, defining herself outside of competition and self-view in
460 relation to others appear to have been partially addressed, and her perspective in considering these
461 had altered. We had not worked explicitly on developing more positive self-talk, though it was
462 important to remember that the discussions were led by Sarah's agenda in line with principles of
463 PCT. I assumed that whilst this may have still been important to Sarah, from her perspective more
464 important topics had needed to be discussed. To understand Sarah's perspective, I asked her to
465 evaluate the consultancy and provide feedback a few weeks after our sessions ceased. I used a self-
466 developed online questionnaire which had been reviewed in peer supervision. Whilst the
467 questionnaire was influenced by the consultant evaluation form (Partington & Orlick, 1987) I sought
468 information about each client's subjective experience. Therefore, my form blended 6-point Likert
469 scale questions, such as How comfortable did you feel talking to <Name>? (0 – not at all, through to
470 5 – extremely), with optional open text feedback for each question. An average score of 5 indicated
471 Sarah was extremely happy with the consultancy.

472 Considering the PCT philosophy I was trying to adopt it was important to capture feedback
473 reflecting my approach and relationship building. This quote provides reassurance that I was able to
474 develop the relationship consistent with the necessary core conditions:

475 <Name> has a relaxed manner that makes it easy to speak with him. He tends to begin
476 sessions with some small talk, and transitions in a lowkey way into the more formal part of

477 the sessions. <Name> manages to balance a professional demeanour (I have never felt in
478 any way that <Name> was passing judgement on any of my thoughts or feelings) with a
479 relaxed, friendly, and open manner. <Name> knows when to share information about
480 himself to make the exchange feel more real, but never in a way that transcends
481 professional boundaries.

482 In respect of my ability to listen, Sarah's feedback suggested that my potential concerns regarding
483 poor timekeeping added to the quality of the relationship:

484 <Name> has an interesting approach to time management! We have had sessions which
485 extended towards the 120-minute mark - and I have appreciated this approach. I talk at
486 length, and <Name> has never made me feel time pressured or that I need to attempt to
487 express myself more concisely - he simply listens for as long as I want to speak.

488 It was important I recognise that for other clients, sessions running for extended periods of time
489 could be viewed differently. In overall assessment of success for the consultancy, Sarah said,
490 “<Name> has been a big factor in shifting my mindset away from a black/white 'all or nothing'
491 approach to sport, and more towards understanding that it is just one aspect of my life” and that “I
492 am still injured but am coping with it much better mentally.”

493 Keegan (2015) suggests that triangulation of data will help to corroborate perceived
494 effectiveness of the consultancy. This was difficult as Sarah remained injured and had ceased
495 working with the rehabilitation clinic. Sarah emailed a link to her professional blog which goes some
496 way to demonstrating the contribution of our work on her journey of actualisation. In the email she
497 said, “This one is about what I do think is a major shift this year in my relationship with sport, and I
498 appreciate your help with that too – I don't think I'd have reached this stage without it.” The blog
499 responds to a social media post about how central running had become in another athlete's life.
500 Sarah described her experience of being injured for a long period, how she had been lost during this
501 time, questioned who she was and the impact on her meaning and worth. Finally, going on to
502 explain the importance of our consultancy relationship in working through these issues.

503 Overall Personal and Meta Reflections

504 In conclusion, Sarah recognised incongruence relating to her identity as a runner, which was
505 guiding the way she processed self-referencing information. It appeared that developing a
506 consultancy relationship consistent with PCT facilitated Sarah's actualising tendency and enabled her
507 to move towards being a more authentic self. Adopting PCT principles meant I did not set personal
508 goals or expectations related to the consultancy, though as a neophyte practitioner experiencing a
509 first opportunity to practice PCT authentically provided a learning and development opportunity for
510 me. I felt during the process, and the subsequent feedback appears to corroborate, that I developed
511 the relationship effectively and consistently applied Rogers' (1957) necessary conditions which
512 supported the client's change process. Although I was anxious, I discovered it felt natural to be
513 empathetic and easy to engage with Sarah. By listening, reflecting and being non-judgemental in my
514 approach I offered unconditional positive regard to her. I noted that I was comfortable with
515 emotions and able to wait when silences occurred, which was different to my expectations based on
516 previous career experiences where I had tended to fill gaps. I recognised that on occasion I
517 wandered from the PCT path, leading to elements of self-doubt, and made observations about my
518 approach to facilitate my development and approach. As a concluding meta-reflection, from a
519 trainee's perspective I typified others at this early stage of development (Rønnestad & Skovholt,
520 2003) by attempting to adopt PCT as Rogers intended. This led to experiencing confusion from
521 apparent conflicts between attempting to practice PCT, follow Keegan's (2015) consultancy model,
522 and comply with training requirements. Specifically, challenges were perceived from Rogers'
523 rejection of processes, such as formulation, which at face value did not align with these needs.
524 Ongoing reflection and supervisory discussion reminded me to recognise potential shortcomings but
525 remain focused on client needs.

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