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

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Abstract

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

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

Context

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

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

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

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

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

The Case

Client

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

Overview

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

Table 1

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.

Introductions/Intake

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

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

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

Initial Reflections

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

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

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

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

Sarah's Story

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

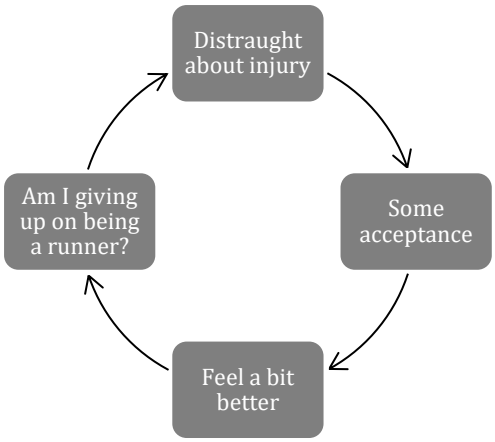
In overall terms Sarah reported that she was following the principles of day-on/day-off style training, describing how she was trying to ascertain coping levels of volume and intensity. She was frustrated and explained that it felt like treading water waiting for a change in injury status. We explored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

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

Finally, Sarah explained that she liked structure and usually adopted the principles of SMART goal setting, though she found this was difficult in the absence of a diagnosis and likely rehabilitation time. I explained to Sarah that what she had described reflected elements of the affective cycle of injury (Heil, 1993). This is where, in the early stages of being injured, athletes can enter a state of denial (experiencing a sense of disbelief) and/or distress (the impact on emotional state) which can lead to multiple feelings including anger or helplessness. This led into a short discussion about different types of goals, as Sarah was not familiar with the concept of open goals, I shared a link to an article[1] which provided her with information we could revisit in future if needed.

Figure 1

Cycle of thinking in relation to injury acceptance and identity



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

'Formulating'

The next steps of Keegan's (2015) consultancy process are to compile the formulation, choose, and then deliver an intervention. My process was influenced by Simms (2011) theoretical framework which supported formulation in a person-centred way (summarised in Figure 2). I did not develop a structured intervention, such as using mental skills, I intended that our relationship would be the intervention, thus remaining consistent with principles of PCT. Having listened to Sarah's story, the key areas which she may see as potential issues and considered these in relation to sport psychology literature relating to injury. In addition to Heil's (1993) affective cycle, I considered how the cyclic relationship between cognitive appraisal, emotional and behavioural responses from the integrated model of psychological response to sport injury (Wiese-Bjornstal et al., 1998) might also be relevant. Specifically, how personal, and situational factors were affecting her emotional responses, as behaviourally she reported being compliant with her rehabilitation plan.

Figure 2

Framework embedding client material to support process of formulation in PCT (from Simms, 2011)

Conditions of Worth
Defined by success
Must take the hardest path

Introjected Values and Beliefs
Must aim high & achieve as much as possible
Failure is bad

Denial and Distortion of Experiences
Others think bad of me
If reduce aspirations (goals) will not be able to get back to previous level
Others are better than me

Critical incident: Undiagnosed injury with no firm rehabilitation plan → **State of Incongruence**
Running identity
Describes self as stupid, useless, pathetic & weak

Psychological Difficulties
Frustration
Fear
Low self-worth

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

Interim Reflection 1

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

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

The Process of Change – Part 1

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

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

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

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

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

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

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

Interim Reflection 2

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

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

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

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

The Process of Change – Part 2

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

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

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

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

Evaluation

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

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

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

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

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

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

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

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

Overall Personal and Meta Reflections

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

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