Using Acceptance and Commitment Therapy for unhelpful thinking towards body image with an elite figure skater

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Abstract

We outline the sport psychology service delivery provided to a 23-year-old elite figure skater, who reported unhelpful thoughts about her body image, which hindered her performance and concentration in training. An Acceptance and Commitment Therapy (ACT) intervention was implemented over 12 sessions across a six-month period. The ACT matrix was used to conceptualise the client's "stuckness" and provide a foundation for the techniques implemented. The aim of our work was to increase psychological flexibility, helping the client sit with, rather than change or remove, her unhelpful thoughts, moving her towards the athlete she wanted to be. This case reports how psychological flexibility was achieved through exercises to help the client "unhook" from her unhelpful thoughts about body image. Reflections from the client were obtained to monitor and evaluate the service delivery process. The trainee's reflections on practice highlight the unpredictability of presenting problems disclosed during service delivery, the isolating and challenging nature of working with elite athletes in private practice, and the need for practitioners to understand the theoretical orientations of their approach.

Keywords: ACT matrix, Defusion, Mindfulness, Psychological flexibility, Relational Frame Theory

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Context

At the time of the case study, I (first author) was in the final stages of the independent training route in Sport and Exercise Psychology (SEP) in the United Kingdom. This qualification, awarded by the British Psychological Society (BPS), offers eligibility to register as a Practitioner Psychologist with the Health and Care Professions Council (HCPC). At the time, my applied experience had been gained from consulting on a one-to-one basis with individual clients from a range of sports (i.e., swimming, golf, figure skating, football) and ages (i.e., youth and adult). The second author was the Co-ordinating Supervisor for the duration of the qualification, serving as a mentor throughout the training process.

Service Delivery Philosophy

The development and understanding of personal and professional philosophy is an integral determinant in the effectiveness of sport psychology service delivery (Poczwardowski et al., 2004). Initially, I adopted a cognitive-behavioural approach, influenced by my academic background and desire for a clear framework (Tod, 2007). Cognitive-behavioural therapy (CBT) describes a diverse group of approaches (e.g., cognitive therapy, rationale emotive behavioural therapy, acceptance and commitment therapy), that combine a cognitive and behavioural approach (Knapp & Beck, 2008). CBT practitioners are concerned with the interplay between thoughts, feelings, behaviours, and physiology, employing strategies that challenge or control unhelpful internal states that hinder athletes' performance(s) (Beck, 2011; Turner et al., 2020). This aligned with my core beliefs (i.e., thought, feelings, and behaviours interact, the practitioner is expert, and the client seeks strategies from a trained professional to help them control their internal state) at the start of my SEP training. This was partly informed by my previous experience in sport coaching and

partly by the way psychological skills training lends itself to psycho-education delivery. Reflecting throughout my SEP training (Anderson et al., 2004; Cropley et al., 2007; McEwan et al., 2019), I transitioned from a belief that I was the expert helping clients control their internal state, towards the belief that the client is the expert and that attempting to control internal states might worsen the presenting problem. My practice moved towards a process of individuation (McEwan et al., 2019) and exploration of Acceptance and Commitment Therapy (ACT; Hayes et al., 2012). ACT has gained increasing attention and use in sport (Hartley, 2020; Price et al., 2022b; Swettenham & Whitehead, 2022) and this case study documents the application of ACT principles in my work. I adopted a client-led approach to assist the client develop an increased self-awareness to "navigate" through challenging experiences and situations. I assumed a *construalist* approach to the consultancy, taking an interpretivist and constructivist philosophical stance (Keegan, 2016).

The primary goal of ACT is the promotion of psychological flexibility — the ability to contact the present moment fully — accept thoughts and change behaviour based on chosen values (Harris, 2019). To do this, ACT interventions focus on switching an athlete's attention to the relevant task versus their internal state, such as anxiety or frustration. Derived from a school of behaviourism, ACT assumes psychological dysfunction is primarily the result of misapplying problem solving and language to "normal instances of psychological pain" (Hayes et al., 2012, p. 19). These tendencies can lead to experiential avoidance, inflexible attention processes, and reduced attempts to pursue valued behaviours. ACT focuses on taking action, guided by core values, to behave like the person we want to be (Harris, 2019). The aim is to have the client identify what really matters to them and use these values to guide, motivate, and inspire what they do (Harris, 2019). ACT comprises six core processes, which can be grouped into three functional units — the "triflex" (Harris, 2019). First, the noticing self, or the *self-as-context*, and *contacting the present moment,* both

involve flexibly paying attention to, and engaging in, here-and-now experience — being present. Second, *defusion* and *acceptance* relate to separating thoughts and feelings, seeing them for what they are, and allowing them to come and go — to open up. Third, *values* and *committed action* involve initiating and sustaining life-enhancing action — or doing what matters. In this way, psychological flexibility can be described as the ability to be present, open up, and do what matters. ACT aims to replace cognitive fusion and experiential avoidance with mindfulness and acceptance; and rigidity and inactivity with clarification of the athlete's goals and values, to inform overt behavioural activity.

Ethics and Assumptions of Practice

During initial conversations with the client, prior to needs analysis and case formulation, I explained that I was a Trainee Sport and Exercise Psychologist in the final year of my supervised training. I understood that a warm, trusting relationship, with good rapport, was vital in producing successful outcomes (Keegan, 2016). I used the intake process to cement five outcomes (Keegan, 2016): establishing the relationship and working agreement; agreeing ethical boundaries, expectations, and confidentiality; and clarifying my approach as a practitioner, and whether that fitted with client's needs. I explained that the client could terminate our working relationship at any stage, shared my supervisor's details, and asked them for a signed consent form agreeing the nature of our working relationship. The aims of the services provided were to promote positive mental health and well-being, personal growth and development, and enhance performance. The agreement assumed working on a long-term, continual basis. Sessions were not established to address a specific problem, but I was aware of the need to be prepared for a variety of presenting problems that might arise. I felt comfortable that I understood my areas of expertise and could acknowledge when athletes needed referring to other specialists.

The Case

The client, Amy (pseudonym), is a 23-year-old female. An internationally competitive figure skater, she began figure skating at five years old and was competing by age six. She recalled that the sport had always been fun, although training had historically been "really serious" and "the most important thing in life". Amy reached the senior competitive level at age 15. At age 18, she injured her ankle and required surgery. At the same time, she had difficulties communicating with her coach, and could not afford — or justify — relocating for her sport. She ended her career, feeling "forced to quit" and desperately wanting to continue. Two years later, aged 20, she relocated to the UK, with her boyfriend, to study at university. Shortly after, she discovered the local ice rink (an hour's drive away) and started coaching to earn money. She started training and, after being approached and encouraged by a coach at the facility, Amy started training with a focus on competing. She was a national team member, four-time national champion, and had competed at European and World Championships. Consequently, she had attended all major events, except the Olympic Games, by the age of 18. Amy discussed her return to competition as a "second chance". Her goal was to qualify for the 2022 Olympic Team.

Sessions commenced in November 2021, online via video call (Price et al., 2022a). At that time, Amy was returning to training after an injury she had sustained during summer training. Amy perceived that her coach and Federation were applying pressure on her to compete at a high level, but her focus was to enjoy training and the sport, generally. Her immediate aim was to recover from her injury. She struggled seeing other athletes in her facility training and she was concerned her foot might not fully heal. She felt periods of "bad" training last season impacted her self-confidence and she struggled to recover from "bad" sessions. In total, service delivery spanned six months, consisting of 12 sessions, which varied in length from 50-60 minutes (Table 1). Sessions were scheduled every two weeks and followed a similar structure (e.g., recap and reflections on/since last session,

psychoeducation, experiential exercises, reflect and recap session content) with some flexibility to meet Amy's needs, altering the focus, flow, and pace of sessions accordingly.

Needs Analysis and Case Formulation

Informed by a interpretive and constructivist approach, questionnaires and measures were deemed unhelpful, impersonal, and unable to fully represent the client's inherently unique worldview and experiences (Keegan, 2016). As such, the primary needs analysis tool was conversation, shaped by the Sport-Client Intake Protocol (SCIP; Taylor & Schnieder, 1992), to gain a comprehensive client history, and the ACT matrix (Polk & Schoendorff, 2014). To frame discussions around Amy's confidence, we conducted a strength audit (Perry, 2020), a performance profiling activity, and the wall of self-belief task (Jones & Moorehouse, 2012). During these tasks, Amy disclosed that she had a range of difficult thoughts about her weight (e.g., "If I lose weight, it will be easier", "I'm the fattest athlete in training") during training. With knowledge of her sport, I had come to learn weight management was a systemic issue within the culture of how athletes, coaches, and officials discussed the topic. She discussed feeling psychologically tired. She evaluated her outfit choice before leaving for training, videoing herself and changing if she did not feel right. This sounded more severe than the narrative throughout our wider conversations about the sport. Amy disclosed that her unhelpful thinking started when she was 10 years old and "felt fat" since her coach at the time told her that she needed to lose weight. She told her current coach a year ago about her thoughts and felt supported. However, she now felt that he assumed everything was resolved.

Amy had received general psychotherapy and counselling services during the covid-19 lockdown, working with a practitioner who specialised in eating disorders. This helped her realise it was because of her coach why she thought this way. Strategies they discussed included: covering the mirrors in her house, which was impractical, but helped a little; and ceasing engagement with social media, as this fueled the comparisons of her body weight and

shape. Amy felt the intensity of her unhelpful thinking had reduced because she wasn't training (due to Covid-19 restrictions). She disconnected with the psychotherapist because he/she did not understand her sport. Again, I reflected on my suitability to assist Amy, questioning if she required specialist support. Disordered eating is common in athletes, and not always a clinical issue (Papathomas & Capicotto, 2017). She had not received a clinical diagnosis for an eating disorder. She was not purging and had a "healthy" Body Mass Index (56.5kg at 163cm; NHS, n.d.). For a clinical diagnosis of anorexia, she would need to be 15% below her minimum expected weight (41.6kg; ICD-10, 2019). She discussed wanting to regain a "competition shape" following the Covid-19 lockdowns, but even a target weight of 50kg is above the 41.6kg threshold for clinical diagnosis.

Reviewing Gardner and Moore's (2004) Multi-Level Classification System for Sport Psychology (MCS-SP), I initially felt Amy's case aligned with elements of performance impairment: thoughts about her weight severely impacted her ability to function, but she did not discuss this impacting other domains of her life. She discussed positive relationships with her coaches and her boyfriend and was thriving in university, achieving firsts in her assessments. Following discussions with my supervisor and peer group of trainees, I began to see that Amy's unhelpful thinking aligned with elements of Gardner and Moore's definition of performance dysfunction. Her progress was slowing because of her thoughts, primarily caused by previous life events. I wanted to explore whether her thoughts were caused by extreme perfectionism, fear of failure, or an irrational need for approval. While Amy refrained from acting upon her thoughts, I felt she stayed within the definition of performance dysfunction and within my scope of practice. I felt we could explore strategies that would allow her to work through these thoughts. Having completed the Mental Health England First Aid course, I felt I had sound 'awareness of eating disorders' (U.K. Sport, n.d.). Amy did not seem a threat to herself and disconnected with the idea of talking to another professional,

based on her previous experience. I explained that eating disorders were not my specialty. I felt comfortable working with Amy on this issue, with the caveat that if I felt things worsened, she would need to speak to another professional.

Taking a client-led approach, it was important for Amy to prioritise the presenting problem and dictate the direction and focus of our work. We agreed our work would focus on helping Amy better handle her unhelpful thinking about her body image so that she could be happier, and feel more confident, in training. It appeared that Amy's negative thoughts and feelings were hooking her away from her desired way of training and, as such, she needed to "be present, open up, and do what matters" (Harris, 2019). In line with the construalist approach, I did not feel there was an 'off the shelf', ready-made approach suitable. So, the activities, examples, and metaphors used, were specific to Amy, guided by her story and what she felt was important.

The ACT Matrix

I felt that challenging Amy's thoughts as irrational or trying to encourage her to cognitively change her thoughts might add to her struggle, rather than ease it. Her unhelpful thinking appeared to dictate her behaviour in a self-defeating and problematic way, which connected with the notion of cognitive fusion (Harris, 2019). I felt that Amy needed to accept and make room for her unhelpful thinking and accept her thoughts in a way that would not negatively impact her training and performance, rather than combat them (Harris, 2019). The ACT matrix (Polk & Schoendorff, 2014) visually represents one's actions and internal experiences from the client's perspective to promote psychological flexibility. It is a tool that captures the client's actions that move them toward (i.e., committed action) or away (i.e., experiential avoidance) from the person they want to be along a horizontal continuum. This is intersected with a vertical continuum that represents mental experiencing (i.e., thoughts and feelings) at one end and physical experiences (i.e., how the client acts) at the other. This

represents the difference between internal and external experiences (Levin et al., 2017). These bisecting lines create four quadrants, which represent the client's experiences (i.e., physical and mental) and the function of their actions (i.e., helpful and unhelpful). This matrix has been successfully applied to sport (Hartley, 2020; Schwabach et al., 2019). The matrix helped to conceptualise Amy's experiences (Figure 1) and framed the strategies we would discuss to target the core processes of psychological flexibility captured in the ACT triflex. Given the online delivery, we used a collaborative Google Doc with restricted access to the two of us, saved on my password protected Google Drive account, and the screen sharing function during calls, to engage Amy in the consulting process (Price et al., 2022a).

Intervention Plan, Delivery, and Monitoring

When setting up sessions with the Amy, I followed Payne et al.'s (2020) guidance, and explained that video calls were my only method of delivery given our geographic distance and asked for her thoughts and concerns about this approach. I maintained a neutral and consistent background to calls, which established therapeutic boundaries, and assured Amy that I was the only one in the room, maintaining confidentiality, and asked that she did the same. I established a strong relationship in the virtual domain by being active in discussions, using more open and directive questions, and ensuring my screen was large enough to see Amy's facial expressions during sessions.

Our work began exploring Amy's current and previous attempts to "solve" the problem, highlighting how ineffective trying to control, reduce, or eliminate unwanted thoughts, feelings, and sensations can be (Turner et al., 2020). Working with other athletes, I had found introducing some concepts of ACT to be quite confusing, especially the self-as-context aspect of the triflex. English was Amy's third language, so I was conscious of the need to keep explanations as simple as possible. I found the ACT matrix useful in this regard. There is no "right" place to start (Turner et al., 2020), so in this case, we began by exploring

in more detail what thoughts show up and the feelings associated with these thoughts. This addressed the bottom left quadrant of the matrix. We then explored her behaviours through the lens of "what would I see you do?". I then introduced the ACT matrix through psycheducation, which framed how these thoughts and behaviours were pulling her away from her desired way of being.

This naturally led to a conversation around cognitive defusion techniques. These techniques aimed to alter how Amy related to her undesirable thoughts and internal events, rather than trying to alter the form of her thoughts – to decrease the believability of, or attachment to, internal events (Hayes et al., 2006; Hayes & Plumb, 2007). We started with some psychoeducation around cognitive defusion, explaining how our thoughts can sometime be like our hands covering our eyes – those thoughts are all we focus on, in the same way all we can see are our hands. Cognitive defusion techniques pull the hands away from our eyes to arm's length – we can still see them, but our vision has opened up so we can see other things, too. I presented this as the choice point, emphasising that she had choice with how she engaged with thoughts, using the words 'hook' and 'unhooking', rather than cognitive defusion. We discussed Amy's thoughts as constructions of words and images, like clouds passing overhead. I linked this to workability – that Amy's thoughts were not as important as the way she allowed her thoughts to dictate her behaviour.

The aim was to reduce Amy's problematic dominance of cognitions over her behaviour and facilitate being psychologically present and engaged in her experience. The nature of Amy's cognitions fused with: self-criticism (self-concept); perfectionist ideas about how she should look (rules); judgements from others; previous failures (connections between bad training and "feeling heavy"); and reasons why she can't do what she wants (reason giving). To aid cognitive defusion, we covered noticing and naming thoughts – e.g., "here it is again" and "thanks brain" – and neutralising thoughts by emphasising how the thought was

unhelpful in supporting Amy towards her destination. Amy found this technique helpful. She reported that it was relatively easy to calm down and discussed neutralising thoughts with comments like “this isn’t helping” and “this doesn’t matter”. Amy shared that thoughts in training are usually in her first language and she struggled to directly translate some thoughts. Amy’s recurrent injury made these techniques difficult to implement. In one session, she recalled her pain was 8-9/10 and she “just wanted to quit”. I explained that defusion techniques required practice, and noticing thoughts were the first step. In relation to her thoughts around body image and weight, Amy felt the defusion techniques helped.

The noticing and naming thoughts and feelings progressed to discussions around self-compassion and using defusion skills to take the power out of harsh self-criticism. I used the two-friends metaphor (Harris, 2019), recapping on Amy’s harsh and uncaring phrases, and emphasising the importance of talking to herself in kind ways, offering gentle messages of support and understanding. Discussing others suffering in similar ways was made easier because Amy’s final year undergraduate dissertation topic was on eating disorder within her sport. This meant she was aware of the prevalence of the topic in others. We followed this with exploration of Amy’s values. I explained values would be like “travelling West”, whereas a goal would be “travelling to the United States”. This highlighted how values were vague compared to goals and can’t be fully achieved. I created a digital online document of a single A4 side compiling a deck of values card to make this task easier to do remotely. We reviewed the sheet together, with Amy asking for clarification on any words she was unsure about. We refined the list of values, completing the bottom right quadrant of the matrix. These values were: balance; enjoyment; professionalism; and consistency. From here we identified how Amy could demonstrate these values through her behaviours. This completed the top right quadrant of the matrix – her committed action. Amy interpreted this as “getting psychologically ready” during her session warm-ups, which she connected with.

Now that we had completed the matrix (cognitive fusion, experiential avoidance, values, and committed action), I drew Amy's attention to the tensions between each quadrant. I asked Amy, "Who can see all these quadrants?" and asked her what she would "wish away" if she had a magic wand. She identified it was herself getting in her own way (self-as-context). From here, we discussed the importance of letting thoughts be and acknowledging difficult inner experiences through mindfulness. Mindfulness-based approaches have gained increased attention and demonstrated their effectiveness within sport (Gardner & Moore, 2017; Hussey et al., 2020). Mindfulness aims to increase contact with the present moment, targeting defusion, acceptance, and self-as-context (Fletcher & Hayes, 2005). The aim was to encourage Amy to be present (Harris, 2019), accommodate her experiences by making space for them to "fit in", adapt them, and help Amy feel grounded and centred.

I introduced the concept and associated benefits of mindfulness through psychoeducation. We then conducted a formal mindfulness exercise, using Amy's water bottle to demonstrate engaging her *see* and *feel* senses. Once Amy recognised our minds have the capacity to wander and we can notice this and bring our attention back to the present moment, I set Amy the task of doing mindfulness for ten minutes every day over a week, asking her to record her thoughts – highlighting if her focus was in the here and now, past, or future. We then discussed dropping anchor (Harris, 2019) and engaging with the world around her by checking in with her senses. The focus was to establish this as a routine in training. We discussed how Amy needed to first acknowledge her thought, and then come back to her body, engaging with the world around her. We agreed "thanks brain" followed by a lap of the ice rink, checking her senses – what she could see, hear, feel, taste, and touch. I avoided discussing feeling her weight on the ground because of her weight concerns. Instead, we talked about feeling the cool air on her face. On review, Amy explained this exercise was

not proving helpful. We discussed breathing as another grounding technique (specifically colourful breathing; Perry, 2020), which she preferred.

Evaluation of Intervention and its Outcomes

SEP practitioners are required to engage in systematic monitoring and evaluation of their work to assess their service delivery (Harbel & McCann, 2012; Keegan, 2016). Evaluation in ACT is ongoing, and constant reevaluation of treatment goals occurred throughout consultancy (Hayes et al., 2004). Informally, I checked in with Amy after each experiential exercise (e.g., values cards, mindfulness, "thanks brain"), several weeks into the intervention, and at the close of the intervention. Following each session Amy completed a session rating scale (SRS; Duncan et al., 2003), scoring her perception of each session on four factors using a ten-point Likert scale (relationship; goals and topics; approach or method; and overall). The purpose of this was to gain reflections on her experiences and ascertained her perception of our progress towards our agreed goals. Duncan et al. (2003) suggest an overall score below 36/40 for each session is a cause for concern. Amy's scores were consistently 40/40 for each session (see Table 1). Amy's reflections on our work together are captured below. I plan to use guidance from Joy et al., (2016) to continue conversations and keep checking in with Amy.

Client Reflections

To strengthen my understanding of Amy's experiences of our work together, I collected reflections towards the end of the intervention. Prompts for these reflections were inspired by Hartley (2020), to generate insights to inform future work.

What progress do you feel you've made during our work together?

Amy reported a big improvement in the way she felt, specifically discussing "feeling better in training" because she was "more accepting of negative thoughts [that] showed up" — which was the initial goal of our work together. She explained that the unhelpful thoughts

about her weight only filled her head 50% of the time, rather than 95% of the time. In some ways, more importantly, Amy shared that when she did have negative thoughts, they were no longer "that negative" and "not as distracting". Amy was, understandably, apprehensive that she had been in this situation before, and then regressed, so was weary that might happen again. This highlighted how this work required constant effort to build from this point onwards. However, for now, Amy was more content, happier, and in a better place, mentally.

To what extent have we achieved the goals of the delivery service?

I asked Amy to rate the extent to which we had achieved the sport psychology service goals on a scale of 1 (not at all) to 10 (very much so). She rated it at 8. When I asked, "why an 8?" she replied that the unhelpful thoughts still show up, but that they pass over her easier now, without distracting her focus. She discussed how it was easier being present and more focused on herself than before.

What would you change about how we've worked together and how we could work in the future?

Amy discussed that she was happy with the current rate of progress and the way the service delivery was operationalised. She was happy with the way sessions were conducted over video call, felt that I attended her needs, and addressed her concerns. She appreciated that the unhelpful thoughts about her weight were so ingrained into her way of thinking that working through them would take time. However, she had appreciated the support, and was happy for me to continue checking in with her about the topic as we progressed our focus to other areas of her performance challenges.

Practitioner Reflections

Here, I draw on personal reflections that highlight the challenges and realities of practicing as a trainee SEP. I hope to highlight some key messages to inform (my own and others') best practice and ensure effective service delivery (Knowles et al., 2007).

Reflection 1 – Demarcating sport and clinical psychology support

The first reflection refers to the initial challenges associated with this case: whether the case was outside of my scope of service delivery. I took a mindful approach, offering Amy my attention in a space that encouraged openness, curiosity, and compassion. I listened to her carefully, kindly, and genuinely, in a non-judgemental way. I aimed to recognise and challenge any personal judgements that arose as they appeared, both in the moment and through self-reflections. This was particularly challenging as the topic, and specifically the way Amy talked about her body, was difficult to hear at times. Openly discussing it, as though it was not an issue — normalising and validating Amy's experience(s) to facilitate self-acceptance — was important for our work together, but felt uncomfortable.

As captured above, I engaged with the available literature, primarily finding support in the British Association of Sport and Exercise Sciences (BASES) expert statement on the frequency of disordered eating in athletes (Papathomas & Capicotto, 2017). I could not administer a clinical questionnaire as I was not qualified to diagnose an eating disorder. However, on reflection, I could have used a screening tool (pre-participation physical examination; Bernhardt & Roberts, 2010) to better support a referral recommendation if needed, rather than my interpretation alone. I am comfortable that I engaged in this case and pleased to hear Amy's reflections around perceived improvements in how she handled her thoughts. Nonetheless, this highlights the challenges of offering sub-clinical psychological support to athletes in a sport setting. My initial reaction was to assume I should not be helping Amy. Although legitimately concerned about my role with this case, and an awareness that I will maintain in future work, this highlights two important considerations: first, that SEPs should be alert to unexpected comments or conversation points that might be raised in any consultation; and secondly, to take a 'person-first' more than 'case-first' approach. In this example, Amy needed, in the first instance, someone to listen,

compassionately and non-judgmentally. Focusing on what she needed in that moment and addressing the needs of the case as a secondary concern was an important lesson to take forward to future cases.

Reflection 2 – Working in the context of elite sport as a practitioner in private practice

With this case occurring during the final stages of my supervised training, my mind had started to focus on the longer-term implications of private consultancy work as an SEP. This case made me appreciate the importance of maintaining engagement with my supervisor in a mentor capacity, as well as building a small peer-group for support and guidance in similar situations, moving forward. Yet it also highlighted the challenge of being on the peripheries of an athlete's team. Working remotely and engaging in the consultancy process via video call did not impact the effectiveness of the service delivery, but did remove me from the athlete's training site and wider team. Amy disclosed that she had shared her thoughts with her coach, but engaging with her coach and social support group (e.g., her boyfriend) seemed beyond the scope of the connections I could establish and explore. Moreover, this case highlighted for me the difficulties of SEPs operating in similar situations truly working as part of a multi-disciplinary team. Without being critical, this case played out in very different circumstances to how similar service provisions may be for those working within more established elite settings (e.g., multidisciplinary support team, athlete entorage).

I started my supervised training delivering a workshop at a local club, in the café of a leisure centre. By establishing myself within the sport, and exploring potential working relationships, I had progressed to working with a whole range of athletes within this sport. However, working with elite athletes was something new – a level I had not achieved in my coaching role. This had been the dream and offered exposure to a broader set of experiences that will better prepare me as a practitioner (Eubank et al., 2014; Owton et al., 2014). However, refraining from advertising this level of experience meant this work did not raise

my profile, publicly(see Anderson, 2004). I felt self-imposed pressure to be busy in sessions – to prove my worth/value, of sessions and the discipline of sport psychology more generally. I also felt a need to be perfect – to always demonstrate my best. Importantly, I was aware that by subconsciously pressuring sessions to focus on a particular problem that needed addressing may well have increased athletes' ambivalence to receiving sport psychology support. Combining this self-doubt with the complexity of the current case and the reflection above, I considered my practice in line with the BPS code of ethics and practice (BPS, 2018). I respected Amy's dignity and knew her sport. I did not make knowledge claims I could not sustain and maintained honesty and openness by accepting this vulnerability, demonstrating integrity. Here, I hope to highlight the learning experience(s) reflective practice offers, seeing it as a development tool, rather than an assessment strategy (Knowles et al., 2014).

Reflection 3 – Developing a working understanding of ACT interventions

I am becoming more comfortable and familiar with the ACT principles we worked through, which meant I felt more confident in explaining the techniques and metaphors I used. I was more comfortable to have a book open during sessions and refer to notes made before and after sessions. I had become accustomed to the feeling of being imperfect, modelling openness, authenticity, willingness, and self-acceptance. Amy connected with the tasks and exercises we went through during our work together. In our conversations she discussed how our work had enabled her to see things in a more agile, self-compassionate way. I felt that these improvements had occurred, firstly, because we had talked about, and consequently normalised, the issue. Secondly, we had diffused Amy's thoughts, helping her to accept that these negative cognitions will keep reoccurring, and emphasising the need to focus on workability. By helping Amy focus on mindfulness and values, her emotions seemed to operate in a way that were no longer toxic, life-distorting, or self-defeating.

Yet it is still rather challenging to discuss with clients the somewhat counter-intuitive approach to ACT. In discussing the fundamentals of the approach with Amy, I explained that the focus was on accepting, rather than changing, her unhelpful thoughts. Here, we discussed previous attempts to address her thoughts, which aligned with a cognitive therapy approach. This helpfully allowed the opportunity to discuss the advantages of trying a different approach and allowed a client-led approach to priotisiting acceptance over change of thoughts without too much resistance from Amy. However, gaining buy-in to try this different approach was something different. On reflection, I think Amy's surface level desire for change was replaced by a growing self-awareness during the consultancy process. I feel that she was open and curious to try something different, trusted in the process, and connected with the metaphors used to introduce the concept of cognitive defusion and contacting with the present moment.

Working with the ACT approach, I have come to understand the importance of values-based work. This serves as a reminder to check-in with my philosophy as a practitioner and challenge myself, where necessary, on what is important to me and whether I am living – and practicing – in line with my values (Poczwardowski et al., 2004). Nevertheless, there is an apparent lack of objective measure to test the effectiveness of ACT interventions in sport. This should be a focus of future research and allow the opportunity to evaluate ACT-based interventions more effectively in sport and exercise psychology.

Reflection 4 – Monitoring and evaluating delivery using the session rating scale

Partington and Orlick's (1987) consultant evaluation form continues to feature as one tool I use to gather data on client's perceptions of my service delivery. However, process evaluation is a key data collection tool in monitoring my work. The work of Miller et al. (2007) highlights feedback as a key part to the formula of success. Their work suggests that rating of the practitioner-client relationship is a reliable predictor of the outcome. Based on

the sessions rating scale (SRS; Miller, 2012), I developed a brief Google form asking clients to rate (on a 0-10 scale): our relationship; how aligned the session was to their goals; the approach/method used in the session; and an overall rating of the session. This took around 20 seconds to complete. The digital link was easy to share with clients and completing the form became part of session plenaries. Although self-report measures risk clients saying what they think they should say, I stressed to clients that the exercise was about my improvement and development as a practitioner. I used a set script to stay away from emotive language, emphasised it was a safe space for clients to offer critical feedback, and stressed the role this form played in improving their experiences of the service delivery. I hoped this would reduce issues of client's offering socially desirable feedback. This 'data' informed my professional development plan, developing a sustainable way to capture feedback, establish areas of progress, and areas for improvement.

Conclusion

To conclude, Amy discussed that her unhelpful thoughts about her weight still arose, but that she was less "hooked" by them. The aim of our work was not to remove these thoughts for Amy, but to help her "sit" with her thoughts, diffusing from them and working through the challenge they presented to move towards what was important and the athlete she wanted to be. Her verbal reports, and consistently high rating on the SRS, demonstrate that Amy was satisfied with our work together. However, this case study highlights some critical recommendations for practitioners. First, the unpredictability of presenting problems disclosed by clients during service delivery and the need to pursue a person-first approach to listen, compassionately, non-judgementally, and curiously to client's challenges, rather than panicking and closing conversations because it appears, at first glance, a problem you cannot address. Second, working in private practice, engaging with athlete at an elite level with under-resourced sport science support, can be isolating and challenging. Here, the importance

of working within the professional standards (e.g., BPS code of ethics and practice), avoiding any potential safeguarding concerns, and using reflective practice as a learning and development tool can provide a much-needed anchor in the complex uncertainty of applied practice. Third, process evaluation, captured through discussions with the client as well as a questionnaire like the SRS, prove valuable in monitoring and evaluating the client's perceptions of the intervention. Lastly, practitioners should have a grounded understanding of the theoretical orientations of a particular school of thoughts and cognisant of the potential pitfalls their approach presents. Specifically, there is a distinct lack of sport-specific objective measures to evaluate the effectiveness of ACT interventions, which should be a focus of future research endeavours in this area.

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Figure 1. *Amy's ACT Matrix*

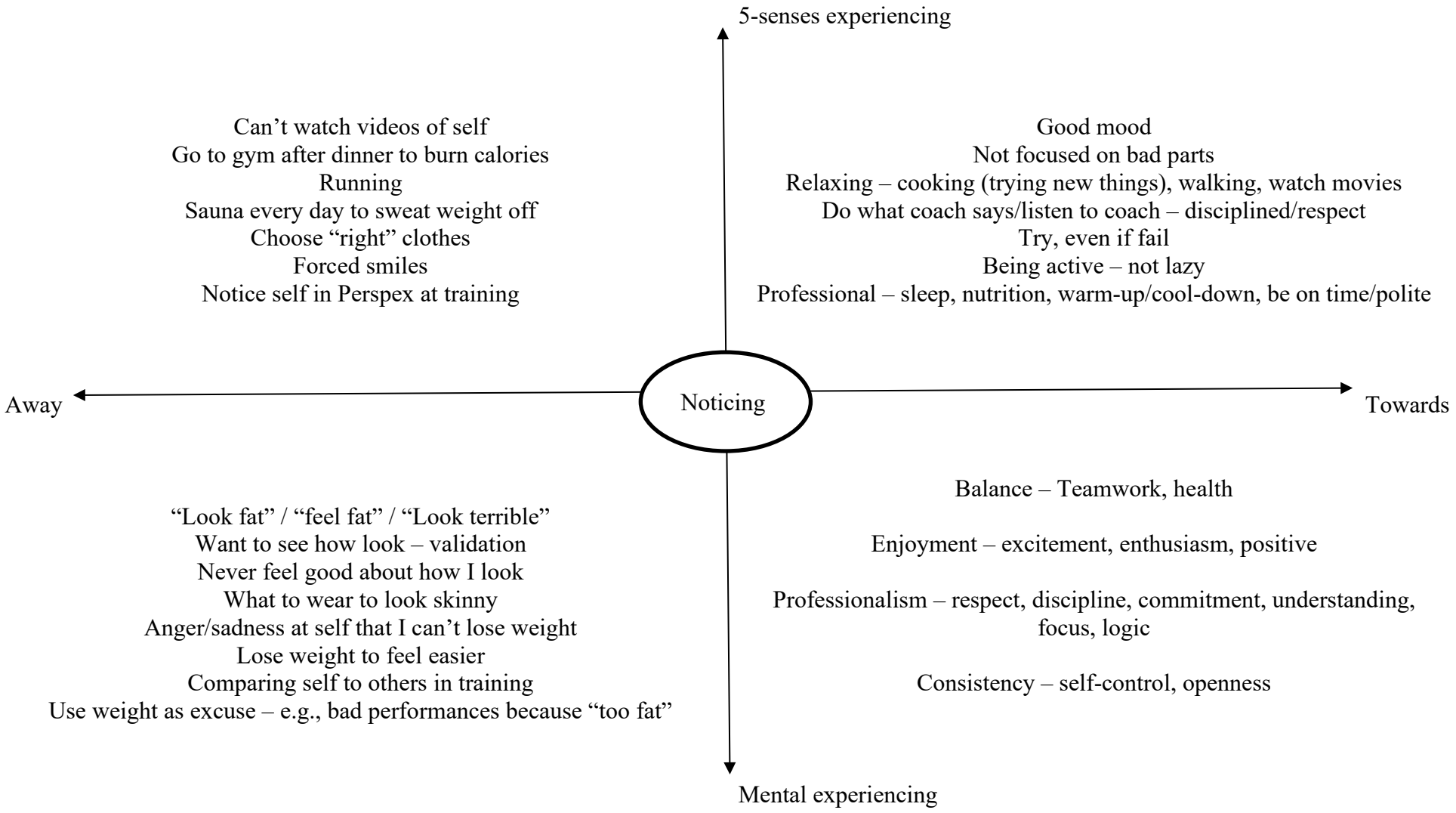

Table 1

Service Delivery Process with Amy (session, content, length, rating)

Intervention Phase	Session	Content	Length (mins)	Session rating
Intake	0	Pre-intake call. Outlined my ethical and professional boundaries, and service delivery philosophy. Briefly discussed Amy's sporting history, her need for sport psychology support, and her goals for the service delivery.	30	N/A
	1	Intake interview (SCIP; Taylor & Schnieder, 1992). Identified a lack of motivation, conducted a strength spotting activity, and explored Amy's "why?" for competing in figure skating.	90	40/40
Intervention Plan	2	Performance profiling identified thoughts about weight as the presenting problem. Explored through questionning ("What thoughts show up?"; "How does that make you feel?").	60	40/40
	3	Explored Amy's behaviours ("What would I see you do?"), the ACT approach, and ACT matrix (through psychoeducation).	60	40/40
Delivery	4	Explored cognitive fusion (i.e., "what shows up?") and experiential avoidance (i.e., the behaviours Amy engaged in to move away from thoughts) framed in the short- and long-term (creative hopelessness) through metaphors and physicalising exercises. Covered cognitive defusion techniques (e.g., notice that thought, and "thanks brain").	50	40/40
	5	Discussed self-compassion using the two-friends metaphor. Highlighted the importance of gentle messages of support and understanding.	50	Not completed
	6	Identified Amy's values. Amy disclosed that her unhelpful thoughts were improving.	60	40/40
	7	Refined values list: balance; enjoyment; professionalism; and consistency. Explored how Amy could demonstrate values (e.g., committed action).	50	40/40
	8	Explored tensions across the matrix quadrants (cognitive fusion; experiential avoidance; values; and committed action). She identified she was getting in her own way (self-as-context). Covered mindfulness (i.e., contact with the present moment) through a formal exercise. Asked Amy to complete a week of mindfulness practice. Amy disclosed she was feeling happier about her weight and feeling better in training.	50	40/40

	9	Applied mindfulness to "real world" moments through dropping anchor, sense-checking, and mindful/colourful breathing exercises. Amy discussed how her ankle injury was disrupting her ability to practice the defusion techniques we had covered.	60	40/40
Monitoring	10	Refocused on committed action. Amy shared that the frequency of her thoughts about weight dropped from 95% of the time to 50% of the time. She didn't feel fat in herself and felt positive about her body – she felt she looked good.	50	Not completed
	11	Amy disclosed a better mood and feeling more positive. We reviewed her values, her progress on defusion techniques, which were easier now the ankle was better, and Amy wanted to explore visualisation techniques now she felt more comfortable about her self-image.	60	40/40
	12	The final session. Amy shared she was feeling more confident and able to handle her unhelpful thinking in training. Training was going well, and she was approaching the start of her competition season.	50	40/40