Person-centred Sport Psychology Practice: A framework for working with Emotions & Complex Processes

Abstract

Person-centred Therapy (PCT) is a client-centred therapeutic approach that focuses on the practitioner-client relationship and has been shown to be an effective practice approach when working with clients presenting complex emotional experiences. We provide a brief outline of PCT theory and specific practice techniques for working with emotions in applied sport psychology practice. Adopting a case report methodology, we outline two specific *self-charting*, and *clearing a space (CAS)* that can be applied when working with complex emotions in the sport context. This case report contributes to the literature as the first study to provide a framework for PCT application in applied sport psychology. By providing a 'how-to apply' framework, we aim to show how to these techniques in practice using 'in vivo' session transcripts. Evaluations of interventions and reflections are demonstrated which will provide practitioners with a case example and reccomendations for context-sensitive application of PCT.

Keywords: therapy, case report, intervention, athlete, humanistic, applied practice

Person-centred Therapy (PCT) Theory: A Brief Outline and Ingredients for Practice

Person-Centred Therapy (PCT) is underpinned by Rogers' metatheory on how individuals develop a sense of self and aetiology of growth and/or emotional distress (Rogers, 1957; Katz & Hemmings, 2009). It is built on the premise that that an effective approach to practice for clients with complex processes starts with placing importance to the client-practitioner relationship (Katz & Keys, 2020). PCT outlines that given facilitative conditions clients are capable of self-understanding, being resourceful, are trustworthy, and able to make constructive changes to live fulfilling and effective lives (Rogers, 1951; Mearns et al., 2013). Rogers (1957), used the phrase 'necessary and sufficient conditions' for the six ways of working that could bring about client growth and change. For the purposes of the current paper we condense these six necessary and sufficient conditions (Rogers, 1957) into four ingredients (i.e., congruence, unconditional positive regard, non-directiveness and empathy) and show how these can be operationalised in sport. We only use the word ingredients as a convenience and not to suggest an alteration to Rogers theory. These four ingredients are outlined below in Table 1. An intensive appreciation of Rogers' metatheory is outside the scope of this paper. Readers are referred to Rogers (1951; 1957) and Mearns (2002) for further reading.

INSERT TABLE 1 HERE

These ingredients are applied using therapeutic micro-skills (active listening, empathy and paraphrasing) to enhance communication and the process of reflective exploration with clients (Mearns et al. 2013). Key micro-skills necessary for applying PCT in sport are highlighted in Table 2. We refer readers to further readings on micro-skills (see Longstaff & Gervis, 2016; Schooley & Hibel, 2018; Tolan & Cameron, 2018).

INSERT TABLE 2 HERE

PCT in Sport Psychology

A review of literature indicates some elements of Rogerian PCT are already present in sport psychology (see Black & McCarthy, 2021; Katz & Hemmings, 2009; Pettipas et al., 1999). For example, prizing the client and active listening have been lauded as fundamental to building a relationship rooted in

'psychological contact' (Cropley et al. 2010; Sharp et al. 2014, 2015) whilst Katz and Hemmings (2009) argued that person-centred work is appropriate when initiating a non-directive conversation about how thoughts, feelings, and behaviour link to sport performance. Ivey and Ivey (1994) illustrate that skills such a reflecting content back to clients and the use of summation can enhance communication and process for an athlete. Chandler et al. (2014) and Nelson et al. (2014) have also endorsed person-centred approaches arguing that empathy is a prerequisite for effective service delivery in sport contexts. Patsiaouras (2008) informed his investigation of motivation on athletic performance and anxiety intervention (Patsiaouras et al. 2013) with tenets of PCT. Moreover, Lindsay et al. (2007) highlighted the centrality of congruence between applied practice philosophy and personal beliefs/behaviours. There have also been a few reflective accounts such as Barrett and Fletchers work with a triathlete's fear of water (2016), Black and McCarthy's work with a professional basketball player (2021) and that by Davis and McCarthy (2022) on the personal growth for a runner. In addition Katz and Keyes (2020) outlined Person-centred approaches in the edited volume on 'Applied Sport, Exercise and Performance Psychology'.

However, despite calls greater detail on the use and efficacy of PCT in sport (see Keegan et al., 2017), there has not been a detailed exposition of PCT in sport, and applied recommendation for its adoption in practice. We hope to add to this extant literature by providing as detailed an account as space will allow of how PCT was adopted as the modality of practice and to showcase two ways of working with client content that, to date, have not been evident in applied sports psychology literature, namely *clearing a space (CAS)* and *self-charting*. PCT as a therapeutic intervention holds value in working with deep emotional processes (Katz & Hemmings, 2009) offering a fresh intervention approach in applied sport psychology**.** Specific to sports contexts these could include stress (Hanton et al. 2005), anxiety (Hanin, 2010; Mellalieu et al. 2009), depressive tendencies (Wolanin et al. 2015), anger (Woodman et al. 2009) and reccurent adversities (Gupta & McCarthy, 2021). Maladaptive emotional processes are detrimental to mental health (Van Slingerland et al., 2019) and long-term athlete development (Rojo & Caro, 2016). It is also important to note that working with PCT informs positive-valanced emotional states (see McCarthy, 2011, for review).

Literature also indicates that athletes, coaches, and others in the sport environment are arguably subject to conditions of worth (Black & McCarthy, 2020; Sarkar & Fletcher, 2014 for review). An explicit example of a condition of worth could be a coach who is only deemed 'valuable' if they win or achieve targets (Sarkar & Fletcher, 2013; Gupta & McCarthy, 2022). The pressure of such an outcome-achievement based environment often shifts the focus away from the person and could lead to athletes being dropped when performance standards are not met causing mental health concerns (Henriksen et al., 2020). This more punitive environment destabilises what Rogers called organismic valuing (the individual is no longer valued for the person they are but for what they can and cannot do to meet demands), which in PCT calls for a focus on the individual actualisation tendency (Rogers, 1961). In such instances, adopting PCT as a therapeutic approach tempers the toxic aspects of a 'win-at-all costs' environment by providing unconditional support from a helping professional (Mearns et al. 2013). PCT finds a place in such contexts due to the increasingly rising importance attributed to mental health and holistic approaches in sport (Moesch et al. 2018). This paper answers calls from educators and practitioners to include these therapeutic skills within training and applied sport psychology practice (Watson et al. 2017).

The rationale and significance of this paper come from its offer of a practice-friendly framework based on professional practice experience and PCT theory via the format of a reflective case report. The aim is to outline a case, describe two specific techniques for a PCT underpinned formulation, namely Self-Charting and Clearing a Space (CAS). Crucially, we provide the 'why of these techniques (that is, the defendable practice philosophy, formulation, and evidence-based) as well as the 'how' to via the vehicle of a detailed case study report, analysis, and critique. Critical reflections from applied practice and literature-based recommendations are provided to permit transferability across contexts and allow practitioners to apply the PCT techniques.

Method

Reflective Case Report

Reflective case reports offer a non-experimental method in which evaluation of applied practice helps us realise a holistic approach to evidence (Hemmings & Holder, 2013). This case report design was chosen to provide practitioners with a theory based applied example of PCT techniques in the real-world

sport environment (Strean, 1998) aligned to Tracy's (2010) criteria for high quality qualitative research. The case report design employed here is not a reflective account of practitioner professional development. Rather, it outlines the application of therapeutic techniques and tracking client change within a real-life context using observational, behavioural, and self-report sources of evidence (Robson, 1993). This is achieved through Anderson et al's (2004), Five Stage Reflective Model (description, reflexivity, evaluation, adapting and action plan) during service-delivery and to structure this reflective case report.

Philosophical Paradigm of Reflective Case Report

A pragmatist-interpretative epistemological approach to enquiry is espoused (see Levitt et al. 2018) in this reflective case report. An iterative, reflective process of implementation and evaluation was adopted through work with the client to uncover a 'practical level of truth' (Giacobbi et al. 2005, p. 22). This case report is underpinned by critical reflective practice (CRP) (Knowles & Gilbourne, 2010) guiding the first author to interrogate the application of PCT in sport. Thus, we provide technical, practical and critical reflections (Knowles et al. 2014) to help readers see where and how PCT can be applied to practice.

Background & Professional Philosophy of Practitioner

The first author is a trainee sport and exercise psychologist enrolled on a professional doctorate programme in the UK accredited by BPS (at the time of casework and writing this paper). The first author received extensive training in the PCT framework (over 50 hours of taught content), had access to skills training (40 hours), peer supervision (25 hours), regular practice supervision from the second author (20 hours) and passed a 'readiness to practice' test before applied practice. The first author had bi-weekly practice supervision, personal therapy and weekly access to process groups of fellow Stage 2 practitioners (Note: Stage 2 is the phase where trainees are in supervised practice while training for full accredited practitioner status). This allowed continuous reflection-on-practice and reflection-on-self which is vital for effective service delivery and experiential learning (Cropley et al. 2010).

The second author is an HCPC registered Sport & Exercise Psychologist, a registered member of the British Association of Counselling and Psychotherapy (MBACP) with a counselling practice that she has run for more than a decade. Her client work aligns with the person-centred/process-experiential approach. She is a qualified supervisor who aided the first authors therapeutic work (formulation and intervention) and reflective practice.

Client profile and presenting concerns

Albus (client pseudonym) is a 19-year-old professional footballer with a serious knee injury. Proximal to the injury onset he had achieved his long-term goal of playing for the senior / main team in a professional football club. Albus was already in the rehabilitation phase for this injury at the start of work with the first author. The coach and physiotherapist had raised awareness of sport psychology provision, leading Albus to contact the first author. Albus sought out the support because he "really needed to talk to someone" and the first author was working at the elite football club he played for. Voluntarily signing up for and scheduling sessions aligned Rogers (1957; 1961) view that individuals are driven to self-actualise. Albus wanted to understand his emotional experience, process his emotions better and wanted to "come out stronger and understand me better". Albus related that he was aware he had been experiencing "almost uncontrollable emotions" in the aftermath of his injury. These included anger, continuous frustration, deep sadness, and regret which led to psychological distress (Podlog et al. 2015). Albus expressed that he *"needed to get on top of this and understand it… it's the first time I have had such powerful feelings, and like, I thought you could help with that".*

Client contracting and ethics

Initial contracting conducted in January 2020 adhered to ethical mandates outlined by the BPS and HCPC Code of Ethics and Standards of Conduct (BPS, 2018; HCPC, 2018). Active monitoring and safeguarding were conducted throughout client engagement (Stapleton et al. 2010). The sessions were conducted in a confidential space (a room in the football club's building). Flexible access to sport psychology support scheduling facilitated choice and autonomy for the client which provided the foundation for an athlete-centred relationship per PCT philosophy (Rogers, 1957). The essence of PCT and parameters of working in such a framework were outlined to the client, allowing space and time for client questions and collaboration (see Bond, 2015). Albus was informed about the audio recording process, data anonymisation and storage per GDPR guidelines to maintain confidentiality (Jenkins, 2020; Mitchels & Bond, 2021) (Note: the audio recording was conducted with consent for training and quality assurance). The parameters of confidentiality and disclosure in the case of risk to himself or others were explained. Written consent via a confidentiality contract was obtained for audio recording and anonymised case reporting. Contracting and initial in-session work was focused on balancing the power dynamic in therapy

(Zucconi, 2011) to help the client view the practitioner as an equal and not an 'expert' who instructs the client to 'problem-solve' (Katz & Hemmings, 2009). This is evidenced in session 6 when Albus stated, *"I like that fact that you just listen… most don't… and it's odd… but as I talk through things and you just support me I can solve some of them myself"* (Session Notes). Being a critical practitioner, the first author found this striving for a collaborative approach to be congruent with his practice philosophy (Cropley et al., 2010).

Albus received one-to-one therapeutic support from the first author with a total of eight sessions of fifty-minute duration, scheduled at ten-day intervals. By our fourth session (40 days from the start of our work together), Albus had returned to field exercise and by our sixth session (56 days) to ball training. Albus was aware of non-session observation. Formal (training sessions with a clear plan and structure) and informal observation (non-sport, unstructured observation) was also conducted to gauge behavioural responses during rehabilitation in line with guidance from Martin et al. (2020). Formal observation were conducted in one hour periods across three days when Albus returned to field exercises and then individual ball training. Three thirty-minute informal observations were conducted where the first author engaged in general conversation (maintaining confidentiality) with Albus and the physiotherapist. Another informal observation was conducted during a sponsors event at the football club and during travel to games where both were present. The formulation with this client was done via the PCT framework and 'Self-Chart'. Specific and relevant evidence from sports injury literature on psychosocial factors, fear, anxiety, and identity (Poglog et al. 2011; Wadey et al. 2014; Brewer & Pettipas, 2017) informed practice.

Therapeutic Process & Evaluations

The therapeutic plan was to (a) reflect with Albus on his ability and potential to change and trust that he could do so, (b) engage in psychoeducation and empathetic reflection to increase Albus's emotional self-awareness and emotional acceptance and (c) to provide him with UPR, warm non-judgemental acceptance, support, and empathy in a genuine and congruent way. Critically reflecting upon practice, the therapeutic plan created an environment where Albus could begin accepting his natural way of being and emotional experience. This was evidenced when he stopped fighting with his emotions (indicated by a lessening of self-blame statements such as *"I shouldn't feel this way"*) and started validating them to move towards a state of congruence *("I feel this way because my football and my career is important to me"*).

The authors wish to make it clear that this is not a call to divorce ourselves from other paradigms, such as CBT, or behaviour therapy. Rather, we offer a framework for a practice underpinned by PCT to add to the current practice paradigms. PCT was a good client-paradigm fit for Albus due to the psychological distress caused by high emotional reactivity to injury.

In addition to a formal review of process after 5 weeks there were regular check-ins to review process and to gain feedback from the client as their own change process (this was achieved by the use of question such as "So, what was your initial thoughts on the self-chart we created?"). Reflections from out-of-session emotional experiences were also processed. These were aimed at identifying transferability of in-session therapeutic work to the clients everyday life and priorities in sport (Bernes et al. 2009). To compliment such check-ins, the self-chart (detailed in section below) was also used to track Albus's progress (elaborated in section below). Critical evaluations were conducted using verbatim transcriptions and recordings of therapy notes. The 'data' and session process dialogues provided in this case study was collected via session audio recordings after obtaining written consent (BPS, 2018). It is to be noted that the sport psychology support offered to the athlete was pre-COVID. Techniques outlined here need to be adapted to suit the online modality.

PCT Framework for use in Applied Practice

PCT was a good client-paradigm fit for Albus due to the psychological distress caused by high emotional reactivity to injury. His post-injury emotional and psychological distress required space and time to accept and adaptively process his experience and provided rationale for the selection of PCT (Rogers, 1961) [see above for a more detailed client case profile]. The previous section outlined the ingredients of PCT practice (Table 2), which is now demonstrated in practice. The sections to follow aim to provide a formulation and analysis of this casework, with particular focus on two therapeutic techniques, namely 'Self-Charting' and 'Clearing a Space'. Ultimately, we aim to provide a framework for others who wish to expand their consultancy and practice repertoire to incorporate person-centred ways of working.

The Self-Chart Technique and Process of use with Albus

Self-Chart allows the client to share (or even vent) their authentic emotional experience in a functional manner. Created by distilling Simms (2011) person-centred formulation map, the 'self-chart' (see Figure 1) serves as a navigational tool for the client to locate the sources of their distress and offers the

practitioner a process map to structure the client's phenomenological experiences. This self-chart can be customised for a person-centred formulation of a client's distress.

INSERT FIGURE 1 HERE

Self-charting is an emergent process that adheres to Rogers' claim that "diagnosis is a process which goes in the experience of the client rather than in the intellect of the clinician" (Rogers, 1951, p. 21). It is a collaborative process whereby the client and practitioner formulate a working hypothesis on what may have led to psychological distress (see Sim et al. 2005; Simms, 2011). The self-chart (Figure 1) contextualises the phenomenological distress of the client (Johnstone & Dallos, 2013). The first author and Albus collaboratively produced the self-chart (Figure 1) of his psychological distress during injury including its impact, precipitating, and perpetuating factors relevant to his experience (Blackburn et al. 2000). Definitions of the components of the self-Chart with common examples found in the field are listed in Table 3.

INSERT TABLE 3 HERE

Aligned to the PCT ingredients, the first author maintained an environment of trust, active listening, empathy, and UPR of PCT. Albus noted that this therapeutic environment helped him be "comfortable to want to describe my injury… and em… all the feelings that were like quite mad". Through reflective questioning and additive empathy (Mearns et al. 2013, p. 71) the client outlined his experiences and distress in vivid detail. He disclosed that the "main issue" was his expectations of a smooth rehabilitation process which were contradicted by the rough reality that it was a "bumpy road". Albus was surprised that the physical injury also included an emotional impact affecting his mental health (Podlog et al. 2014). Clarification questions were used to generate a more collaborative formulation, to co-experience (Schmid, 2005) since the formulation is a map of the client's phenomenological experiences (Yalom, 2001). PCT miroskills (see Table 1) were operationalised as a 'strategy' to engage in collaborative reflection which helped Albus unpack his psychological distress (Reupert, 2008; Van Scoyoc, 2010). An example from session 1 is outlined below:

First Author: If we look at this chart, let's start with risk factors? Factors that you think are currently rather unhelpful and making your life a bit difficult

Albus: You mean related to the injury? Or in general?

First Author: That is completely up to you, whatever you feel is relevant

Albus: Well, I am quite anxious these days… I guess I am… umm… (gulp) a bit afraid that my knee… it won't heal… and if it does heal, what if it goes again?

First Author: Of course, I understand. How is that impacting your view of yourself? (Configurations of self)

Albus: Well, it doesn't make sense, does it? I am a professional athlete, but I can't play! I may never actually play to my full potential again…

First Author: If we look back to go the chart again, can you see the link between the risk factors and how you are feeling?

Albus: Yeah…

First Author: If it's okay, could you spell out the link?

Albus: Yeah, it's okay… I guess, I'm feeling like shite, anxious, afraid because I…umm… I wonder if I'll never be able to play to my full potential ever again. I guess that is my main thing

Critically reflecting, this 'strategy' allowed Albus to have a sense of control/ agency. He had active involvement in reflecting upon the phenomena/personal relationships/internal make-up of the self that is leading to incongruence and psychological distress. Self-chart became like a map which facilitated emotional awareness, identification of the sources of psychological distress, understanding of triggers and a willingness to compassionately respond to oneself which are key skills of emotional regulation (Berking et al. 2012). Self-charting was conducted primarily in session 1, with a reflective review of the self-chart in session 3.

Reflecting on these sessions the first author noted that Albus presented with multiple instances of 'expectations' from his parents and close friends. His content also pointed to the competitive nature of being a professional footballer which he perceived as a block to disclosure. He said he couldn't really, "open up and you know properly talk through this with someone" and that he had "not spoken to anyone about this before you". Feeling and admitting vulnerability is often regarded as a weakness in sports culture (Haggland et al., 2019), encouraging a process of 'armouring up' to try and be bulletproof and to go to great effort to actively conceal distress (see Uphill & Hemmings, 2016). Self-charting with the PCT approach allowed Albus to be in a safe, non-judgemental space where he could shed his armour and understand the sources causing emotional pain. With reference to Anderson et al's (2004) model, we note that reflexivity and adapting to the client's needs are crucial during the application of the self-chart. Clients usually bring diverse life experiences (early life, current experiences), future aspirations, and values into the session which influence the issue they are facing (Rogers, 1957). Fundamentally, the self-chart is about

the client's self and life experience which provides essential context that the practitioner should adapt to. See transcript from session 3 below:

> Albus: This is having such a big impact on my life… and now I can understand… well sort of understand where and how
> First Author: (nodding), would you like to elaborate on the 'impact' you mentioned?
> Albus: Yeah like, it impacted me as a footballer, an athlete… but this injury has also been so restrictive like on my life… I can't drive anymore, no cycling either… physio has told me not to even jump out of bed… and it's like… a cloud that's hanging over everything I do, or actually cannot do
> First Author: That must be hard…?
> Albus: Yeah… cause… when stuff used to happen I dealt with it in football, my mates are at the club too… so can't do that anymore. And the timing too!
> First Author: The timing?
> Albus: So unfair! (voice raising). I had just made it into the first team and now this and now… I've lost that dream… I have to restart all over again… which scares me too…
> First Author: I get that… I appreciate your trust in sharing that with me. It can't have been easy.
> Albus: Nah, it isn't. Hard to do this in the club, we're all competing… but I think the psych stuff… it really helped to like release.
> First Author: I am glad it did. What else do you think complicates this rehab process?
> Albus: It's all the expectations too, isn't it? Like my parents… they're amazing, but I know they can't wait to get back to their season seats to watch me play. I expect to be a good player too… my coaches want me to recover because they know I can make it… they have given so much to get me where I am...
> First Author: And if you don't play…?
> Albus: Then was it even worth it? Am I worth it? If I am not a footballer, then I am nothing really….

The psychosocial impact of his injury (Podlog et al. 2015) seemed to manifest in a clear distinction between his 'athlete self' and a 'personal self', each with their own configurations of thoughts, feelings, and ways of perceiving the world (see Table 3). For instance, his social coping resources at the club and team were restricted as he was at home for an extended period. His task-based coping by playing football (Gaudreau & Blondin, 2004) was also no longer an option. Restrictions on pleasurable daily life activities such as driving and engaging in quality relationships were also major impacts. It could be argued that pre-injury, Albus experienced congruence between his 'personal self' and 'athlete identity'. However, the psychological distress following injury destabilised these integrated parts leading to incongruence. He noted, "It wasn't so hard before you know…I was me and I was a footballer… but now there is this problem because I can't be a footballer and I can't be me".

Albus disclosed that he felt it was "unfair" that "it" (injury) had happened right after he had achieved a long-term goal of playing with the first team. Re-injury increased the time needed for the

rehabilitation process causing greater incongruence. Albus hypothesised that "I did not have any emotional and mental support before you… I think that made it worse". Indeed, Fletcher and Arnold (2017) identified that not being able to process major life and career events within the highly stressful performance environment is problematic. Albus displayed an external locus of control (Watson, 2016) highlighting that others (e.g. coaches, parents, teammates, friends) "expect" him to be a professional footballer and fulfil his potential. This was a clear indication of his conditions of worth i.e., 'I am worthy and accepted if I am a good professional footballer'. Yet, he had also held a deep desire to have his parents see him play, declaring that he was "dying to be able to tell them that I am playing once again". These were external pressures which could increase the risk of re-injury. He also deeply desired to play at a packed stadium where his parents could see him. We note that during times of intense emotional disclosure, the maintenance of a warm empathetic stance reflecting patterns in the client experience is perceived by clients to be highly effective and helpful (Mearns et al. 2013). The collaborative self-chart made by Albus and the practitioner is outlined in Figure 1. The first author consistently maintained a warm, empathetic stance to reflect the patterns in the client's experience. Collaborative formulation signposts that Albus exhibited characteristics typical of Stage 2 in the Rogerian process of change (see Table 3), which is marked by externalisation of the cause of the injury (i.e.,"it just happened") and his efforts to push away his emotional experience (Rogers, 1961).

Critical Reflections for applying Self-chart

Fluidity and evolution of self-chart

Case reflection highlights that the self-chart was a fluid, continually evolving, rather than static process (Rogers, 1957). This change often occurs due to a) therapy does not occur detached from other events in the client's life (Yalom, 2001) and b) the impact of therapy itself (Rogers, 1957). To fully maximise the self-chart, this change process needs to be constantly monitored through collaborative reviews and reflections of the client's progress (Grant et al. 2009). In Albus's case, we revisited risk factors, such as his slow physical rehabilitation process and feelings of hopelessness. But also processed the impact of positive phases, such as being physically recovered enough to move from the gym, to outdoor rehabilitation and then on to ball training. Reflecting on change allows the client to see the shift which

accelerates the process. The first author engaged in the restructuring of 'bad feelings' by evoking and exploring healthy emotions utilising client reflections using the self-chart. For example, risk factors causing anxiety and fear of in-injury were accepted unconditionally during the therapeutic process and CAS was used to help Albus understand his emotional experience. This resulted in a healthy emotional alternative in place of dysfunctional negative emotions and beliefs (Greenberg, 2015). It was thus important to conduct frequent collaborative reviews and to foster opportunities for reflection with the client on their progress (Grant et al. 2009). Doing so allowed for the capture of change as evidence in the fourth session when Albus seemed to have moved to Stage 5 of Rogers processes of change (see Table 3). This was evidenced by his ownership of decision making, acceptance of his emotions, and his expectations (Rogers, 1961).

Therapeutic relationship & the self-chart

Albus shifted from a negative avoidance of "why me why now?" to "delighted that I get to play again, even though I am a bit afraid and cautious" about things out of his control. The therapeutic relationship underpinned by UPR, empathy, active listening and practitioner authenticity (see Table 2) gave him the space to come to an eventual acceptance of his injury. Another avenue is Immediacy i.e., grounding the client's experience in the here and now (Kasper et al. 2008) during self-charting. This helps the client process emotions and map the sources of their distress in the here and now. The therapeutic relationship underpinned by UPR, empathy, active listening and practitioner authenticity (see Table 2) gave him the space to approach a sense of acceptance of his injury. Albus noted that "you know the stuff we did… I think it helped me understand my emotions and the way I react… like I realise now I always do that when football is threatened like when I was subbed… I don't know if it's mental health or anything, but it's better".

When conducting the self-chart, it is important to provide non-directive psychoeducation on the dimensions of the charting process (Mearns et al. 2013), especially with young individuals (Gupta & Sudhesh, 2019). To ensure maximum client-centred practice, it is crucial to use open-ended, non-judgmental questions to maintain the centrality of the client in the process of self-chart. These allow the client to verbalise their own experience in their language allowing a process of meaningful acceptance (see Rogers, 1957). Furthermore, practitioners with limited applied practice training (i.e., limited training on

formulation and client intake) may find it difficult to engage in the process of discovery using the Self-Chart. Any action plan for other practitioners must include a focus on building a strong therapeutic relationship (Pettipas et al. 1998; Katz & Hemmings, 2009) while collaboratively undertaking the self-chart. To ensure maximum client-centred practice, it is crucial to use open-ended, non-judgmental questions to maintain the centrality of the client in the process of self-chart. These allow the client to verbalise their own experience in their language allowing a process of meaningful acceptance (see Rogers, 1957). Furthermore, practitioners with limited applied practice training (i.e., limited training on formulation and client intake) may find it difficult to engage in the process of discovery using the Self-Chart. Some essential reading in addition to this paper on formulation work is required in addition to regular practice supervision (see Gardner & Moore, 2005).

Unlocking complex emotions & the self-chart

Clients often face difficulty in verbalising complex emotions (Rogers, 1957). Evidence suggests that verbalisation and processing of complex emotions can be achieved by the use of objects (tactilely or via imagery) (Greenberg, 2015). Care needs to be taken to allow the clients to take ownership of the imagery or object and that it be culturally appropriate to avoid alienation (Gupta, 2022; Ryba, 2017). Objects are effective to facilitate agency and empathetic exploration of self-chart among athlete-clients since sight, touch and/or moving helps the verbalisation of deep emotion (Greenberg, 2015). Visual representation facilitates clients to have a deeper reflective understanding of the dynamic, multiple configurations of self. Startfing with a blank page/whiteboard and filling it in allows the client to have a sense of control and awareness of the various phenomena going on in their life (see Wright & Chung, 2001). Guided imagery with reflection can help the client note down his incongruence and distress in the middle. Eventually, the practitioner and the client would workaround to complete the self-chart. Once the client and practitioner have explored all areas of the distress with the self-chart, deeper experiential techniques such as *clearing a space* (CAS) can be applied.

Clearing a Space

Clearing a space (CAS) can be used when clients struggle with the identification/expression of complex emotions. CAS was developed by Gendlin (1961), who like Rogers, attributed importance to the

therapeutic relationship in enabling the client to feel understood and valued (Purton, 2004). CAS is founded on the principle that individuals change and alter emotions after understanding their origins, accepting them, experiencing them, and then transforming them (Greenberg, 2015). The theory indicates that psychological distress and emotional upheaval are held in the body through a 'felt-sense (Greenberg, 2015; Gendlin, 1961). 'Felt-sense' reflects the intricacies of unaware, vague but encompassing human emotional experiences that are often trapped in the body. CAS allows for the identification of the specific felt-sense impact of the psychological stressors. The practitioner reflectively guides the client to the physical felt-sense and body feeling of their psychological distress by placing each issue outside the body or at a distance. This safe and right distance combined with an active listener helps clients to experience emotional release and reduce psychological distress (Hendricks, 2009).

Clients spend time in a 'cleared space' with the aim of helping them experience a sense of physical relief and emotional well-being. (Grindler, 1991). The client is empowered to find a handle for the sense by identifying and being aware of it. This allows clients to experience emotions without the physical felt-sense of the psychological distress (Gendlin, 1981; Greenberg, 2015). Through CAS, the client finds a way of representing the physical felt-sense and articulates it to themselves, often through imagery causing the healthy release of those emotions (Gendlin, 1961; 1981). CAS is client-directed with the practitioner having a facilitating role. This technique has good efficacy when applied to client presentations which include a physical source of psychological distress (Greenberg, 2015). Through reflective learning from practice adhering to Anderson et al's (2004) reflective model, we have contextualised a version of CAS adapted to the sporting context. First, we outline what CAS looks like in practice (description stage) before showing the application with Albus. We then reflexively evaluated the session and obtained client experience feedback to further develop the semantics and delivery of CAS in sport (adaptation stage). CAS was chosen as an intervention since it would allow experiencing the spectrum of emotions adaptively by deploying a cleared space as a rapid stress management tool for Albus (McGuire, 1984).

CAS with Albus

CAS was introduced to Albus in the third session. In previous sessions, a shared metaphor of climbing a hill (rehabilitation process is the hill Albus metaphorically describes himself to be climbing) had been used. Albus noted that 7 months ago he had been *"rock bottom"* with a feeling of *"why me? Why now? This is so unfair"*. He noted a recent *"slide"* (re-injury and emotional upheaval), elaborating on how it's *"still difficult to deal with the feelings which are kinda a lot"*. Albus experienced high-intensity anger, anxiety and frustration in response to his injury and the lengthy rehabilitation. The emotion was a direct cause of feeling *"stuck"* due to the external situation that he could not change. The reality that he *"can't accelerate this stupid healing"* only served to intensify his distress provoking emotion spirals. The goal was to provide Albus with a sense of psychophysiological relief and downregulation of anxiety/anger/frustration provoked by high arousal (Gendlin, 1981; Klagsburn et al. 2005; Pettinati, 2002) since CAS helps separate self and anxiety (Leijssen, 1990). CAS was used as a freestanding emotional distress management method with Albus to identify the felt-sense of distress in the body. It was carried out using a brief imagery script that would allow the client to elaborate upon the emotional schemes associated with the experience of his injury.

INSERT TABLE 4 HERE

The client was encouraged via the CAS imagery protocol (see Table 4) to sequentially place the issue (of injury) at a distance and feel their body without this burden (Grindler, 1991; Pettinati, 2002). A CAS imagery protocol for use while working with emotions is provided in Table 4. Initial signposting focused on how Albus should notify the practitioner at any point if the exercise became overwhelming or if he wanted to reduce intensity in line with safeguarding and ethical practice (BPS, 2018; HCPC, 2018). Albus was encouraged to have free imagination and the practitioner was tentative, non-directive and facilitating using a mirrored vocal tone and explorative empathy (e.g. match the vocal tone and volume to that of client's expression). Albus imagined a "dirty cardboard box" where he put his injury, rehabilitation and all the "weird sensations" associated with it to "throw" it in the bin. Semantics and a focus on the body language of the client are advised since it provides rich reflective information which can be relayed to the client using additive empathy ("is it that the powerful feelings are something you want to keep away from you by throwing it?").

Critical Reflections for applying CAS

Using the CAS process

The CAS process script (Table 4) is a suggested framework guide, not a direct instruction manual. Practitioners can refer to the script for the necessary steps in the CAS experiential framework (Table 4, column 'Impact on Client'), however, they are recommended to contextualise the script to the client. Reflecting on the feedback received from clients in applied practice experiences, we note that checkbacks and paraphrasing (see Table 2) are important factors while employing CAS. This facilitates client understanding and increases reflective awareness (Greenberg, 2015). This also provides the practitioner with the necessary qualitative data (from client responses) to evaluate the intervention (see Brzeley, 2017). For example, Albus noted that he felt "mentally and physically relaxed and relieved" after the exercise. He noted that the very act of imagining that "my injury could be stuffed inside a box and chucked away made me feel in control of it, like for once it was not dictating what I could do, what I can eat, how I can run". This indicates that CAS as an intervention fosters agency and increased mastery during adversity whichis to resilience during uncertain periods and injury rehabilitation (Gupta & McCarthy, 2021; Podlog et al. 2014).

Potential Applications of CAS

Sporting injuries have a major impact on athletes causing psychological distress through anger, anxiety, fear, lowered self-esteem, identity confusion and depression (cf. Appaneal et al. 2009). Therefore, it is prudent to consider CAS as an adjunct to rehabilitation work. Authors note that CAS is also relevant as a possible intervention for competitive anxiety which is widespread among athletes of all levels (Rice et al. 2019). For example, the first author has used CAS as an intervention for a cricketer struggling with competitive anxiety. Engaging in a collaborative modification of the "uncontrollable" by facilitating the athlete to focus on the deep visceral emotional experience (Rogers, 1951, p.76) and 'felt sense' (Gendlin, 1981) associated with competitive anxiety. This intervention resulted in spontaneity and awareness (Leijssen, 1990) resulting in a positive change in affective schemata (Greenberg & Safran, 1987). The cricketer then had an adaptive reaction to competitive anxiety resulting in adaptive thoughts, behaviours

and emotions (Gendlin, 1996), thereby allowing an optimal emotional arousal state for competitive performance.

Practitioner skills for using CAS

Reflexivity and adaptation to improve service-delivery (Anderson et al., 2004) helped the first author adapted his communication style to be non-directive and reflect verbal feedback provided by Albus. Repetition of client verbalisations became an action plan during CAS intervention. For example, Albus stated, “space feels okay”. Therefore, “Okay” was reflected and incorporated within the exercise to reflect the client experience. Similar key words or phrases that are organic to the client allowed allowed Albus to have control of his visual imagery of the distress experience and sense of agency which has greater efficacy (Hasson-Ohayon et al. 2016). McLeod and Mcleod (2011) argue that active listening and the use of metaphors are crucial in framing a client’s experience of complex emotional processes. Such elements mirror the semantics of the sporting contexts since athletes have their own ‘lingo’, culture, lifestyle, and rituals (Greene, 2017). Using these practitioner skills allows for deeper and consistent psychological contact in the therapeutic relationship essential for CAS and other PCT work (Mearns et al. 2013). This aids a growth-promoting mindset enabling the athlete-client to shift from a rigid to a fluid self-perception (Rogers, 1961). By verbalising the ‘self’ the incongruence and its impact on performance and well-being are reduced. It is also important to have an extended debrief and check-in post CAS to return the client to an acceptable level of emotional arousal which does not impede daily life and performance functioning (Gendlin, 1961) (e.g. “What are you feeling in your body now?”).

Evaluation of CAS

The evaluation was an ongoing process involving multiple strands. Every session began with a review of the previous session and Albus’s judgement on how that session brought up elements that made an impact on his daily life. Bi-weekly supervision reflected on practice and service-delivery and a final evaluation post final session (Sutton & Stewart, 2008). This included the first author’s professional and personal debrief to provide ethical service delivery through peer process groups and supervisor (see Gordon, 2014). Reflecting on practice of CAS and self-chart using Anderson et al. (2004) model during

these meetings improved service delivery and production of this case report outlining specific PCT techniques for applied sport psychology.

Post-session reflexivity and client feedback guided reflective practice using Anderson et al. (2004) model. For example, Albus's expressed that his experience of volatile experience made him feel "out of control". This was reflected upon, and CAS was introduced as a freestanding emotion regulation exercise to process these emotions. This was effective as post-CAS Albus indicated that CAS allowed him to *"experience them in a way… you know where it doesn't drive me crazy… I don't know how, but we managed to make all those feelings okay to feel"*. Post session evaluation after two weeks could not be conducted due to COVID-19 related closures. Using out-of-session information sources for evaluation (team sheets and television broadcast), I note that Albus has successfully rehabilitated his injury to resume first-team football. During the contract closure of consultancy with the club, manager reported the sport psychology sessions to be crucial to Albus's mental health and overall development which was threatened by the psychological impact of the injury.

Effective Practice Recommendations for CAS

Developing from the critical reflections we arrive at certain best practice considerations for effective service delivery using techniques of CAS. First, in line with recommendations from experiential techniques (Gendlin, 1984), care needs to be taken while working with powerful emotions. CAS includes emotional reaction and upheaval, but an overwhelming emotional experience does not allow adaptive processing. An acceptable threshold should be contracted with the client pre-CAS. The practitioner needs to be on alert to identify when the client is flooded with emotions. In such cases, techniques to regulate emotional distress need to be implemented. Aligned to ethical mandates of the BPS (2018) and HCPC (2018), a continuous risk assessment and a pre-CAS consent of 'acceptable distress' needs to be undertaken with the client.

Second, the practitioner needs to embody the PCT ingredients of warmth, UPR, non-directivity and congruence. Since the client is the 'expert' (Rogers, 1957), CAS must be collaborative, not prescriptive. It is facilitated by the practitioner reflecting the client's experience via shared metaphors, similar linguistic framing and emotional descriptors. Clients should lead the process to ensure engagements are based on

equality of status (see Tod, 2014). Based on the author's experience, being familiar with the sport allows familiarity with the 'lingo' (specific words/terms/phrases/tactics/positions found in that sport). This facilitates reflection of client experience through mirroring (see Table 2) and adds to the therapeutic relationship (Rogers, 1959).

Third, it is critical to use open-ended questions to maintain the centrality of the client in the process of self-chart and CAS (Greenberg, 2015). These allow the client to verbalise their own experience in their language allowing a process of meaningful acceptance. For example, "what do you want your cleared space to look like?" is an open question whereas "do you think your cleared space is a warehouse or a room or a table?" is a closed question which limits the phenomenological experience of the client. It is important to generate feedback on how CAS is progressing and invite clients to suggest areas/directions they want to pursue (see Cox, 2014; Tod, 2014). Biases of culture and race should be managed via antidiscriminatory practice (see Gupta, 2022).

Finally, practitioner training in applied psychology, psychotherapy, and in-situ training of 1-on-1 work with clients under supervision is crucial to "practitioner characteristics" when employing CAS. Individuals with theoretical training with limited applied supervised therapeutic experience (e.g. MSc students) may find CAS to be beyond their competency with therapeutic training. Training in risk assessment is also an important skill to conduct CAS effectively and ethically (see BPS, 2018). Logistical factors should also be considered during session preparation and planning. For Albus, sessions 3-5 had CAS used within them, randing from 6 minutes to 15 minutes within the session.

Potential Pitfalls of this reflective case report

Firstly, as a case report, although the work detailed will not apply to all cases and lacks traditional ecological validity due to focus on an individual, it provides a rich example of 'how-to' framework of two evidence-informed techniques to apply PCT in sport psychology practice. Future research can employ multi-case multiple baseline designs to evaluate efficacy in larger trials (Barker et al. 2011). Second, this reflective case report is not a prescriptive thesis on how to apply the PCT techniques for every client. It is crucial to engage in reflective practice (Cropley et al. 2018) to incorporate client factors and other contextual factors (nature of sport, age, environment, culture) in practice (Schinke et al. 2012). Third**,** it is important to note that CAS is a therapeutic tool that involves powerful emotions. The practitioner can get

overwhelmed if the client experiences mimic the practitioner's life experience (Greenberg, 2015). Practitioners must actively monitor themselves and learn from the experience of applying both techniques using a reflective practice model (see Bolton, 2010). Last, CAS is difficult to apply in a team context and is applicable only as one-on-one intervention work therapeutic tool.

Conclusion

Applied sport and exercise psychology is a major field of play where PCT can be an effective therapeutic frame for service-delivery. We outline the foundations of PCT necessary for practice and two applied practice techniques relevant for working with intense emotional processes. We hope this encourages practitioners to examine PCT rigorously in sport and exercise settings like Turner et al. (2020). Although more consolidated evidence is required, this paper provides practitioners with the avenue to go beyond selectively drawing upon person-centred elements, and practice PCT with the foundational 'ingredients'. We also hope that practitioners report their use of PCT and that greater research follows this foundational study to deepen and widen the evidence base.

Data Availability Statement

Appendix A and related data substantiating the case report are provided in an Open Access repository (https://osf.io/zx38g/?view_only=e8500473d70e4d8e8ccd3dccfb49309f).

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Table 1

Ingredients / Necessary Conditions for PCT work

PCT Ingredients	Definition	Common Examples from the field
Congruence	Congruence refers to being authentic, real and genuine with clients. This goes beyond what we *do*, to the point where inner experience and outward expression match. This includes authenticity and genuineness from the therapist allowing the client to trust the therapist. This serves as a model to encourage clients to be their true selves (Rogers, 1959; Mearns et al., 2013).	The therapist is genuine and authentic to client expression. As such, the client does not feel that the therapist is 'putting on a face' or 'trying too hard' to promote/present a certain behaviour.
Unconditional Positive Regard (UPR) and Acceptance	UPR and acceptance refers to the genuine care a practitioner has for the client without evaluation and judgement. This allows the client to feel accepted and valued for who they are without conditions, therefore allowing them to express themselves freely without fear of rejection (Rogers, 1957). This is crucial since individuals in the sport environment must constantly adjust and change to meet evaluations of self and that of coaches, parents, managers and/or teammates. Total unconditionality is freeing for the client contributing to the relationship.	The therapist allows the client to express with self-agency in awareness about the process of their self, free from evaluations and conditions of worth (Bozarth, 2009). Clients are treated 'person first' before performances, contracts, presentations
Accurate Empathetic Understanding	Where the therapist understands the free expression of the client in an accurate and empathetic way from the client's experience and frame of reference (Rogers, 1957; Mearns et al., 2013). Empathy has different forms such as cognitive empathy, inferential empathy, affective empathy and others (see Mearns et al., 2013). Empathy has been demonstrated by 60 years of research to be a powerful determinant of client change (Nienhuis et al., 2018)	The therapist accurately captures the emotional experience and frame of reference of the client. By doing so allows them to express positive and negative emotion.
Psychological Contact	This refers to a strong therapeutic relationship characterised by trust and familiarity with communication patterns where the client feels safe to reveal their authentic self to the therapist. The UPR and empathy received from the psychologist creates a non-judgemental environment (Rogers, 1957). This allows the process of emotional disclosure related to their distress to be utilised therapeutically	The therapist and client have a deep relationship, where the client can engage in being authentic and express with no inhibition. The client can also engage with what the therapist offers (techniques) with a sense of trust.

Table 2

Micro-skills for Applying PCT in Sport Psychology

Micro-skill (Definition)	Example	How it Contributes to Therapeutic Relationship
Active Listening (i.e., the practice of listening to the client while providing feedback in the form of affirmations or questions indicating the therapist hears and fully understands the depth of the message that the client is presenting)	*Athlete*: "So, there I was in the dressing room, and it hit me. This was it. I wouldn't have this experience again" *Therapist*: "I understand… it must have felt big" *Athlete*: "Yeah.. it was! Which was quite weird to be honest" *Therapist*: "Mm-hmm… what was quite weird?" (nodding)	Clients feel more understood (Weger et al., 2014) and feel that they are receiving empathy from their therapist (Haley et al., 2017; Rogers, 1951)
Mirroring (i.e., the practise of subtly emulating the client's verbal and nonverbal behaviour)	*Athlete*: "It was so pissing off… but then something weird happened" Therapist: "What was the 'weird' thing that happened? *Athlete*: "I realised they're only criticising me because they believe that I can deliver. Why shouldn't I?' *Therapist*: "Why shouldn't you?" *Athlete*: "Exactly! You know I've always struggled to believe in myself, and yeah…"	Mirroring communicates that the therapist shares the client perspective and thus helps with rapport building as well (Navarre, 1982). This happens through the activation of mirror neurons which promote empathy and help in forming connections with others (Gallese, 2010)
Empathetic Attunement (i.e., an ongoing active effort by the therapist to stay in the moment to moment experience of the client)	*Athlete*: "I have to finish schoolwork, do rehab for my injury and deal with everything happening at home. I have been feeling so tired and on top of this, the pandemic just won't end. Everything is a never-ending mess, you know?" *Therapist*: "That sounds hard. Feels like you are being pulled in a trillion different directions, of course, that sounds exhausting"	When empathetic attunement is conveyed to the client, they feel more heard and understood. Thus, are more open to being honest and open about what they are dealing with (Feller & Cottone, 2003)
Metaphorical Summation (i.e., the practice of picking up all the important details and presenting it in the form of a metaphor that encompasses what the client could be feeling)	*Athlete*: "I feel like I can finally pick up my racquet and work toward winning a tournament, there seems to be more clarity, especially with the pandemic restrictions reduced and more people getting vaccinated" *Therapist*: "Sounds like there seems to be some light at the end of the tunnel?"	It forms a "creative condensation of multiple meanings" (p.534, Stine, 2005) adding interest and emotional power to the relationship.
Global Syncing (i.e. the therapist synchronises their body movements, tone and pitch of	*Athlete*: "I don't know… I have never felt… felt so… lost (hollow voice)" *Therapist*: "when you say (pause)… lost (lower tone in sync)…is there also a sense of confusion?"	Helps in establishing and maintenance of rapport and emotional regulation (Imel, 2014)

voice and the responses to the patterns deployed by their client	*Athlete:* "Yes… but also like… powerless"	
Eye-contact (i.e., maintaining culturally appropriate levels of eye contact with the client and noticing breaks in the same)	The client breaks eye contact in parts when they feel very emotional "It feels pretty bad to have lost the match in the tiebreaker, after fighting it out for 3 whole sets"	Eye contact helps with positive perceptions of the therapist, forming rapport (Darrow & Johnson, 2009), genuineness and perceived responsiveness (Dowel, 2013, Maisel, 2008)
Checkback (i.e., phrased at the end of a summary or a paraphrase, ensures that the client has the opportunity to ensure that therapist has accurately understood them)	*Athlete*: "I just couldn't react faster that day, it felt like I was perceiving the ball coming at me more slowly than I would usually. And it felt very out of my control. I could only see my coach be disappointed in the side-lines" *Therapist*: "Sounds like that particular day was harder because your mind wasn't reacting as fast as it does usually. And you were very aware of how your coach was reacting. Did I understand that correctly?"	Checkback offer a way for the therapist to show the client that they are making an effort to understand exactly what the client is feeling and also, offers a chance for the client to think about what they have said (Ivey, 2013)
Paraphrasing (i.e., the practice of using short sentences to clarify the essence of what the client has said)	*Athlete*: "I am unsure about my longevity in tennis, feels like I will never reach where I want to, even though I train really hard, eat right, sleep right and do everything right. Maybe it is just not for me, you know?" *Therapist*: "Right, sounds like you are feeling doubtful of your ability to reach your goals even though you are doing the best you can"	Clients feel more heard and add to the information already shared while also having an opportunity to correct the therapist (Ivey, 2013)

Table 3

Dimensions of the Self-Chart

Terms /Phenomenon	Definition	Common Examples from the field
Configurations of Self	Configurations of self, constitute the coherent patterns of thoughts, emotions and standard behavioural responses associated with a dimension of their person (i.e., a self (Mearns et al., 2000))	An athlete thinks they will be accepted if they are successful, have a lean body shape which impacts configuration of their 'self' (McHenry et al., 2019). Self-esteem linked to performance.
Locus of Evaluation	Locus of Evaluation is the mode people refer to in order to make judgements about themselves and the world (Tolan & Cameron, 2016). This can be external (introject values of others through conditions of worth) or internal (have an intrinsic process of trust and judgement)	Internal- 'my decision, my future' says an athlete who is about to be dropped from a squad External- 'I have always been told I will not make it… maybe they are right' says an athlete struggling with self-efficacy after negative media coverage after a failure.
Incongruence	Incongruence (i.e., the discrepancy with actual experience and self-picture of that experience (Rogers, 1957))	A player being angry, the prankster and doing things 'half-assed' thereby supressing his real self of being caring and inquisitive (Black & McCarthy, 2021)
Stages of Change	Rogers outlined a process-continuum of change ranging from stage 1 to stage 7. (Rogers, 1961). It is important to note that individuals do not have a linear progression across stages, they move both ways. Readers are guided to (Merry, 2014; Tutor, 2020)	Stage 1 (fixity and remoteness) i.e., athlete declines to talk open and places blame on others, 'if the coach selected me I would be fine' Stage 2 (reduced fixity, open to exploration) i.e., athlete is hesitant of vulnerability, but is open to initial conversation, 'they should have selected me… it would have worked out then I guess' Stage 3 (acceptance with generalisation) i.e. 'I feel angry about missing out, but everyone feels angry' Stage 4 (critical of self and description of here-and-now) i.e., 'I feel angry, but its my fault for not becoming better' Stage 5 (initial ownership of situation) i.e., 'I kinda get why I may be angry' Stage 6 (initial acceptance of self) i.e., 'Anger might not be all that bad, it isn't nice… but I guess its normal?' Stage 7 (fluid self-acceptance) i.e. 'I think I can come to accept the limitations I have, but… I can still grow'
Risk Factors	Risk factors include events/triggers that initiate the incongruence fostering psychological distress.	Athlete dealing with the anxiety from injury gets reinjured

Perpetuating Factors	Perpetuating factors are those which work to maintain the incongruence once it is established.	Athlete returns to sport while dealing with anxiety from an injury has feelings of uncertainty that 'my knee can go again', which adds onto anxiety
Protective Factors	Protective factors are resources individuals possess/develop that allow an individual to be resilient	An athlete who cannot train refers to how a WhatsApp group with her team is instrumental in building her up with the realisation it is not forever (see Gupta & McCarthy, 2021)

Table 4

CAS Imagery Script Blueprint

CAS Imagery Script Blueprint (to be adapted to client case)	Impact on Client
"Just be in a position where you are comfortable… you can close your eyes or keep them open… taken a deep breath (pause)… inhale through your nose and exhale (pause)	Emphasis on client comfort zone allows the initiation of ownership of the process
*Now that you are grounded… could you imagine a **space** (with emphasis and pause)… this space can be anything… it can be as big or all small as you want… it can be something familiar or something you create… it can be in this planet or in space… can you think of such a space? (pause-let client think, stay with silence)*	Client is being centred and grounded
If you are comfortable… can you describe that space to me? (pause).(After client describes it/chooses not to) do you feel safe in this space?	It is crucial to be non-directive and allow the client to verbalise their own space. This allows agency and mastery.
Is this space in your control? (pause) *Are you able to relax and be yourself in this space? (pause)* *This space is a space you have cleared and created for yourself… a space that is for you, built by you…* *In this space that is detached from the other world… would you like to process your emotions or think about a painful memory?*	It is crucial to take this at the client's pace with a warm, tentative, empathetic voice. It needs to be ensured that the client feels completely safe and secure in this space, in total control
Now we will slowly bring in the emotions and the experience that you want to bring to this space… what does this emotion look like? Is it big, small, heavy, light, thorny, smooth, slippery, solid… you can give it any shape or form it feels appropriate	This allows the client to process painful emotions without the fear of being overwhelmed in their daily life.
Now that you have brought this (describe the emotion the way the client did) into this space of yours… what do you want to do with it? (pause and wait for client)	This allows the client to verbalise the emotion and process it in their cleared space. The verbalisation also labels the emotion for the client.
You can keep it somewhere… send it away…put it in a box or a shelf or inside a safe… you can imagine anything you want to do with the emotion (reflect client description of it) and do it	This allows the client to gain agency of how to control and process their emotions
Have you figure out what to do with it? (pause) *Would you be comfortable sharing it with me?*	This is an act of visualization that allows the client to 'do' things with their emotional experience which increases the sense of controllability
Now we will try to imagine you doing that to that emotion (reflect client description of it)- can you feel yourself picking it up or moving it (or whichever action is relevant)… is it heavy light, where it is going? (reflect relevant action) *Have you completed whatever you wanted to do with the emotion? (pause)*	This allows the client visualizes a visceral experience of dealing with the emotion, and rids the body of the felt-sense or 'weight' of the emotion it was carrying
Now, could you breathe in with me once again…. Let us inhale 4-3-2-1… and exhale 4-3-2-1 (if client knows or practices other breathing techniques, they can be used as well)	This is a grounding exercise that reduces the volatility of the deep and heavy emotional experience they went through
Now… we will try to dissolve this space of yours for now… and come back… whenever you are ready… you can come out of this cleared space and open your eyes… *I am waiting for you in the other world out of your cleared space..*	It is important to be gentle and go with the client's pace at this stage as we bring back the client from the cleared space.
Guideline: It is important to have a gentle voice tone, use the language the client is using and facilitate the client. CAS works if the client constructs their own space. This space can only be authentic with minimal interruption and guidance.	

Figure 1

A) "Self-Chart" Template; B) Self-Chart of Client Albus