



Practice Notes For Clinical Sports Social Worker

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Clinical sport social work involves a coupling of the heart and mind. An unrelenting passion for helping people/systems, combined with an unquenchable desire to learn. This is essential to become an exceptional sport clinician. The power and utility of the mental health provider in athletics lies in the establishment of a solid foundation of theory and practice. This commentary conceptualizes the role of the clinical sport social worker, along with key considerations relative to practice and collaboration. Appreciating the complexity of the athletic system, the diverse backgrounds of the athletes/staff, power differentials, personal biases, ethical issues and an abiding awareness of the scope of one's clinical competence, are crucial to expert practice.

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Developing a strong clinical practice, including consultative skills in individual/group psychotherapy, provides the scaffolding upon which the clinical sport social worker can interface with the multifarious world of athletics. As a clinician the work is comprised of the art of relationship and the science of theory using a biopsychosocial perspective. Clinical sport social workers are instruments of healing; detectives of the heart and agents of the mind. An individual or system presents with a problem that typically involves suffering or struggle. Understanding the contextual pieces of the suffering, determining the best course to follow, setting the stage for change/growth, is the job. This task involves collaboration; working with the individual/system to search for the missing pieces to the puzzle of suffering and less than helpful thought patterns. A search for subtleties is often required. It is important to look beyond the obvious explanations for the distress and distortions. Clinical sport social workers must carefully investigate the less than conscious reasons for the athletes' undoing. Imparting ongoing cognitive skills and psycho-education to help reduce suffering hopefully increases the individual, team or departments' ability to function at its most capable level.

Foundations of Clinical Practice

Clinical practice is comprised of many factors, depending on the practitioner and the scope of their interests/capabilities. Expert practice evolves over many years, utilizing the kind of determination and openness to learning, that high performing athletes need to be their best. This includes expertise in psychodynamic/relationship-based therapies (e.g., CBT), and short- and long-term individual and group approaches to care. Familiarity with substance abuse issues, trauma related disorders, eating disorders, bipolar disorders and psychopharmacology strengthens the practice foundation. A strong suit clinical sport social workers bring to athletes/athletic systems, is the keen appreciation for the cultural context of the athletes' background, as well as the repercussions of functioning within the top-down authoritative culture of athletics. Utilizing an understanding of systems and dynamics is foundational to consultative services to athletic teams and athletic departments. These skills allow the clinical sports social worker to provide consultation intra- and inter-departmental crisis', athletic program development, advocacy and education. Regardless of the task at hand, clinical sport social work is founded upon the value of relationship, and the notion of starting where the client is.

Humans are hardwired for relationships (Geller & Porges, 2014). Understanding and appreciating developmental theory provides a solid base to understand why relationship health lowers the risk of developing mental health symptoms. The culture of athletics has protective factors, with built in opportunities for connection and belonging. It also has significant risk factors, particularly as an athlete becomes identified as elite. The more commodified and objectified the individual, the more differentiated they become from their peers. This separation can become a risk factor for developing mental health symptoms. The culture of athletics as a whole can be isolating, particularly as skill levels increase. The more elite athletes become increasingly secluded increasing the risk factor for sexual abuse. (Reardon et al., 2019).

Strong clinical practice is firmly rooted in theory. Theories are built upon the given knowledge base at a time. Grounding one's professional self in a theory base provides the scaffolding upon which to think about, appreciate, and understand where the strengths and areas of vulnerability are for a client. Developmental theory, psychodynamic theory, cognitive behavioral theory, existential theory, and humanistic theory all bring important clues to further make sense of a client's struggles. The intersection of race, diversity, and gender has implications for socio-political oppression within the context of sport (Carter-Francique et al., 2013). Theory is the backdrop. Cultural context is where the action takes place, including the culture of athletics.

Nut and Bolts of the Therapeutic Interface

The essence of a clinical social work interview is focused upon relationship (Goldstein et al., 2009). The athlete's relationship to the clinician in the room, the relationship of the athlete to their sport, family, friends, culture, and essentially their relationship to the context of their lives establishes the base for clinical intervention. The initial meeting represents a microcosm of all of these factors. This meeting provides the emotional container of safety (e.g., listening carefully, being attuned to the athlete's experience), which allows the clinical sports social worker to gather data that will contribute to an initial impression of the athlete. This data needs to be historical, including family history and their educational/social history. Close attention needs to be paid to significant personal/family events. For example, frequent and/or disruptive moves, significant illness in any family member, divorce, death, etc.

Gathering the data is accomplished by creating clear parameters, letting the athlete know what you will be doing with the designated time, maintaining a fidelity to the structure of the session without a rigidity, and addressing the protocols relating to confidentiality. Solving the therapeutic puzzle requires a great deal of inquiry beginning during the initial session. The exception to this is if the athlete presents in crisis. The first task then is safety and containment, both in the therapy room and the person's life. There are different kinds of interview questions (Sommers-Flanagan, & Somemers-Flanagan 2013). Closed-ended questions are necessary to get key facts and demographics. Open-ended questions allow more autonomy for the client to share their experience, which in turn fosters an environment in which the client is less defensive and more likely to open up. Swing question can be answered yes or no, but is constructed to allow the client the option to not respond, which often will result in increased safety within the room for the individual. An example of the same question asked three different ways:

- Closed-ended: Did your first panic attack happen on the football field?
- Open-ended: Tell me a bit more about your first panic attack.
- Swing: Would you be willing to share more about the panic attack you experienced?

By paying attention to the athlete's strengths and viewing vulnerabilities as by-products of life circumstance, allows the clinical sport social worker to interact with the client in growth-promoting ways that the athlete may not have previously experienced (Kohut, 2010). Clinical sport social workers must be careful with assumptions they could make about the athlete's experience. This allows for a different kind of interpersonal experience for the athlete; where their experience is the one that matters. There are times clinicians need to go beyond empathy and point out self-sabotaging/destructive behavior. In the end, it is the athlete's choice on whether they want to embark in the change process. Helping the athlete appreciate that there is a choice to be made can be empowering (Sommers-Flanagan & Sommers-Flanagan, 2013).

Being patient with the therapeutic process can be difficult, particularly given the pressures of performance. Healing from emotional injury is no different than healing from physical injury (Hainline & Reardon, 2019). The athlete may need to understand the rehabilitation of one's emotional life can be slow and also steady. It is common for athletes, as well as other members of the multi-disciplinary team, to want advice. Offering concrete tasks within an overarching framework typically is most effective. Simple advice may be requested, but often is not what is wanted or needed at the time. Advice can perpetuate dependency, undermining the athletes' self-efficacy. This can affect the athlete's sense of autonomy, as well as their developing sense of self. It is important to recognize the athlete's wish to get better. The best advice resides in the development of a treatment plan with mutually agreed upon goals, shifting the goals as needed with the task at hand.

Assessment and Diagnosis

Assessment and diagnostic skills are an essential part of a clinical sport social worker's job. This takes ongoing education and direct service experience. Clinical sport social workers need to be able to make a differential diagnosis based upon the presentation of symptoms and a careful history. It is important to know when to make referrals and for what. With athletes the presenting problem often relates to performance complaints and/or somatic concerns. These issues are frequently expressions of anxiety and depression in disguise. They are manifestations

of underlying distress that are split off from the consciousness of the athlete. In addition to being hidden from the athlete themselves they present real life problems that restrict the athlete's freedom to perform in their sport. (Aron & Lefay, 2021)

Case Example One

A 20-year-old, male transfer football player is referred for an evaluation as a result of explosive anger episodes and fighting at practice. The athlete described his behavior as uncharacteristic and a surprise to himself. He said that he would feel triggered by a small comment of a coach or player. The notable events in his childhood were experiences in foster care until the age of four, when he and his siblings were adopted by a stable, loving family. He reports his childhood experience being positive (e.g., success in school and sports). He has a particularly strong attachment to his father, who was his childhood coach as well as being an educational administrator and coach in the community. When the athlete was ten, he recalls being unexpectedly picked up at school by a relative who took his siblings and him home to tell them that their father had died suddenly that morning. As the oldest child he became the man of the house. Although this is a role, he expressed being proud of, it did not come without cost. He described having to fight for everything athletically. He was undersized for his position but had the speed and agility to be effective. Fast forward to the current circumstance. After unpacking the family history as well as his history of anxiety it became quite apparent that he had an underlying anxiety disorder as well as PTSD from the death of his father. This is an insightful young man who could use the overarching dynamic frame to understand what is going on in practice, as well as some specific cognitive skills to manage the arousal he experienced during practice. Another explosive event did not happen after the first session. He continued in treatment to work on his history and management of anxiety disorder.

It is not enough to simply identify depression or anxiety symptoms. It is crucial to the treatment of the athlete to tease out the underlying causes of these symptoms. Effective clinicians need to be able to distinguish between anxiety that indicates an anxiety disorder, versus a mood spectrum disorder, versus an adjustment reaction, versus trauma. It is crucial to consider medical conditions, unrelated to psychiatric presentations that contribute to the expression, leaving no proverbial stone unturned. Co-morbid conditions, such as substance use/abuse need to be evaluated. Solving a diagnostic puzzle needs to transpire in an ongoing manner; as long as there is suffering, a sport social worker needs to continue to explore and examine all possible ways to understand the athlete's experience. When giving our diagnostic impressions providing a big picture (macro) way for the athlete to think about their current experience, coupled with a here and now (micro) perspective that sets the stage for movement forward.

Case Example Two

An African American freshman football player is referred for treatment as a result of frustrated football and educational staff members. These staff members state the he was not showing up for compulsory meetings, would show up late, leave early, and was out of compliance with mandatory requirements. In addition to the inconsistent behavior, a point was made that he had been in special education classes throughout high school and that he perhaps did not intellectually understand expectations. At the initial meeting with the young man who was understandably anxious, he expressed he was not sure why he was behaving as he was. He shared how he simply becomes overwhelmed from time to time must retreat to his room. After a

few sessions of working with him around managing to follow what is expected it became very clear that he had social anxiety. This was undiagnosed and likely had been operative with him for a long time, which contributed to why his school performances suffered. It is also likely that there was a racial bias involved in the placement in the high school special education classroom. Once this was properly identified, medication was put into place, as well as using cognitive behavioral techniques to manage anxiety. He was able to successfully participate in school and sport. He graduated and went on to have an outstanding career.

Collaboration

Collaborative work is the cornerstone of working in athletics (Purcell et al., 2019). There are a variety of stakeholders interfacing with the athlete and/or team. Communicating appropriately/ethically within the system and the boundaries of confidentiality can be extraordinarily complicated. The boundaries in athletics can be blurry. Multi-disciplinary teams need to maximize the collective intelligence of the group, be inclusive in their work together, and maintain open communication. Being territorial, competitive, or cavalier has no place in clinical work. This can be remarkably challenging as a result of the systemic devaluing that can take place within the culture of athletics regardless of the role one plays. Clinical sport social workers often take the lead promoting informational diversity and collaboration, with the belief and understanding that it will likely benefit the athlete most. This perspective can, at times, challenge the hierarchies within established systems. It is expected that reactance to change on a systemic level happens. It is impossible to do the work of moving a field forward without personal and professional risk. It is not for the faint of heart.

Professional and Personal Development

Supervision/consultation address the necessary boundaries of clinical care, as well as the less than conscious boundary violations. Ethical care is fundamental to successful care. Ongoing examination of the therapeutic process can yield information about dynamics relative to the power differential between clinical social worker and the athlete. It is useful to learn how to use inevitable mistakes therapists will make, as an opportunity to help the athlete have a corrective experience. This happens when mistakes/lapses/empathic failures, can be addressed with the athlete. This provides the athlete with an opportunity to be visible and heard, without negative repercussions.

The safe haven a supervisor/consultant can provide clinicians is a parallel process to what clinicians are offering clients. Providers need the necessary holding environment for work experiences. Solid supervision is not therapy, it is a hybrid experience that can involve exploration of vulnerable aspects of self, intertwined with the psycho-educational aspects of the work. This can be the secure base from which one can try new and/or challenging clinical interventions. The salient message is - we cannot do this work alone, just as we cannot live our lives alone. We need each other.

This is crucial to foundational success during the early years of practice, creating the strong foundation upon which to continue developing practice competencies. Additionally ongoing involvement in organizations for networking, continuing education, and professional enlightenment brings a richness to our work and our lives.

Conclusion

Athletics is a rapidly changing field. To develop competencies, ongoing supervision/consultation, as well as continuing education, working towards integrative, multi-disciplinary provider teams, is the essence of being a clinical sport social worker. The social work discipline views context as part and parcel of the client experience. This ability to assist can only be as strong and vast as the willingness to explore different aspects of ourselves, our limitations, our biases, and our knowledge base. Stay humble and stay hungry.

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