CHAPTER

20

When to Refer Athletes to Other Helping Professionals

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There are many ways of getting strong, sometimes talking is the best way.

—*Andre Agassi*

When you open yourself up mentally, you do so only with someone you trust from the bottom of your heart, someone you feel very close to. To open yourself up in this way is an important step in overcoming mental problems.

—*The Dalai Lama*

A sport psychology practitioner had been working with a gifted collegiate male hammer thrower for about three months. A close trusting relationship had formed, and together they had addressed a number of performance and communication issues. Recently, however, the thrower started to miss sessions, although he always contacted the sport psychology consultant and rescheduled. The practitioner was concerned because he also had noticed the athlete had been losing weight. One day when the young man failed to attend a session and did not call, the sport psychology consultant tried to contact him and left a message. After not hearing from the thrower for two days, the sport psychology consultant attended practice and found out from the coach that the thrower had missed the last two days of training because of the flu. Later that evening the practitioner finally contacted the athlete via the telephone. The thrower was very apologetic and also scared because he had lied to his coach; he did not have the flu. On further discussion, the athlete admitted that he had not been able to train, go to school, or even bring himself to eat. He had fallen into a dark place, and he wanted to go to sleep without waking up. The sport psychology consultant, recognizing the signs of depression, and realizing the associated risk of suicide, managed to convince the athlete to come to his office straight away.

Depression is "the common cold" of mental health disorders among the general population (Andersen, 2004) and athletes (Wolanin, Gross, & Hong, 2015). Athletes often experience depressed moods following losses or failures to perform as hoped or expected. If depressed moods are particularly severe or seem to last longer than usual, athletes may need help to get through the sense of loss or disappointment. In many cases, individuals hide their depression from others or may self-medicate with alcohol or other substances. People experiencing depression may show social withdrawal, hopelessness, or loss of self-esteem. Lethargy is also a common symptom and may prevent sports participants from training. Verbalizations indicating depression, hopelessness, or poor self-esteem are red flags for coaches and sport psychology consultants. Overt and covert signs may signal a call for help. With depression there is often the possibility of suicide, which may take the form of unusual risk taking (Doherty, Hannigan, & Campbell, 2016). Treatment may include psychotherapy and antidepressant medication, and unless the sport psychology consultant is competent and qualified to work with depressed athletes, a referral to another professional is needed. Referral is a sensitive issue, and practitioners need to show compassion and care (see Andersen & Van Raalte, 2005, for how the case example here was successfully resolved). In general, when a sport psychology consultant is faced with an athlete or coach whose presenting concern is outside the practitioner's realm of expertise (e.g., in need of medication), then the practitioner needs to (a) refer the client to a suitable helping professional for treatment and (b) consider upskilling through training courses, professional development, workshops, clinical supervision, and self-study, along with gaining any necessary qualifications, to become competent to work with future athletes presenting with that issue.

Most athletes' requests for assistance with performance issues, such as prerace anxieties, will not necessitate referral to professionals trained to help individuals with clinical, deep-seated, or severe emotional difficulties. Over time, however, sport psychology consultants and coaches will come into contact with athletes they are not equipped to help, and in these situations referral is the ethical path to follow. The goal of this chapter is to provide a set of guidelines that people working with athletes, coaches, and exercise participants can use for referring individuals for professional counseling or psychotherapy. We will also provide suggestions about making suitable referrals for varying circumstances, and we will present dialogue from a referral session. Referring athletes to other helping professionals does not mean sport psychology consultants need to stop working with their clients. There are no ethical violations or professional problems when performance enhancement sport psychology consultants and other helping professionals work with athletes at the same time, as long as all parties are informed with the clients' consent. In many cases, a team approach can be the optimal way to deliver services. In the space of a chapter it is impossible to describe the symptoms, methods for assessment, and suitable interventions for the many possible mental health issues athletes may present. Such information already exists, and readers are referred to the American Psychiatric Association's (2013) *Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition* for information on specific issues. Instead, we provide some information on many of the common issues for referral to other helping practitioners that might arise in sport settings.

The False Dichotomy of Performance Enhancement Versus Problematic Personal Issues

In many (probably most) instances, it may not be possible to disentangle performance from personal issues, and sometimes they may be one and the same. Imagine, for example, that a performance enhancement practitioner has worked with an athlete for several months, and the client's skill level

has improved to the point that making an international team is now a realistic possibility. The athlete's life may have changed considerably. She is now living her dream; her self-worth has risen, and her relationships with her coach, parents, and siblings have improved. She has become a happier person. A useful question is: "How does performance fit in the rest of the athlete's life?" Performance enhancement techniques, such as goal-setting and self-talk, may be of limited value if the athlete's life is a jumble of confusion and conflict. For an athlete experiencing prerace anxiety that is intimately tied to parental love and acceptance or feelings of worthiness as a human being, relaxation may prove to be an inadequate Band-Aid for what are deeper issues than prerace nerves.

In much of the performance enhancement literature, problems in performance are related to issues such as competition anxiety, low motivation, poor self-talk, and lapses in concentration. Determining whether other factors might be involved requires understanding a number of interrelated issues. An athlete coming to a coach or sport psychology consultant may be uncomfortable if discussions probe personal areas. Likewise, the practitioner may be reluctant to ask highly personal questions. It is possible, however, to get at least a feel for some of the salient issues in typical discussions of sport performance factors. It is natural for the sport psychology consultant or coach to build rapport by asking athletes about themselves. Helping athletes talk about their lives can lead to understanding their performance or motivational problems, as well as getting a picture of the whole person.

Often, many requests for assistance with performance enhancement will be just what they appear to be, and practitioners with supervised experience and adequate sport psychology training will be able to assist the athletes with whom they interact. In some cases, however, athletes will present with issues outside the realm of practitioners' expertise, and sometimes those concerns will emerge after the sport psychology consultant and athlete have worked together for a while. The next few paragraphs provide some guidelines to help practitioners decide if an issue warrants referral to another professional for assistance (see Box 20-1).

Box 20-1 Considerations for Deciding If an Issue Warrants Referral

1. *How long has the issue existed?*
2. *What is the severity of the issue?*
3. *How does the issue relate to other factors in the person's life?*
4. *Does the person display unusual emotions or behaviors around the issue?*
5. *How well is the athlete using existing interventions or coping strategies?*
6. *Does the practitioner have the knowledge, skills, and competencies to address the issue?*

First, how long a problem has existed, its severity, and its relationship to other issues in the person's life may signal a need for referral. A problem that is relatively recent, that is not severe in its emotional implications, and that does not have substantial overlap with other aspects of a person's life is less likely to require professional assistance. For example, an athlete who is facing a tough competitive situation and who experiences mild to moderate anxiety and negative self-talk is not likely to require referral. A person for whom each athletic competition becomes an all-or-nothing battle for a sense of self; whose emotional state is dependent on performance outcomes; and where strong anxiety, depressive states, or substance abuse may also be involved is more likely to need a referral than the athlete in the earlier example.

Second, unusual emotional reactions may also need to be considered. Anxiety that generalizes to situations beyond the athletic arena may signal that

other issues are present and that interventions may be needed to help deal with other areas of the person's life. For example, anger or aggression is likely to be an issue presented by an athlete only if it has become a problem to others. Unfortunately, it may take the form of fights with strangers or teammates, which sometimes involve legal complications, as well as familial abuse issues. In other cases, an athlete may lose control within the competitive context. This emotional reaction may inhibit otherwise good performance or be a performance threat, in that the person becomes a liability in terms of penalties or ejections from the game.

Third, it may also help to examine the effectiveness of performance enhancement interventions. For example, perhaps an athlete has not disclosed the full extent of the issue or is not aware of it. It may be that the person working with the athlete did not come to understand the nature and extent of the problem. The practitioner may also misunderstand how to use interventions, such as those that have recently become fashionable (e.g., mindfulness, see Zizzi & Andersen, 2017). If interventions such as self-talk and imagery do not seem to be working, there are several possibilities to consider. Perhaps the athlete did not respond well to the particular intervention (e.g., many individuals are not naturally adept at imagery). It may be that the sport-related problem was not accurately assessed or was stronger than initially assumed. It may also be, however, that the sport-related concern is intimately tied to other issues in the person's life and may have deeper, stronger, or more chronic patterns than the practitioner first believed.

How to Start the Referral Process

The referral process is not usually a straightforward one. If trust and rapport have been built between the sport psychology consultant and the client, sending the athlete directly to someone else when material comes up that the practitioner does not feel competent to handle may not be the optimal choice. Instead of referring out, *referring in* may be the better choice (Van Raalte & Andersen, 2013). Bringing in a qualified professional and having all three parties sit down and discuss a plan may be less threatening to the athlete and help ease the individual into the therapeutic process. Referring in may be the best way to keep the therapeutic process going.

Most articles on referring athletes to other practitioners (Andersen & Van Raalte, 2005; Van Raalte & Andersen, 2013) focus on what to do, what not to do, and what should happen. Many students ask, "How do you do it?" There is probably no better way (except for a live role-play) to demonstrate how to do a referral than through dialogue and commentary. The third author's experiences when he knew he was not qualified to work with an athlete with an eating disorder illustrate several issues.

Quite early in my training, I (Mark) had been seeing a swimmer, Angela, for about two months, working with her primarily on self-talk and arousal regulation. When she arrived at our eighth meeting, I could see something was wrong. We had built a strong working alliance, so when she answered my question about how things were going with a flat "Okay, I guess," I jumped in:

Mark (M): From over here, it doesn't look like things are okay. It looks like something not very good is going on.

Angela (A): I don't know, Doc, I'm just kind of worried. [I kept silent to see if she would go on, but she just sighed.]

M: So, what's troubling you, Angela?

A: [beginning to have tears in her eyes] I am just outta control [now full tears flowing].

M: I can see that this is really painful; tell me what's going on.

A: You'd be disgusted with me.

M: We've worked together for about two months, and I think we've built up a good relationship. I don't know everything about you, but what I know is that you are a fine person. I can't imagine that

anything you could tell me would put me off. So let's look at what's going on and see if we can figure out what to do.

At this point, I know something big is coming. Angela is having trouble talking to me about the problem for a variety of reasons. First, she is disgusted with herself and thinks I will be disgusted too. Because of our strong working alliance and her positive transference to me, she does not want to say anything that will disappoint me (Tod & Andersen, 2012). I am trying to reassure her of my unconditional positive regard and to remind her that we are in this endeavor together and that we will look for solutions. Angela then began to tell me of being stressed with swimming, her weight, and school pressures and how her long-standing once-a-week binge–purge episodes had turned into an almost daily occurrence.

A: How can I do that to myself? Don't you think it's terrible?

M: No, I don't think it's terrible. In fact, right now I am feeling really proud of you for having the courage to talk about all this. I know it's gotta be one of the harder things you've done. . . . I want to do everything I can to help, but Angela, to tell you the truth, I am not trained in eating problems. I think we need to talk to an expert.

A: But I don't want to talk to anyone else. I want to talk to you. Those people over in Student Health don't understand athletes.

M: I know what you mean, but I know a great psychologist over there who is a runner herself and competed in college. She is a major sweetheart and really understands eating problems and weight concerns in sport.

A: I just hate going over there, and I don't want to go to sports medicine. If I did that, I know it would get back to the coach.

M: Nothing is going to get back to the coach unless you want it to. I have an idea. How about if I ask Dr. Kerstner [the expert] to come over here and you and she and I all sit down together? We could meet right here in my office just like our usual appointment. How's that sound?

A: I guess that would be okay. I just feel comfortable with you.

M: I'll be there with you all the way, and I know you and Dr. Kerstner will hit it off.

A: Can I still keep seeing you?

M: Of course! I am your sport psychology consultant as long as you want me to be. We can keep working on your swimming, and I'll be checking in with you and Dr. Kerstner occasionally on how things are going. How's that?

A: Okay, ask her to come over.

M: I'll get hold of her right after our session.

A: Doc, could we do a nice long autogenic thing today? I'm kind of frazzled.

M: You bet, you know the drill. All right, get yourself in a comfortable position and take a nice deep breath. . . .

This interchange contains many different processes, all directed at making the referral an acceptable option. First, I assure Angela that instead of seeing her problem as terrible (and disgusting), I am proud of her. I am letting her know that my opinion of her has changed only for the better because of what she has told me. Next, I introduce the idea of referral, but she is quite resistant. Athletes at large North American universities (from my experience) often feel that services on "main campus" are not geared for their needs. I attempt to overcome the resistance by telling her a little bit about the psychologist's sport background and by letting her know that I think quite highly of Dr. Kerstner. This last point illustrates the importance of having a referral network of health care professionals who are sensitive to athletes' issues. Angela is coming around, but she still wants to stay with me. Her reaction is understandable; our relationship has grown to this intimate point, a point where she is able to talk about truly painful issues in her life. Getting here

was a long process, and she may not want to tell her problems to a stranger. I address Angela's lingering resistance by suggesting that we see Dr. Kerstner on familiar turf (my office) and by letting her know I will be with her all the way.

At the end of this emotionally draining session (for athlete and sport psychology consultant both), Angela wants to return to the familiar and the soothing, so we do something together that we have done several times before—we relax. In time, other professionals (e.g., a physician or nutritionist) would be called in to help Angela (see Roberts, Faull, & Tod, 2016, for a description of ongoing support when referring an athlete to other helping professionals). This first, and largest, referral step helped Angela get on the path of treatment. No two referrals are alike, and some referrals are easier than others. But almost all referrals are complex and sensitive in nature.

When Referrals Don't Go Smoothly

Some athletes may not follow their sport psychology consultants' advice to seek assistance from other professionals. Van Raalte and Andersen (2013) identified reasons why athletes may not act on their practitioners' suggestions. First, sport psychology consultants and athletes may not have solid working alliances. In the absence of close relationships, athletes may not trust that their sport psychology consultants have their best interests at heart. Practitioners' recommendations, for example, might be interpreted as attempts to rid themselves of their athletes and pass them on to other professionals. From such interpretations, athletes might infer they are damaged goods and possibly unworthy.

Second, if handled insensitively, athletes might feel unsupported and believe their trepidations regarding referral have been ignored. One fear might be that the mental health practitioners will take away from athletes what made them high achievers in sports. Confidentiality is important as well; if word gets around that athletes are seeing other practitioners, they might feel they have lost some of their dignity. Although society has become more aware and accepting of mental health problems in recent years, there are those who still stigmatize people seeking counseling.

Third, practitioners may not have prepared athletes adequately for the referral process. Sport psychology consultants need to inform athletes about what referrals involve, who the other helpers are, why they might help, and what the implications are for the existing sport psychology consultant–athlete relationships. Practitioners can begin preparation right from the start by signaling to athletes in their first sessions together that referral might be a possibility in the future. Athletes poorly prepared for referral may have unrealistic expectations about how helpful the new practitioners might be, particularly if sport psychology consultants have oversold the benefits to convince athletes to seek help.

Fourth, in the absence of any follow-up or facilitation, athletes might never contact the recommended practitioners or may not persist after the initial meetings. The match between the athlete and the other helper may not be close enough for benefits to accrue. Also, it may have been a huge step for athletes to share sensitive material with their sport psychology consultants, who may be among the few trusted people in their lives. Athletes may not be ready to establish new relationships with other strangers.

When faced with referrals that do not appear to be working well, sport psychology consultants can still keep in contact with athletes. To maintain a close relationship, the perception that the sport psychology consultant's continued help is conditional on the athlete meeting with the external helper needs to be avoided. It is probably inadvisable, and impractical, to force athletes to meet with other professionals if they are uncomfortable, except in some situations, as when there is a threat of harm to self or others. Then practitioners have ethical (and legal) obligations to consider. Sport psychology consultants who maintain their relationships

with their athletes can continue to provide performance enhancement assistance and can reinitiate the referral process in the future if athletes change their minds.

Some Specific Athlete-Related Issues

Sometimes, in addition to performance issues, or related to them, other concerns confronting athletes may surface. Insights into depression were presented at the start of this chapter; let's now examine some other concerns in more detail.

Identity Issues

One of the most problematic issues for many athletes is that sometimes most of their sense of self has centered on their roles as athletes, the development of which may begin in childhood (Carless & Douglas, 2013). This overidentification may be particularly salient for competitors at elite levels, but it can occur for any person in any sport. Often the athlete's hopes for the future and social support from others may revolve around the sport and competitive success. For someone working with these issues, attempts at performance enhancement may take on an extreme urgency, because the athlete's sense of self may well be riding on performance outcomes. When individuals identify with the role of athlete exclusively, they are said to have *foreclosed* their identities, as Petitpas and Danish (1995) have discussed:

> In psychological foreclosure people rigidly adhere to their identities to maintain security or to cope with intrapsychic anxiety. This might be seen in athletes who are adult children of an alcoholic parent. They may be resistant to change and more vulnerable to threats of identity loss because their method of coping with their life situations is to seek approval through their athletic successes. The loss of their athletic role would compromise their entire defensive structure. (p. 263)

Major threats to identity can come through athletic injury, deselection, and career termination (Arvinen-Barrow, Hurley, & Ruiz, 2017; Blakelock, Chen, & Prescott, 2016; Park, Lavallee, & Tod, 2013). These threats represent critical moments, often accompanied with existential anxiety, in which athletes are forced to reassess their self-perceptions (Ronkainen & Nesti, 2017) and may need to rewrite their personal stories.

Although we normally think of the identity of athletes as something both individuals and peer groups see as positive, valuable, and rewarding, there are also negative self-narratives (Erikson, 1968). A *negative identity* is the acceptance and valuing of an identity that is generally disapproved of by society. The dumb jock is one such negative identity. Individuals and subgroups may hold opinions that athletes shouldn't care about school or shouldn't do well, and so forth. This negative identity, although disapproved of by many, may become important to an individual or subgroup. Similarly, the tough jock identity can be problematic. For many, being an athlete means being tough, and it often involves intimidating others verbally or physically. Substance abuse issues also can become part of negative identity patterns. To be a successful jock, one may need to be able to consume a great deal of alcohol or other drugs. In some cases such activity is done covertly, with an eye to the clean-cut image that has to be maintained for public relations purposes.

As with many other human affairs, unless individuals see these identity issues as areas that are problematic and that they would like to change, it may only be possible for coaches or sport psychology consultants to communicate concern for these areas and to point athletes in the direction of those who can help them work on these difficulties.

Sexual Orientation and Abusive Environments

Athletes' sexual orientation, especially for lesbian, gay, bisexual, and transsexual (LGBT) athletes, has received limited attention in the sport psychology literature (Krane, 2016; Krane, Waldon, Kauer, & Semerjian, 2010), and one must go to sociological and popular writings to learn about LGBT athletes'

experiences and the culture of abuse and discrimination in sport (e.g., Anderson & Bullingham, 2013; Krane, 2019; Thomas, 2014). Although LGBT athletes may struggle with the *coming out* process, for most of these sports participants, their sexuality is not their primary issue. The abuse and discrimination present in the sporting world is usually a far more serious concern, and it raises fears in athletes about getting less playing time, being kicked off teams, being harassed, and being physically abused if their orientations were made public. Reactions to the abusive environments of sport may manifest in anxiety disorders, relationship problems, depression, and even suicidal ideation. All of these potential problems may require referral to clinical professionals. If sport psychology consultants are uncomfortable interacting with LGBT athletes or are not sensitive to the abusive environments and issues these athletes experience, then referral may be the optimal and ethical decision.

Sex- and Health-Related Issues

Most athletic careers start seriously sometime during adolescence and usually end somewhere in the mid-20s to late 30s. In Erikson's (1968) psychodynamic framework, many athletes are in the middle of the challenges of either "identity versus role confusion" or "intimacy versus isolation." Both these times are periods of experimentation, exploration, and finding out about oneself. For some athletes, the exploration of self and intimate relationships may involve risk-taking behavior, especially in the realm of sex. Athletes in general engage in sexual behavior more frequently, have more partners, and are at greater risk for a variety of sexually transmitted diseases (STDs) than their nonathlete peers (Butki, Andersen, & Heyman, 1996; Wetherill & Fromme, 2007). Some STDs (e.g., hepatitis C) may also be contracted through other means, such as needle sharing. Athletes may approach sport psychology consultants to talk about anxieties related to their risky sexual behaviors. Some of these activities may have been consensual, but athletes also experience sexual abuse and rape, both as victims and perpetrators (see Mountjoy et al., 2016 for signs, indicators, and prevention of harassment and abuse in sport). If a professional is uncomfortable discussing intimate behavior or is not knowledgeable about STDs, referral to a counselor with expertise in sexual health is appropriate.

Eating Disorders

Given the complexities of eating disorders and the accompanying psychological, physical, and physiological effects, referral to a variety of health care professionals (e.g., dieticians, gastroenterologists, psychologists, team doctors) is becoming the norm. Eating disorders among athletes have received much attention in the sports medicine and sport psychology fields (Reel & Galli, 2012). Prevalence rates of eating disorders among athletes are similar, if not higher, than among the general population (results vary from 0 to 19 percent in male athletes and 6 to 45 percent in female athletes; Bratland-Sanda & Sundgot-Borgen, 2013).

Eating disorders historically have been considered a *female* concern. In the general population, however, disordered eating behaviors are increasing at a faster rate in males than females (Michison, Slewa-Younan, & Mond, 2014). Current rates may not accurately reflect male athletes' actual prevalence, and these individuals, especially those in sports with a focus on leanness or that have weight divisions, may experience adverse health issues that mirror the female athlete triad, such as impaired bone health (Tenforde, Barrack, Nattiv, & Fredericson, 2016). Compared to women, men may seek therapeutic help less often (Olivardia, Pope, Mangweth, & Hudson, 1995); have less chance of successful outcomes (Oyebode, Boodhoo, & Schapira, 1988); and be more likely to use saunas, steam baths, and exercise, rather than purging, diet pills, and laxatives (Braun, Sunday, Huang, & Halmi, 1999).

A central feature of eating disorders is often a disturbance in body image, and over the last two

decades interest in the ways men view their physiques has grown. Increasingly, men are feeling as if they need to attain a highly muscular mesomorphic body shape (Edwards, Molnar, & Tod, 2017). In addition to eating disorders, body dissatisfaction has been related with body dysmorphia, some forms of somatic delusional disorders, poor self-esteem, depression, social anxiety, inhibition, sexual dysfunction, and a variety of health-risk behaviors, such as excessive exercise and steroid use (Grogan, 2016).

The etiologies for eating disorders and body dissatisfaction in the general public and in athletes are probably, in some cases, dissimilar. Andersen and Fawkner (2005) identified a number of reasons why athletes may experience disturbed eating and body dissatisfaction. First, although poor body image might motivate exercise and sports participation, there may be no changes in some anatomical features, and the source of the dissatisfaction may not be alleviated. Second, some sports and types of exercise may not produce desired body changes. Third, participation in sport and exercise may raise expectations beyond what is realistically or genetically possible. Fourth, comparing oneself against others may result in a negative evaluation. The chance of dissatisfaction may be heightened in sports where comparisons are part of the competitive process, especially in sports such as diving or gymnastics. Fifth, participants may be reinforced for developing an excessive preoccupation with weight and physique, notably for those athletes whose coaches dwell on body appearance. Disturbed body image may continue past an athletic career into retirement (Park et al., 2013). Sixth, individual, psychosocial, and cultural factors also need consideration. In men, for example, gender and sexuality-specific stressors may elevate disordered eating behaviors (Norris et al., 2012).

The United Kingdom's National Institute of Clinical Excellence provides guidelines on how to help people with eating disorders (https://www.nice.org.uk/). A more important question, however, is whether the pathogenic sport environment should be the object of treatment (see Cosh, Crabb, Kettler, LeCouteur, & Tully, 2015 on the normalization of body regulation practices in elite sport). I (Mark) worked with a collegiate gymnast whose disordered eating was primarily environmentally dependent. When she was away from school, the coach, and the gym, her bulimic behavior dropped to zero. After returning from semester break, she said, "I was just fine at home; it didn't happen, not even once. But as soon as I get back here–Blam!–it's starting all over again." I met this gymnast in her senior year, and we worked together on some cognitive-behavioral interventions to decrease the frequency of her bulimic behavior. She was successful at reducing the bulimic behaviors, but the eating disorder did not go into full remission until she finished her competitive career and left the sport.

Eating disorders are difficult to treat, and among athletes, more than many other issues, bring up the question of whom or what is really in need of referral. Stimulated by the previously mentioned case (and others), the Eating Disorders Team at my (Mark's) university (composed of general practitioners, a psychiatrist, psychologists, a dietician, and a sport psychology consultant from the student mental health center) ran educational seminars in the athletics department. These seminars were aimed at increasing coaches', administrators', and sports medicine personnel's awareness of the signs and symptoms of eating disorders and helping them make referrals to appropriate services. The athletics department was receptive to these interventions, in part, because they and the university were facing litigation from a former student athlete who claimed she arrived at the university healthy and left with an eating disorder directly related to her sport.

There is an extensive body of literature that coaches and sport psychology consultants can read to learn how to help athletes with eating disorders (Arthur-Cameselle & Baltzell, 2012; Bratland-Sanda & Sundgot-Borgen, 2013; Dosil, 2008), such as how to identify warning signs. Some indicators of eating disorders to watch for include a marked loss in weight, preoccupation with weight, avoidance of

team and other socially related functions involving food, eating little at such functions, visits to the bathroom after meals, bloodshot eyes after bathroom visits, decreases in energy levels and ability to concentrate, chronic gastrointestinal complaints, and increased mood swings.

Alcohol and Other Substance Use Issues

Perhaps due to the public fascination with celebrities' problems with alcohol and drugs, this domain is one in which athletes' problems have received extensive attention (Backhouse, 2012; Stainback & Taylor, 2005). The association in the United States and other Western countries between masculinity and drinking (as well as the ability to consume large amounts of other substances) may make some athletes vulnerable to developing problems in this area. Research suggests that student-athletes are a high-risk group (Doumas, Haustveit, & Coll, 2010): they consume more alcohol, start drinking earlier, and engage more frequently in alcohol-related risk behaviors (e.g., driving after drinking) than their nonsporting counterparts (Taylor, Ward, & Hardin, 2017). Athletes' alcohol consumption may vary with different sports, at different times of the year, and by gender (Taylor et al., 2017). In addition, individuals inclined to take risks, or *sensation seekers* (Zuckerman, 1979), are also likely to indulge in large amounts of alcohol and drug use. Certain sports may disproportionately attract sensation seekers.

Someone working with athletes should recognize the general symptoms of excessive alcohol or drug use. Common signs involve chronic use or binges, centering major events around drug and alcohol, personality changes during use, and alcohol and drugs interfering with other life activities or relationships. Unfortunately, high school and college life in general, and often the athletic environment, will cloak problem usage with different forms of social acceptability. Given denial and defensiveness around alcohol and drug use, coaches or sport psychology consultants worried about these issues can note their concerns, but not in lecturing or threatening ways. It is important to have sources for referral available, particularly if athletes become apprehensive about their usage and would like to seek help.

Practitioners working in competitive and recreational sporting contexts are likely to meet individuals who consume drugs to enhance performance and body composition, of which anabolic steroids are probably the most commonly discussed. Athletes and exercisers initiate and sustain their use of these substances for various reasons, and not just for performance enhancement. In addition to an individual's motives, substance use is influenced by intrapersonal, interpersonal, social, and societal factors (Bates et al., 2019). For example, athletes may become dependent on performance drugs, such as steroids, via psychological, physiological, and sociological mechanisms. In some contexts, such as elite sport, athletes may perceive a need to consume drugs to be competitive. In other contexts, drug consumption provides users with social capital allowing them acceptance into desired communities. Similar to eating disorders, the sporting environment is structured in ways that it is unsurprising that doping is likely to be more common than currently recognized (De Hon, Kuipers, & van Bottenbury, 2015). Although there is some encouraging data, most interventions for reducing or preventing performance-enhancing substance use have limited evidence of their effectiveness (Bates et al., 2017). Helping individuals abstain from image- and performance-related drug use is seldom straightforward, especially if they have become dependent on the substances. Substance users may acknowledge the presence of side effects, but believe they are controllable and are outweighed by the benefits. These individuals typically see themselves as healthy and distinguish themselves from the stereotypes of recreational drug addicts. Often, users also view scientists and medical personnel with suspicion, believing they have limited knowledge and are untrustworthy. Similar to other mental health problems discussed in this chapter, unless

athletes perceive they have issues, practitioners may have difficulty instigating successful referral. Doping in sport is a topic on which entire books are written and, like other mental health topics, a full discussion is beyond the scope of this chapter (Mottram & Chester, 2018).

Anger and Aggression Control

In many competitive sports, coaches and players encourage psychological attributes of toughness and competitiveness, and they may portray opponents as enemies to be defeated. In contact sports in particular, but in other sports as well, physical aggression often is sanctioned. Most athletes are able to control their anger and aggression both on the field and off, although some require a little time after competition for their behavioral controls to reset.

For some athletes, however, who experience difficulty with anger or aggression control, a referral might be appropriate. Some individuals may have had a reputation for conflict. For athletes, this tendency may have a negative identity component that cloaks the problem in an acceptable way for a peer group. The athlete may be tough on and off the field, someone *not to mess with*. Unfortunately, the frequency and severity of conflicts may escalate to harmful levels. In other cases, someone going through a personally difficult time may be less able to control anger or aggression. This difficulty may be expressed either on or off the field. Particularly when anger and aggression have not been issues for a person before, they might be discussed with the athlete and a referral made.

Alcohol and drug use may also be related to such behaviors. In general, when people are intoxicated, bottled-up anger or rage may be expressed more easily than when sober. In recent years, *roid rages,* or violent reactions in some individuals who are taking steroids, also have been noted (e.g., Backhouse, 2012).

There are ways to help individuals deal with anger and aggression. For example, there is a growing body of work on aggression using rational-emotive behavior therapy in applied sport psychology (e.g., Turner, 2016; Turner & Bennett, 2018). It is easier to help individuals resolve conflicts and reestablish controls if they have had a reasonably good history of anger and aggression control (Novaco, 1975). Helping athletes with more problematic histories is possible, but it may be a slower process.

Romantic and Family Relationship Issues

Athletes and sport participants are likely to have relationship problems similar to those of others in their peer groups. Some problems, however, might be more common for athletes than their nonathlete peers, but similar to others who are celebrities or who are dedicated to demanding activities in which their partners may not be involved.

Many athletes are away from friends or family for extended periods. This absence can cause loneliness, anxiety, and depression for both the athlete and family members. There may be conflicts in the relationship, or fears, or suspicions, and these problems can manifest themselves in decreased performance, increased anger and aggression, or in a number of other ways. At the same time, practice and competition place demands on the athlete's time at home, and this pressure, too, may be problematic for the partner. For many marathoners, who may not be elite or competitive athletes, the time taken to train may disrupt family or relationship patterns. Someone who spends years involved in training and competition may need an understanding or mutually involved partner. Also, given the amount of time that athletes, coaches, and teammates spend together and the closeness of their interactions, romantic relationships may occur (Johansson, Kenttä, & Andersen, 2016). The glamour and celebrity-like status that can surround some athletes, as well as the long periods they can spend away from home, offer opportunities for infidelity. Even when an athlete is not unfaithful, the partner may have fears about straying when the athlete is away, or the athlete may have anxiety about the partner left behind.

Sport psychology consultants may not find it easy to identify relationship problems. In some cases, when performance becomes problematic,

the athlete will indicate that the source is an interpersonal or relationship problem. In other cases, a relationship problem may manifest itself in changes in mood; the expression of anger, depression, or anxiety; or increases in alcohol or drug use. Often teammates will be told of the situation, and they may discuss it with a coach or others. Sometimes, the athlete or sport participant may just need to talk with someone individually such as a sport psychology consultant or another counselor to come to understand personal reactions and to make decisions about commitments and behaviors. In other cases, marital, relationship, or family counseling therapy might be the best referrals.

Professional Development Tasks for Sport Psychology Consultants and Students

Sport psychology consultants and students can engage in numerous professional development tasks to help make referral processes go smoothly and to ensure that athletes feel accepted and supported (see Box 20-2). Becoming familiar with the psychopathology and psychopharmacology of various mental health problems is a valuable first step, particularly for those individuals without clinical backgrounds. For example, some anxiolytic drugs (i.e., medications designed to inhibit anxiety) may lower blood pressure, and if relaxation treatment is also being used, blood pressure may drop to unhealthy levels. Also, sport psychology practitioners, coaches, and athletes need to be aware of what medications are prohibited by national and international sport governing agencies (e.g., the World Anti-Doping Agency [WADA] at http://www.wada-ama.org/en/). Sport psychology consultants, well informed about psychopathology and pharmacology, may have a keen appreciation of what life is like for people with mental health concerns, and they may be able to use that empathic understanding to maintain helpful working relationships with their athletes. Being able to talk knowledgeably and nonjudgmentally about mental disorders with athletes will help practitioners support their clients and prepare them for referrals to recommended mental health professionals. Along a related line, learning how to use suitable clinical assessment technologies may help consultants identify mental health concerns needing referral, such as the Athlete Apperception Technique (Gibbs, Andersen, & Marchant, 2017; Gibbs, Marchant, & Andersen, 2016). Texts and chapters (American Psychiatric Association, 2013; Andersen, 2004) contain useful information for practitioners' continuing education, and sport psychology consultants can supplement their technical knowledge by reading biographies of athletes who have experienced mental health issues (Carlise, 2013; Thomas, 2014). With increased prominence of athlete mental health concerns, the UK government

Box 20-2 Professional Development Tasks for Practitioners

1. *Become familiar with the psychopathology of various mental health issues*
2. *Increase awareness of various other physical, medical, and social challenges*
3. *Develop knowledge of psychopharmacology*
4. *Enhance awareness of currently banned substances, their consequences, and their side effects*
5. *Read about athletes' experiences with mental health issues*
6. *Develop a network of professionals from various disciplines*
7. *Engage in career-long supervision with mentors and colleagues*
8. *Role-play possible scenarios and receive feedback*
9. *Undertake reflective practice*

has advised that all elite sports must have a clear mental health strategy in place by 2024 (Department for Culture, Media and Sport, 2018). Such strategies, supported by mental health practitioners, will provide training and education to coaches and sports governing bodies' staff on how to identify the signs of mental ill health and develop referral pathways. If such a trend reflects a global movement, then individuals who are trained in sport and exercise science departments may find it worthwhile considering further training to become state-approved (registered, licensed) psychologists.

Another way students and practitioners can prepare themselves for handling future referrals well is by identifying and cultivating relationships with professionals they know and trust. Sport psychology consultants can select from a range of suitable individuals, depending on athletes' needs. These professionals may include psychiatrists, clinical and counseling psychologists, social workers, pastoral care providers, marriage and family therapists, substance abuse counselors, and career guidance experts. Many athletes' concerns may not be related to mental health, but instead to other domains such as nutrition or physical well-being. Sport psychology consultants' networks could include nutritionists, biomechanists, sports medicine specialists, and exercise physiologists. Understanding the sporting backgrounds of the individuals in sport psychology consultants' professional networks will help practitioners suggest experts who are best suited to helping and forming working alliances with athletes. For example, a clinical psychologist who has participated in track and field events may be a good choice for the depressed hammer thrower mentioned at the start of this chapter.

Sport psychology practitioners and students also can engage in role plays to prepare themselves for making referrals (Tod, 2007). By rehearsing the referral process, sport psychology consultants can practice ways to interact with athletes in a caring and compassionate manner. For example, an athlete may feel threatened by meeting a clinical or counseling psychologist, and role playing helping the athlete overcome those anxieties adds another dimension to the sport psychology consultant's repertoire. Peer-group supervision is an ideal place to conduct role plays because fellow practitioners can receive feedback from their colleagues in a safe, problem-solving environment.

Supervision generally can be an ideal place for practitioners to seek guidance from senior practitioners and colleagues about specific athletes whom they are unsure if they can help. Seeking advice and guidance from others may be instrumental in deciding if referral is suitable and how best to handle such instances. Supervision is also a place where practitioners can self-reflect and develop their skills. Practitioners who do not examine their own attitudes and behaviors may not be in a position to help others. A person who is open and accepting of others, however, will convey an important message to athletes and will increase the likelihood of the athlete agreeing to referral procedures.

Summary

Throughout this chapter, we have tried to address a variety of issues involved in deciding when to refer an athlete to other helping professionals. We hope that this chapter has provided helpful information for recognizing when athletes present issues beyond the scope of the usual performance enhancement realm. It is also important, however, for individuals working on performance-enhancement

issues to recognize the need for sensitivity towards the athlete's other life issues when making referrals. These helping individuals should also be cognizant of their own issues and values, because they might affect their ability to work with and to be sensitive to the issues others might have.

This chapter has been a difficult one to write (and rewrite) because referral involves many complex issues that should be discussed, or at least acknowledged. Many of these topics, such as career termination or injury rehabilitation, merit chapters on their own. This chapter has explored ways to help those not trained in counseling or psychotherapy to recognize these issues and to facilitate sensitive and caring referrals.

Study Questions

1. From the dialogue in the chapter, what are some important issues to be sensitive to when making a referral?
2. What are three patterns someone might note as indicating other serious problems when working with an athlete on performance enhancement?
3. What are some reasons why the hammer thrower presented at the beginning of this chapter may not meet with a mental health practitioner?
4. How does homophobia in society and in the sport world contribute to problems for athletes who may manifest in mental and behavioral disorders?
5. How might a concern with food or weight gain reflect a serious eating disorder problem?
6. What can sport psychology consultants do to prepare themselves for making referrals?
7. What are some signs that aggressiveness in an athlete has become problematic? Is it likely that an athlete who has been driven by anger will become less successful if underlying conflicts are resolved?
8. What factors related to sport can cause or exacerbate relationship problems for athletes?
9. How might a coach or sport psychology consultant find professionals to refer athletes for counseling or psychotherapy?
10. What might you do if an athlete currently does not want to take your referral advice?

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