3
FOUNDATIONAL COMPETENCIES OF A CLINICAL SPORT PSYCHOLOGIST

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The purpose of this chapter is to identify foundational competencies for clinical sport psychologists (CSPs). It includes a review of the knowledge, attitudes, skills, and expertise related to competence in CSP. Specifically, I review the competencies in clinical psychology and sport psychology as they coalesce to form competencies for CSPs. There is very limited literature on competence in CSP, and there is no list of measurable competencies from governing bodies or professional associations. Therefore, I suggest using several existing models to guide the formation of foundational competencies in CSP and make additional training recommendations.

Ethical Use of the Title “Clinical Sport Psychology”

A challenge in identifying competencies for CSPs may be due to the fact that applied sport psychology (ASP) is an interdisciplinary field that draws from kinesiology, sports medicine, psychology, and other disciplines (Petrie & Harmison, 2012). ASP professionals typically attend graduate programs in kinesiology or clinical/counseling psychology. Those with kinesiology degrees are equipped to assist athletes with sport performance but are expected to refer clients with clinical issues to appropriate professionals. Yet, many believe that it is impossible and ill-advised to dichotomize athletes’ presenting concerns as either performance or clinical in their nature (e.g., Hays & Baltzell, 2016), finding it preferable to holistically address athletes’ sport-related and non-sport-related concerns (e.g., Roberts et al., 2016). There is evidence that athletes with mental health issues benefit less from performance enhancement interventions than those with higher psychological functioning (Wolanin & Schwanhausser, 2010). Therefore, to effectively enhance performance, training in clinical psychology or counseling psychology may be necessary.

In addition, the sport environment contains unique norms and stressors. It is, therefore, no surprise that many believe that knowledge of the sport milieu is necessary to effectively treat athletes (e.g., Petrie & Harmison, 2012). Moreover, sport psychology research has grown in the last few decades, and there is now a large body of work to inform best practices and ethical considerations with athletes. It is unwise, if not unethical, for psychologists to
work with athletes without understanding sport-specific theory and research. Like Gardner and Moore (2006, p. 9), I recommend that practitioners using the term CSP conceptualize their work with athletes as the “promotion and maintenance of psychological and physical health and well-being,” which includes interventions aimed at “the optimization of athletic performance” while also focusing on “prevention, assessment, and amelioration of personal or performance difficulties” by way of applying appropriate clinical techniques to treat behavioral and emotional disruptions. A problem with this recommendation is that there are no standards for using the term CSP to determine which professionals can competently apply this conceptualization.

Nonetheless, many countries restrict the use of the terms “clinical psychologist” or “psychologist.” For example, in the United States, most states require a doctoral degree in clinical or counseling psychology to use the title “psychologist;” thus, in most states, the terms “clinical sport psychologist” and “sport psychologist” are restricted to licensed psychologists. Therefore, when defining minimum foundational competencies for CSPs, a doctoral degree in clinical or counseling psychology is the starting point. Other licensed mental health providers who wish to treat athletes must use terms such as “clinical sport counselor” or “clinical mental health sport counselor.” Although the term CSP will be used throughout this chapter, the reader should replace it with the appropriate title if they are licensed in a mental health field other than psychology. Relatedly, globalization within ASP brings forth the issue that sport performance consultant training varies internationally. There is not enough space in this brief chapter to review these differences (see Wylleman et al., 2009), but it is important to note that without licensure or recognition from governing bodies to treat mental health, practitioners cannot ethically use the title “clinical” in their ASP work.

**Competence: Definitions and Debates**

Before delineating the proposed competencies in CSP, it is necessary to fully understand the term *competence* and its use in the literature. *Competence* can be defined as a multidimensional construct marked by the attainment of interrelated knowledge areas, skills, and attitudes, in addition to the maintenance and broadening of these factors through continued education (Rubin et al., 2007). Competence also encompasses the values and personal characteristics, which are all “context-dependent,” meaning that “different competencies, aspects of competencies” or “execution of each competency varies depending on the setting” (APA, 2006b, p. 11). The competence approach has led to clinical/counseling psychology training programs that are designed so that students achieve (or begin to develop) observable aspects of competence, often referred to as *competencies*. These competencies indicate “suitability for the profession” (APA, 2006b, p. 11) and an acceptable level of practice. Although CSP competencies overlap with both ASP and clinical psychology, the context-specific nature of CSP requires unique competencies.

There are several debates about competence within psychological fields. For this chapter, I will focus on the debates within ASP, where a primary disagreement relates to whether the term “competence” indicates minimum levels of proficiency for practice or if the term is aspirational, indicating ideal end-goals (Fletcher & Maher, 2014). A related debate is whether it is preferable to focus on “competence” or “expertise.” Collins et al. (2015) argued that *expertise* is the ideal target because it denotes going beyond minimum standards by achieving master levels of understanding, knowledge, and reasoning. Further, Cruickshank et al. (2018, p. 4) described expertise as “the ability to make value judgments to identify and
deploy the optimum blend of techniques to meet complex and dynamic situations” continuing that expertise is appropriate in ASP where one has “to look for the best answer rather than the right answer.”

Although this is a persuasive argument for the pursuit of “expertise,” Fletcher and Maher (2014) asserted that many in ASP have misunderstood “competence.” Like many other scholars, they utilize Epstein and Hundert’s (2002) definition of competence, which is “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice,” including “the ability to solve ambiguous problems, tolerate uncertainty, and make decisions with limited information” (p. 227). Using their definition, competence and expertise are likely more similar than different. Notably, the American Psychological Association (APA, 2006a) uses the term “clinical expertise,” which is defined as performing duties that are consistent with one’s training and also using evidence-based practices that are applied in a culturally sensitive manner. Their definition includes the need for maintenance and expansion of competence throughout the career lifespan.

I also rely on Epstein and Hundert’s (2002) definition and will, therefore, focus this chapter on essential content knowledge areas, skills, behaviors, attitudes, and characteristics to best serve the clinical athlete populations. I also view competence on a continuum and agree that competence implies both practicing within one’s areas of training and a continual pursuit of knowledge (APA, 2006b). When using this conceptualization, a CSP with high levels of competence would demonstrate expertise (Fletcher & Maher, 2014). Given that CSP is a relatively new field, I believe that identifying foundational competencies for entry to practice is the appropriate starting place. After conducting the assessment of competence specifically in CSP, scholars can identify markers of high levels of competence (i.e., expertise). Before identifying potential competencies in CSP, it is necessary to examine the literature in professional psychology and ASP.

**Competence in Professional Psychology**

A full review of the history of competence in professional psychology is outside the scope of this chapter (see Rodolfa et al., 2014), but three key milestones are described below. Most notably in this timeline is the Competencies Conference, held in Arizona in 2002, where a variety of stakeholders discussed eight competency areas as well as the assessment and acquisition of competence (Rodolfa et al., 2014). Two noteworthy products emerged. First, Roberts et al. (2005, p. 355) published a paper that encouraged moving the field from lists of competency areas toward a “culture of competence” that encourages continual refinement of knowledge and skills. Second, regarding the acquisition of competence, Rodolfa et al. (2005) proposed a “competency cube model” to visually depict competencies that were agreed upon at the conference (see Figure 3.1). On one side of the cube are six “foundational competencies,” both knowledge and value-based, including (1) reflective practice/self-assessment, (2) scientific knowledge and methods, (3) relationships, (4) ethical and legal standards/policy issues, (5) individual and cultural diversity, and (6) interdisciplinary systems. On another side, they articulated six “functional competencies,” relating to service delivery and professional activities, including (1) assessment/diagnosis/conceptualization, (2) intervention, (3) consultation, (4) research/evaluation, (5) supervision/teaching, and (6) management or administration. Five developmental career stages make up the final side: (1) doctoral education; (2) doctoral internship; (3) postdoctoral supervision; (4) residency/fellowship; and (5) continuing competency. Importantly, the model’s developmental focus suggests that competence is a continual pursuit.
The cube model, though useful and concise, lacks specificity and behavioral anchors. To address these concerns, an Assessment of Competency Benchmarks Workgroup was formed, using the cube model as a guide (APA, 2006b). The group identified competency benchmarks, which indicate readiness for practice across three developmental stages (practicum, internship, and entry to practice), essentially operationally defining the cube model. The benchmarks were later revised (APA, 2012), leading to six competence clusters, 16 related competence benchmarks, and behavioral rating scales. One example of the essential components of each benchmark at the entry to practice level is included in Table 3.1.

The benchmarks are not licensure requirements or graduate curriculum requirements; rather, the document is meant to be used as a resource for graduate programs. Given that practitioners must be licensed psychologists to ethically use the term CSP, these benchmarks should be a starting point in the development of competencies in CSP, with sport-specific adjustments and additions.

### Competence in Applied Sport Psychology

Compared with the ample literature in the field of professional psychology, there is a dearth of information on competence in ASP. As noted above, to ethically use the title “CSP,” one must demonstrate competence in “sport.” Yet, defining competence in ASP has been relatively slow and fractured. To date, there are no generally agreed upon competencies for practice in ASP.

In 2000, members of APA Division 47 called on APA’s Council of Representatives to develop standards for psychologists who wanted to call themselves “sport psychologists”
Competencies of Clinical Sport Psychologist

Table 3.1 Summary of APA’s (2012) Competence Clusters and 16 Related Benchmarks

<table>
<thead>
<tr>
<th>Competence Clusters</th>
<th>Related Benchmarks for Cluster</th>
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<tr>
<td>Professionalism</td>
<td>(1) Professional values/attitudes (e.g., professional deportment); (2) Individual and cultural diversity (e.g., applies knowledge of self and others as cultural beings); (3) Ethical, legal standards, and policy (e.g., advanced knowledge of ethical standards); (4) Reflective practice/self-assessment/self-care (e.g., accurately assesses competence);</td>
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<tr>
<td>Relationships</td>
<td>(5) Relationships (e.g., relates effectively with others);</td>
</tr>
<tr>
<td>Science</td>
<td>(6) Scientific knowledge/methods (e.g., independently applies scientific methods to practice); (7) Research/Evaluation: (e.g., applies scientific methods to evaluate practice);</td>
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<tr>
<td>Application</td>
<td>(8) Evidence-based practice (e.g., independently applies knowledge of evidence-based practice); (9) Assessment (e.g., independently selects and implements multiple methods of evaluation); (10) Intervention (e.g., implements interventions with fidelity to empirical models); (11) Consultation (applies literature to provide effective consultation);</td>
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<tr>
<td>Education</td>
<td>(12) Teaching (e.g., didactic skills); (13) Supervision (knowledge of models);</td>
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<tr>
<td>Systems</td>
<td>(14) Interdisciplinary systems (e.g., initiates interdisciplinary consultation); (15) Management/Administration (e.g., offers constructive criticism regarding leadership and management); (16) Advocacy (e.g., promotes change at individual or systems levels).</td>
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Note: One example of the essential components of each benchmark at the entry to practice level is indicated in parentheses.

(APA, n.d.). In 2003, APA accepted the recommendation, and sport psychology became a formally identified proficiency area within APA, which was intended to protect the public. APA’s (n.d.) documents call for supervised service with athletes and sport-specific content knowledge. Yet, APA has not taken action to create a certification process, examination, or formal review of qualifications other than adding a self-assessment checklist in three areas (APA, 2005): (1) Specialized Knowledge (e.g., foundations of sport psychology, sport-specific assessment and mental skills, counseling issues with athletes, and biobehavioral bases of sport); (2) Knowledge of Persons and Groups (e.g., youth, high school, collegiate, professional athletes, athletes with disabilities, and injured athletes); and (3) Skills (e.g., goal-setting, visualization, confidence, eating disorders, grief, depression, loss, and career transition). While useful as a general guide, the checklist and proficiency descriptions were not written as benchmarks for entry to practice or goals for expertise, they are simply “recommendations for specialized knowledge” (APA, n.d.).

In 2003, the International Society of Sport Psychology (ISSP) published a position stand on competence in ASP (Tenenbaum et al., 2003). Their list of competencies ranged from knowledge areas in general psychology, sport psychology, and kinesiology to knowledge of research design and statistics. They also included practice-based techniques in sport performance, personal development, and critical interventions as well as supervised experience. Similar to the APA’s document, Tenenbaum et al.’s (2003) competencies do not appear to be based on research nor are their competencies measurable. In fact, the authors noted that they are simply non-exhaustive recommendations for education.

At present, the Association for Applied Sport Psychology (AASP; 2019) offers the only credentialing process in ASP, which now includes a standardized examination as part of its newly revised process for certification as a Certified Mental Performance Consultant (CMPC). There
have been several iterations of AASP’s certification requirements. At present, requirements include eight coursework areas, supervised experience with athletes, and a knowledge exam. There is no particular degree type required for certification. Rather, the required courses reflect the interdisciplinary nature of the field, as they include: Professional Ethics and Standards; Sport Psychology; Sport Science; Psychopathology; Helping Relationships; Research Methods and Statistics; Psychological Foundations of Behavior; and Diversity and Culture (AASP, 2019). Although this certification process requires passing classes and an exam, which certainly relates to competence in knowledge areas, the process does not measure skills, attitudes, or values that relate to competence and thus does not satisfy the multi-dimensional definition of competence.

Another event related to ASP competence is the relatively recent completion of the AASP’s Job Task Analysis (JTA; Rosen & Lipkins, 2016, p. 26), which states that ASP practitioners “employ an evidence-based understanding of the psychology of human performance to conceptualize and enhance the expression or improvement of performance, holistic well-being, and social functioning.” The JTA identified six general work domains, including (1) Rapport, Roles, and Expectations, (2) Assessment, (3) Goals, Outcomes, and Planning, (4) Implementation, (5) Evaluation, and (6) Professional Issues (Rosen & Lipkins, 2016). The domains were accompanied by 21 sub-tasks and 38 related knowledge areas, which are too detailed to enumerate here. There appears to be redundancy in some tasks, indicating that they are likely related to one competency. For example, task three is to “explain what is expected of the client/performer,” which is arguably similar to task four, “explain the consulting process,” which also resembles task five: “discuss and/or clarify the consulting process…” (Rosen & Lipkins, 2016, p. 27). Knowledge areas span from broad topics, like building rapport, to very specific issues, like neuropsychology of performance. I share these observations not as critiques of the report per se, but rather to point out that the JTA does not replace the need for stakeholders to identify and behaviorally anchor core competencies.

Several authors have critiqued these attempts to define competence in ASP. Most notably, Fletcher and Maher (2013) identified multiple flaws, including the fact that self-reflective practice is missing from each document above and the fact that most ASP competencies are not measurable. Moreover, Fletcher and Maher (2013) noted that too many of the competencies rely on self-assessment, which can be inaccurate. They then argued that Rodolfa et al.’s (2005) cube model would be effective in ASP. Moreover, Cruickshank et al. (2018) stated that past attempts to define ASP competencies are also faulty because they are not hierarchical, which suggests that each competency is of equal importance. They argued that decision-making and flexibility to apply knowledge across situations should be prioritized. A final critique is that, despite the JTA’s mention of well-being in ASP’s role, mental health is not listed in any ASP duties (Petrie, 2019).

Given these critiques, Fletcher and Maher (2013) called for an ASP conference, like the 2002 Competencies Conference. Petrie (2019) echoed this call and added that discussions should include the training required to practice under professional titles used in ASP. I agree that such conference is necessary; articulation of ASP and CSP competencies cannot be completed in silos. Perhaps, the difficulty in arranging a conference and agreeing upon competencies stems from the issue that Petrie (2019) and others wish to address: ASP practitioners come from kinesiology or psychology backgrounds, which lead to different competencies upon graduation and different philosophies. For example, Petrie (2019) questioned whether the definition of ASP in the JTA, which includes supporting athletes’ well-being, can even be accomplished without a mental-health degree. In sum, although AASP has revised its certification processes and added a knowledge exam, no organization has identified holistic, measurable practice competencies.
Competence for Clinical Sport Psychologists: Education and Training

As detailed above, it is logical that competent practice in CSP requires training in both clinical and sport psychology. Indeed, Hays and Baltzell (2016, p. 339) defined that a CSP is “a licensed psychologist who has knowledge regarding systemic, interpersonal, and intra-personal issues in the competitive sport context” with “particular competence to offer performance enhancement and well as clinical interventions.” They continued on to state that competent CSPs have three interdependent knowledge areas: (1) psychological skills training and performance enhancement techniques; (2) sport culture; and (3) psychological disorders. However, important unanswered questions related to Hays and Baltzell’s (2016) description of competent CSPs are: to what level must CSPs be trained in sport psychology to be competent in areas one and two above? How many sport psychology courses and/or what experience with athlete populations is necessary? As one CSP with particular experiences (doctorate in counseling psychology, licensed psychologist, CMPC), I cannot answer these questions alone. Moreover, it would be difficult to identify competencies in CSP without first having agreed upon ASP competencies.

Contributing to this difficulty is the fact that there are currently no accreditation processes for ASP graduate programs. Petrie (2019, p. 807) commented that the CMPC course requirements represent a “de-facto curriculum” that guides training; however, without program accreditation, students may be unsure which programs to select to achieve competence in ASP knowledge. Students pursuing a career in CSP, particularly those who also want to become CMPCs, must find programs that offer both clinical and sport coursework. Given that so few doctoral programs offer degrees in counseling/clinical psychology as well as sport psychology coursework, one time-consuming option is for students to pursue a master’s degree in sport psychology, in either kinesiology or counseling, and then a doctoral degree in clinical or counseling psychology.

To date, Petrie and Harmison (2012) have presented the most thorough recommendation for an educational training model in ASP. Because their model is grounded in a counseling psychology philosophy and would produce graduates who are eligible to become licensed psychologists, it appears appropriate for CSPs. They advocated for programs with the following core knowledge areas, using a combination of courses and/or experiences: (1) Sport psychology (e.g., sport psychology theory and interventions); (2) Exercise/Sport science (biomechanics or motor learning); (3) Counseling/clinical (abnormal psychology, psychological assessment, theories of counseling, cognitive-behavior therapy, counseling skills); (4) General psychology (social psychology, learning); (5) Professional issues (e.g., ethics and multicultural counseling); (6) Research and scholarship (e.g., courses in research methods and statistics, writing a dissertation, evaluating interventions); (7) supervised counseling/clinical practica (with diverse clients who have a variety of mental health issues); (8) Supervised sport psychology practice (with athletes of various ages, sports, and genders). This training model offers coursework and supervised practice that could lead to competence in knowledge areas of both professional psychology and ASP; therefore, I propose that it is appropriate to recommend as a training model for CSP.

To continue, Petrie and Harmison (2012) called for credentialing or recognition of graduate programs in ASP to ensure standardized training. Recently, AASP formed a Graduate Program Review Committee, of which I am a currently member, to begin such a task. The committee began its work in the spring of 2020 by identifying (tentative) accreditation standards and pilot rubrics to use when evaluating programs. The committee will then review several graduate programs that volunteered for a pilot review. If this process materializes into
a formal accreditation process, it may be easier for students to seek and document competence in sport psychology knowledge areas by way of attending an accredited program. However, for those who began careers prior to the professionalization of ASP, or for those who develop an interest in CSP after graduate school, the route to competence in ASP knowledge is less clear. The limitation remains that there is no formal guidance on the number of sport psychology courses (for those without sport psychology degrees) or the number of supervised hours working with athletes necessary to competently work as a CSP (for those who are not CMPCs). Notably, the CMPC coursework requirements include just two sport-specific courses (AASP, 2019); however, the required exam and supervised hours with athletes provide additional opportunities to achieve competence. Therefore, stakeholders in CSP must determine how licensed psychologists can gain foundational competence in ASP if they are not also CMPCs. I provide some initial suggestions in this regard within the section below.

**Competence for Clinical Sport Psychologists: Foundational Competencies**

The above section reviews potential training for CSPs, which is just one element of competence. Other key attitudes and skills must also be delineated. Only one published study has identified such competencies specifically for CSPs. Ward et al. (2005) recruited 20 licensed psychologists who were also certified consultants through AASP (now referred to as CMPCs) and also APA Division 47 members. Their sample represented 71% of the 28 practitioners who met all three inclusion criteria. First, the researchers agreed upon core competencies in CSP. Then, participants rated the 26 proposed competencies on the following three-point scale: “not necessary for competent athlete-counseling;” “a useful competency, but not necessary;” or “essential for competent athlete-counseling” (Ward et al., 2005, p. 323). The researchers retained items that achieved a minimum content validity ratio, which resulted in 17 “essential” competencies that they arranged into three categories: Knowledge, Attitude/Beliefs, and Skills (Ward et al., 2005, p. 326–327). Five essential knowledge competencies were: distinct sport/athlete culture; influence of athletic environment on clients; institutional regulations and how they affect athletes’ behavior; how race, culture, ethnicity affect interventions with athletes; and supervised experience with athletes. Attitudes/beliefs competencies included: recognizing that athletic identity may be as core as race; respecting coaches’ help-giving practices; respecting athletes’ beliefs about physical/mental training; awareness of one’s own values and biases about athletes and sport; and not automatically assuming that athletes’ issues are clinical. Seven skill competencies were: referring athletes to more qualified professionals when needed; prioritizing the counseling relationship when a dual relationship is unavoidable; accounting for culture when selecting techniques; intervening with institutions when appropriate but appreciating complexity of confidentiality in sport contexts; educating athletes/coaches on the counseling process; ethical consultation with coaches; and utilizing theories/techniques most compatible with athlete culture.

As Ward et al. (2005) noted, a clear theme in the essential competencies was knowledge of unique sport culture. Returning to the question of training, stakeholders must determine what experiences are necessary to achieve these core sport-specific knowledge, attitudes, and skills. A sport psychology ethics course (or related continuing education class) may be a logical starting point for building foundational competence for CSPs, given that such courses typically require students to analyze ethical dilemmas that require the skills that Ward et al.’s (2005) participants deemed essential (e.g., confidentiality in sport contexts, dual roles, and ethically consulting with coaches). It is possible that many of the above competencies could be gained by supervised experience with athletes (e.g., distinct sport/athlete culture and
influence of athletic environment); however, the essential competency of utilizing theories and techniques most compatible with athlete culture would be difficult to achieve without a sport psychology theory or applied course.

I believe that the 17 competencies described above are essential to effectively work as a CSP, though there is a need for additional research to determine if these competencies accurately reflect all current practices in CSP. Moreover, Collins et al. (2015) and Cruickshank et al. (2018) noted that decision-making and judgment are often undervalued in the proposed ASP competencies. I wish to similarly advocate for a foundational competency related to judgment, particularly because some clinical issues, like eating disorders (EDs), concussions, and substance abuse are related to serious physical health consequences that can be exacerbated by athletes’ physical training. For example, a CSP might have to decide if an athlete with anorexia is too symptomatic to train or they may need to assess an athlete with a concussion to contribute to the determination of when it is safe for the athlete to return to play. In these and other instances, clinical decision-making is of utmost importance and should, therefore, be prioritized in CSP competencies.

Moreover, given that just one study is available on the topic, it seems judicious to turn to theoretical models to guide the development of competencies in CSP. Just as Petrie (2019) suggested that Rodolfa’s (2005) cube model offers a template for ASP, I believe that the model should also be used in CSP. Knowledge and publications in CSP are increasing rapidly; therefore, CSPs must be willing to continue their education (Roberts et al., 2016), embracing a “culture of competence” (Roberts et al., 2005), which aligns with the competency cube model’s tenets.

Given the highly specialized nature of CSP, I also propose adopting another model: The competency constellation model (CCM; Johnson et al., 2013). Johnson et al. (2013, p. 347) define a competency constellation (CC) as “the cluster of relationships a professional has with people who take an active interest in and action to advance the individual’s well-being and professional competence.” These relationships include: “individual colleagues, consultation groups, supervisors” and others (Johnson et al., 2013, p. 244). Embedded in the model is the notion that competence is not solely the responsibility of the individual, but rather, it is a multi-level, socially interdependent, collectivist venture. As indicated in Figure 3.2, the individual is in the center of the model, followed at the next layer by the “inner core” of primary mentors. The layers continue to expand to the collegial community, collegial acquaintances, and professional culture, respectively. Johnson et al. (2013) proposed that an effective CC includes a broad range and density of membership. In addition, one must have strong ties within the constellation, evidenced by the regularity of communication and depth of disclosure.

Using CCM language, the field of CSP would benefit from a collegial community from which individuals could seek mentorship and identify supervisors to form an inner core. This process would require identifying those who can ethically practice as CSPs, who also have the six foundational competencies for CC membership: authenticity and self-awareness; other-oriented empathy; vulnerability and nondefensiveness; self-care; fluid expertise; and collegial assertiveness (Johnson et al., 2013, p. 350). Given the small number of individuals trained in both clinical and ASP, it seems feasible to organize this type of collegial community.

**Continuing Competence for CSPs: Sport-Specific Risk Factors and Related Disorders**

Although conversations between stakeholders are necessary before core competencies can be proposed in CSP, it is possible to identify particular sport-specific risk factors and related disorders that are most relevant to CSPs. Notably, Arnold and Fletcher (2012) identified 640
stressors faced by athletes. Although it is unreasonable to expect CSPs to assist athletes with each of these stressors or to have expertise in all disorders that athletes experience (Gardner & Moore, 2006), it is reasonable to suggest that CSPs should develop competence related to several common sport-specific triggers that are known to have mental health consequences such as sport injury, career transitions in sport such as retirement, and sport burnout. Although not an exhaustive list, these experiences are related to anxiety, depression, suicidality, EDs, and substance abuse. Notably, each of these stressors and clinical issues appears in the APA’s (n.d.) document on proficiency in sport psychology. This book includes chapters dedicated to these topics, but a brief review is included here to denote their relevance to the competence in CSP.

**Psychology of injury.** It is highly probable that CSPs will treat clients with sport injuries, given that injury is a common sport-specific stressor (e.g., Arnold & Fletcher, 2012). Although many athletes recover with relatively little difficulty, others encounter serious psychological distress. If the athlete has a very strong athletic identity, an injury can disrupt psychological and social functioning (e.g., Christino et al., 2015). This finding may explain why Ward et al.’s (2005) participants described understanding the importance of athletic identity as an essential competency for CSPs. Some possible clinical reactions to injury are depression, suicidality, and anxiety including reinjury anxiety (e.g., Christino et al., 2015). Similarly, athletes who sustain concussions may experience psychological symptoms including increased depression (e.g., Kontos et al., 2012). Overall, severe injuries can trigger grief-like reactions that rise to the clinical level in 10–20% of athletes (Walker et al., 2007), possibly triggering suicidal behavior (Wiese-Bjornstal et al., 1998). Moreover, athletes who
struggle to cope with an injury may abuse substances to manage pain (Martens et al., 2007). Elite athletes have also reported that they began restricting their caloric intake, which led to EDs due to concerns about weight gain or loss of fitness while away from training due to injury (Arthur-Cameselle et al., 2017).

**Transitions and career termination.** Transitions in sport present developmental shifts that require adjustment and adaptation. The most relevant transition for CSPs is likely to sport career termination (retirement), which may be normative and expected (e.g., graduation and thus an end to one’s college athletic career) or non-normative and abrupt (e.g., career-ending injury) (Stambulova et al., 2009). Literature indicates that non-normative terminations (e.g., injury and cut from a team) lead to greater psychological difficulty for athletes and that negative reactions to termination include drug use, depression, and suicide (Park et al., 2013). Moreover, a stronger athletic identity is associated with poorer adjustment to transition (Park et al., 2013).

**Sport burnout.** Researchers have tested theories on causes of sport burnout, leading to explanations of risk factors within the sport environment. Studies indicate with some consistency that female athletes and individual sports athletes are at higher risk for sport burnout (e.g., Cremades et al., 2008), as are athletes who report low satisfaction of basic psychological needs such as autonomy and competence (Hodge et al., 2008). Researchers have examined the relationship between sport burnout and depression, with several studies finding that the two are positively correlated in both elite youth athletes (e.g., Gerber et al., 2018) and adult collegiate-athletes (Martignetti et al., 2020), which indicate that for many athletes, symptoms of sport burnout represent a concurrent serious mental health issue.

**Anxiety, depression, and suicide.** There is growing consensus that athletes are at risk for anxiety, depression, and suicide to the same degree as non-athletes (e.g., Rice et al., 2016). For example, collegiate athletes experience depression at similar rates to non-athlete peers (Wolanin et al., 2016). Although most CSPs have experience treating clients with depression and anxiety, it is important that they understand sport-specific triggers, some of which are reviewed above to inform interventions for athletes. For example, athletes’ risk for suicide is believed to be higher following sport performance failures (Rice et al., 2016).

**Eating Disorders.** Licensed psychologists may also be accustomed to treating clients with EDs but may not be aware of unique triggers in the sport environment for symptom onset and maintenance. A primary sport-specific trigger is performance pressure, particularly in gravitational sports where there may be a performance advantage to low body weight or in aesthetic sports, where one’s performance is judged (Ackland et al., 2012). Revealing uniforms, public weigh-ins, critical comments from coaches, and sport injuries are additional triggers unique to competitive sport (e.g., Reel et al., 2010). Given that EDs appears to be more common in some athlete subgroups than the general population (e.g., Bratland-Sanda & Sundgot-Borgen, 2013), I recommended that CSPs have knowledge of sport-specific triggers and athlete treatment recommendations or, at a minimum, know ED symptoms well enough to assess their presence and refer athletes for specialized care as needed.

**Substance abuse.** Substance misuse can be particularly complicated to treat in athlete populations. Athletes abuse substances like alcohol for recreational purposes, typically at higher rates than non-athlete peers (e.g., Barry et al., 2015), but they may also abuse substances for sport-specific reasons such as managing performance anxiety and coping with pain from injuries, as well as for performance enhancement (see Martens et al., 2007 for a review). Relatedly, CSPs should be aware of rules from national and international organizations like the World Anti-Doping Agency regarding banned substances so that they can provide accurate psychoeducation to athlete clients who may knowingly or unknowingly commit drug-related rule violations.
Competence in Clinical Sport Psychology: Conclusions

To summarize, the identification and measurement of foundational competencies in the field of CSP is in its infancy. Although authors have referred to the importance of competence for CSPs, they have rarely defined the construct or employed existing models from professional psychology to enumerate specific competencies. In this chapter, I have argued that the creation of measurable competencies in CSP cannot begin until key stakeholders discuss core knowledge, attitudes, and skills. Although this task may seem daunting, there are established models to draw from, including a proposed training model (Petrie & Harmison, 2012), as well as the competency cube model (Rodolfa et al., 2005), the CCM (Johnson et al., 2013), and competency benchmarks in professional psychology that pertain to CSPs (APA, 2012).

At present, the only option to formally document training in clinical psychology and ASP in the United States is to become a licensed psychologist and CMPC. However, Petrie (2019) noted that completing both tasks could take eight or more years, which may deter applicants given that the benefits of achieving CMPC status may be unclear for licensed psychologists. His comment aligns with my experience; although I finished my supervised hours with athletes many years earlier, I did not apply for CMPC until I left a full-time counseling position for academia and wanted to mentor students seeking to become CMPCs. Moreover, only four of Ward et al.’s (2005) 20 participants rated certification as an “essential” competency. Overall, what is clear from Ward et al.’s results (2005), my own clinical experiences, and numerous others’ accounts is that knowledge of sport-specific contexts is essential for effective clinical treatment for athletes. Although stakeholders must collectively determine competencies for CSPs, I recommend that courses (or substantial continued education) in sport-specific ethics and sport psychology theory/techniques, as well as supervised experience with athletes, should be minimum expectations for licensed psychologists (without degrees in sport psychology or CMPC status) who wish to practice as “clinical sport psychologists.”

When core competencies for CSPs are eventually identified, it will be important to note that CSPs will also need additional specialized training if they wish to serve athlete populations of all ages. For example, a CSP who wishes to work with youth athletes must have the necessary training to provide psychological services to children competently. Likewise, a CSP with clinical expertise only in child psychology would first need training with adults before treating adult athlete populations. These are just two examples of why, as noted in the models described within this chapter, it is necessary to view competence as a continual pursuit. Finally, irrespective of the specialized populations served, I believe that it is essential for CSPs to exhibit competence in decision-making (Cruickshank et al., 2018), particularly related to the many ways in which the sport environment, intense physical training, and sport competition intersect with or exacerbate clinical mental health issues.

References


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