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RESEARCH ARTICLE

Psychiatric Treatment with Elite Athletes: A Stepwise Approach to Mitigate Risk

Andrew M. Manocchio[1], Abigail O. Akpobiyeri[1], Mark A. Stillman*[1]

[1]Department of Clinical Psychology, College of Health Professions, Mercer University, Atlanta, GA, USA

***Corresponding author:** stillman_ma@mercer.edu

ABSTRACT

Research has suggested that elite athletes display a proneness to psychopathology, as well as increased likelihoods of engaging in risky behaviors, compared to the general population. This review addresses a gap in the literature pertaining to the pharmacotherapeutic and psychotherapeutic modalities in sports settings, resulting in either monotherapy or combination therapy. We advocate for a risk-benefit assessment to guide this process, with an aim to implement the least invasive, pragmatic option for intervention. This assessment is informed by weighing potential barriers to psychotherapy with elite athletes, (e.g. stigma, time constraints, altered expectations of outcomes, and personality factors) against the benefits and barriers of pharmacotherapy (e.g., side effects that may impact performance). We recommend evidence-based practices that align with a balance of both the athlete's and the organization's goals; ultimately, preserving the well-being and rights of the athlete. Finally, treatment must be tailored to address variables that are relevant to elite athletes (e.g., side effects impacting performance, altered expectations, doping regulations). We suggest the notion of "flexibility within fidelity" in our stepwise guide, in that there can be fluidity and movement across the assessment stages to adjust recommendations as needed for the sake of optimizing the athlete's care and goals.

Introduction

Literature from the last several decades has identified a heightened risk for clinical symptomatology and clinical disorders in elite athletes, some even categorizing such athletes as a vulnerable population.[1,2] Reports of these concerns include elite athletes demonstrating a propensity for death by suicide, problematic gambling behaviors, and binge drinking.[3-5] Glick et al[6] demonstrated the scope of this issue by identifying a 60% prevalence rate for eating disorders in female athletes, particularly to maintain or attain physiques that would optimize athletic performance. Elite athletes are often subject to injuries which may impact their ability to perform that subsequently affects their livelihoods. Thus, injuries have been shown to augment their risk for pathology. In particular, Leddy et al[7] reported higher rates of anxiety, depression, and low self-esteem in injured or recovering athletes compared to a group of healthy athletes. In the case of elite athletes, their circumstances are unique - clinical syndromes, disorders, and/or isolated symptoms can have a detrimental impact on athletic performance which, in turn, can have resulting psychiatric consequences. Thus, prior literature has advocated for disrupting this problematic cycle via various methods.[2]

Prior literature has provided a review and theoretical structure for understanding the different treatment options available to integrative treatment teams when engaging in psychiatric work with elite athletes.[2] Such include pharmacotherapy, psychotherapy, or combination therapy. The foundations and implications of such interventions are well-documented.[8-11] However, the nature of this work is often preventive, educating treatment providers of the costs and benefits to the isolated modalities or combined approach. For example, prior work solidifies the effectiveness of psychotherapy for individuals, families, and groups, but the question remains whether these findings apply to elite athletes as a unique population.[12,13] There is scarce literature, some of which is anecdotal, that investigates psychotherapy as a sole mode of intervention for elite athletes. Some of such work demonstrates cognitive-behavioral interventions to be efficacious.[9,14,15] Additionally, pharmacological interventions are quite effective in isolation, but utilization is cautionary given their side effects.[8,10,11]

Rationale for Combination Therapy

The nuanced nature of navigating the psychiatric treatment process with elite athletes requires sports psychologists to be flexible when considering treatment options and implementing treatment. To be clear, there is repeated evidence that pharmacotherapy alone, psychotherapy alone, and combination therapy are all effective. Thus, we advocate for the recommendation of Glick et al[1] to utilize all pharmacological and psychotherapeutic interventions that are at the disposal of the provider and to add, subtract, and/or modify aspects of such via risk-benefit assessment.[1,2] Ideally, this assessment is conducted by an integrative team that includes synergy and expertise of trainers, sports psychologists, sports psychiatrists, physicians, etc., who are all aligned with the ultimate goal of improving the athlete's personal functioning and effectively addressing their athletic concerns (e.g., performance-based metrics).

When any intervention is implemented, three outcomes are possible: no effect, negative effects, and positive effects; however, such are uniquely modified in their characterization in the context of combination therapy. Specifically, when no effect results from a combination approach, it may still mean that the monotherapies yield some positive effects in isolation that are simply not potentiated when paired with another monotherapy. Although less common, similar mechanisms may be at play when a negative effect is yielded, in that either monotherapy could have a combination modulate their individual effects. Regardless, negative effects would indicate that the intervention was harmful to the elite athlete because their symptoms were exacerbated by treatment.

With regard to positive outcomes associated with combination therapy, there are three conceptual models that encapsulate their mechanistic qualities: additive, facilitative, and synergistic.[2] In additive models, the two monotherapies have a summed therapeutic effect, their respective benefits that occur in isolation are preserved, and the benefits of each can be clearly delineated. When the positive outcome is facilitative, one therapeutic modality is likely superior to the other, and the combination of the modalities results in a net increase in therapeutic effect. The modality that is inferior in yielded benefits compared to the seemingly stronger modality appears to "unlock" therapeutic gains that would otherwise not be possible. Glick et al[16] describes an example of the facilitative model, in which clinical practice for treating schizophrenia-like presentations often utilizes pharmacotherapy to address positive symptoms (e.g., hallucinations, delusions) in order to permit a state for the client to be amenable to psychotherapeutic intervention. Finally, synergistic outcomes resulting from combination therapy are characterized by achieved therapeutic benefits that exceed the

individual capacity of either monotherapy, even further than what would have been achieved should their efficacy have been summed. Altogether, the neutral, negative, and positive outcomes that may be yielded from the implementation of combination therapy demonstrates the importance of the aforementioned risk-benefit assessment to determine if either monotherapy (i.e., pharmacotherapy, psychotherapy) or combination therapy is warranted. Thereafter, if combination therapy is warranted, investigating whether pathophysiology could be a key factor should be considered to elicit target treatment outcomes.[2,17] These considerations highlight the value of having multiple therapeutic modalities at one's disposal and the utility of having an integrative team to conduct a risk-benefit assessment of these modalities.

The Stepwise Guide

Previously, we noted 1) that the athlete population is one subject to psychiatric vulnerability, 2) the implications for treatment modes (i.e., pharmacotherapy, psychotherapy, or combined treatment) are nuanced and even unclear at times, and 3) combination therapy provides unique opportunities for therapeutic outcomes, but should not be applied dogmatically given recommendations for intervention to be parsimonious, effective, and beneficial. It appears that there are a multitude of variables for clinicians to consider when engaging in clinical work with elite athletes. Yet, there is a lack of literature that directly provides a coherent guide for sports psychologists and the integrative team to abide by when assessing treatment options for psychiatric conditions. Thus, the purpose of the current review is to address the relevant need to develop a stepwise guide that treatment providers, especially those navigating integrative teams, may refer to in an aim to provide elite athletes access to optimal treatment that integrates consideration for their unique limitations (e.g., awareness of interventions that would impact athletic performance). Consequently, the scope of the current guide is to describe 1) a flow for variables of consideration for both pharmacotherapy and psychotherapy, 2) a guide for selecting whether a monotherapy or combination approach is indicated, and 3) a general blueprint for the execution of the selected model.

STEP 1: PHARMACOTHERAPY

In alignment with our aim to utilize the least invasive, parsimonious, yet clinically effective intervention option, medication should be considered first and ruled out only if appropriate before assessing other modalities. The reason for beginning with medication options is rooted in the difficulties that commonly arise with regard to the utilization of psychotherapy with the elite athlete population. First, stigma associated with psychotherapy often deters athletes from considering its use due to sentiments (on societal and individual levels) that the athlete is weak, untrustworthy, or even crazy.[1,6] There have been recommendations to mitigate these perceptions, including 1) indicating to the athlete that the focus of the therapeutic work can be on athlete-specific concerns as well as normalizing the intervention mode to friends, family, teammates, and their coaches and 2) reframing individual psychotherapy as "performance help" that targets symptoms that would inhibit their athletic performance.[18] Second, athletes may come to expect "special treatment" during the course of their athletic careers, which may reduce their willingness to engage in the necessary behaviors to fulfill their role as "client" in the therapeutic relationship. For example, they may expect assistants and agents to handle communications with therapists, may have reduced flexibility in terms of when and where therapy sessions occur, and may demonstrate inconsistency in payment for their services if they are external to their respective organization.[1,6,19] Thirdly, personality factors have proven to be a variable with implications for psychotherapy with elite athletes, particularly narcissism and aggression.[18] These traits are likely to diminish the likelihood that the athlete will seek services at the outset and even if services are sought, their expectations regarding the course of treatment outcomes may be problematic (e.g., timeline for therapeutic change).[6] Further consequences of narcissistic and aggression tendencies may include grandiosity, as well as altered empathy and a propensity towards anger in psychotherapeutic work.[11,18]

The aforementioned variables that are often implicated in the utilization of psychotherapy with elite athletes inform a standpoint in which psychiatric medication will be the primary point in our decision tree. However, the inherent risks of using medication for the treatment of elite athletes will need to be assessed. We would like to clearly state that we do not necessarily advocate for medication as first-line treatment but assert that pharmacotherapy-based options should be considered first.

Step 1a. First, the clinician must assess whether the presenting concerns of the athlete are expected to be transient - their symptoms are normative given a particular event (e.g., grief). Depending on the course of their clinical presentation, it is recommended that the integrative team consider

whether it would be warranted to continue to explore pharmacotherapy or to skip to psychotherapy-based options (e.g., whether their grief-related symptoms exceed expected timelines and are causing clinically significant distress).

Step 1b. Second, there should be careful consideration of the athlete's family history, psychiatric history, and medication history to assess for risks of employing any one medication regimen. Such concerns that arise from this assessment could include, but are not limited to: allergies, a personal or family history of harmful response to the medication of interest, and/or inherent risk of using certain medications given a diagnosis or target symptom (e.g., misdiagnosis). For example, cautions against the utilization of antidepressants to treat bipolar depression, rather than unipolar depression, due to risk for a treatment emergent affective switch.[20,21]

Step 1c. Thus far, the factors that we have recommended be ruled out before employing pharmacotherapy with elite athletes are relevant to nearly all populations seeking services. Some factors, however, are unique to athletes, including whether a specific medication and/or class of medications may negatively impact their performance. Conversely, medications may augment their performance which would put them at risk for violating doping regulations.[10] We refer those interested in the nuance of such implications to Reardon and Factor[10] who put forth an encompassing review of psychiatric medications used in the elite athlete context.

Some specific examples of pharmacotherapeutic factors include antidepressant class drugs like paroxetine and fluoxetine that have been shown to have no impact on athletic performance. However, their relative bupropion has shown some effectiveness in augmenting one's endurance in heat related to its modification of perceived effort in such environments, though it is worthy of note that there is inconsistency in these reported findings.[22-24] There is additional variability in research investigating which pharmacodynamic mechanisms of these antidepressants enhance performance, but most report their dopaminergic action to be the culprit.[24,25]

Mood stabilizers also present their own concerning properties, especially lithium and valproic acid. When lithium is prescribed to an athlete, it is recommended that dosing be discontinued ahead of any physical exertion, and caution is expressed due to unfavorable side effects that are likely to impact athletic performance (i.e., weight gain, tremors, dehydration).[26, 27] The variables of concern regarding using medication with the elite athlete population are demonstrated by reported preferences of sports psychiatrists across the literature: 1) 63% preferred fluoxetine to other antidepressants since weight gain is not an expected side effect,[26] 2) 58% preferred valproic acid to other mood stabilizers since weight gain, tremors, sedation, and dehydration are not expected side effects,[28] 3) avoidance of beta-blockers as an anxiolytic since such have been correlated with reduced muscle strength,[28] and 4) avoidance of sedative hypnotics (for either sleep and/or anxiety) since such have been associated with reduced output impacting athletic performance.[29] Separately, pharmacotherapy-based options could result in performance enhancement, which could place the athlete at risk for violating anti-doping policies. Some such issues could include beta-blockers and stimulants (especially for athletes with ADHD), which have been correlated with elevated fine motor control and increases in strength, endurance, and heart rate, respectively.[26,30,31] Altogether, the integrative team must consider the range of aforementioned variables when selecting or ruling out medication options.

Step 1d. In the final assessment point for Step 1, we recommend that the integrative team consider variables that can serve as a transition to assessing psychotherapy (Step 2). This may include circumstances in which pharmacotherapy and psychotherapy are used in tandem and the projected timeline for observing therapeutic effects of medications may not coincide efficiently with the treatment plan. For example, selective serotonin reuptake inhibitors (SSRIs) have been shown to take at least six weeks to begin manifesting therapeutic effects.[32] If the criteria for psychotherapy are met (discussed further in Step 2), we recommend beginning psychotherapeutic intervention strategies in concert with the selected medication(s), while minimum drug concentration reaches therapeutic levels.

Finally, with target timelines for therapeutic change set, the integrative team can use this transition point to assess whether the athlete themselves are satisfied with a tentative approach before assessing psychotherapeutic options. Regardless, we recommend presenting at least some education regarding details and potential benefits of psychotherapy to the athlete in either scenario. In other words, flexibility to meet athlete preferences will be vital throughout the course of treatment selection.

STEP 2: PSYCHOTHERAPY

As the integrative team moves to consider psychotherapy, the team may have selected a pharmacotherapeutic intervention or opted to consider psychotherapy as a potential isolated approach for addressing the athlete's presenting concerns. In justifying the assessment of medication options as the starting point for the treatment of certain clinical presentations for elite athletes, Step 1: Pharmacotherapy conveniently highlighted some of the relevant factors when working with the population of interest (e.g., personality factors, stigma, altered expectations for services). Specifics regarding options for psychotherapy will not be reviewed here, but we refer those interested to Glick et al[1] for an overview of modalities at the disposal of the clinician.

Step 2a. Similar to Step 1b, the clinician should consider factors that are expected to have relevance for psychotherapy. Again, this includes family and personal psychiatric history, history of psychotherapeutic treatment, as well as potential barriers to treatment. Answers to these questions will help elucidate aspects of treatment that are expected to work or be counterproductive.

Step 2b. The integrative team should revisit the nature of the presenting concern. For example, whether there are family-related variables at play (e.g., personal conflicts within the family unit), as well as some athlete-specific concerns that may include performance anxiety as a core factor, or whether there are teammate cohesion or coach-player relationship concerns.

This step of the decision-making tree is perhaps the most sensitive to role-related misunderstandings within the integrative team. It must be clarified whether a psychiatric symptom or disorder of clinical threshold contributes to the issue at hand. For example, teammates may experience cohesion concerns when they are competing for starting roles, which could be rooted in significant performance anxiety or normative competitiveness. Understanding the complexity of athletes' presenting concerns is imperative to selecting treatment options and understanding whether either modality is ultimately appropriate. Usefully, many subthreshold concerns can be addressed with psychotherapeutic techniques in the short-term within the context of working with elite athletes (e.g., solution-focused strategies, cognitive restructuring, motivational interviewing).

Step 2c. The next and final step of psychotherapy is the integrative team's collaboration with the elite athlete, coaches, and/or other members of the organization to understand treatment goals. Of note, this can be a nuanced process given the need to protect athlete confidentiality when working with certain presenting concerns or referral reasons. Specifically, it should be clearly understood whether the goal of the intervention is to address symptoms that interfere with athletic performance, personal functioning, teammate cohesion, coach-player relationships, etc. However, a unique responsibility of the sports psychologist will be balancing the agreed-upon goals with the ethical codes of the American Psychological Association.[33] Understanding each party's treatment goals will guide whether psychotherapy is necessary or whether the issues of concern can be addressed with less formal methods (e.g., a "sit down" with two players or a player and coach).

STEP 3: SELECTION

Thus far, we have reviewed the range of variables that are at play when navigating interventions for elite athletes, some of which have applicability when working with clinical populations broadly and, some, idiosyncratic and athlete-specific. We now aim to provide guidance for the sports psychologist and integrative team when selecting an intervention model (i.e., pharmacotherapy, psychotherapy, or combination therapy), though the following are through the lens of the sports psychologist. We encourage each professional to consult with their colleagues for expertise in other implicated areas (e.g., sports psychiatrist, physicians, physical therapists). We further recommend that this process be applied with flexibility to achieve target outcomes while simultaneously preserving the athlete's interests.

Step 3a. Here, the integrative team may conclude impressions of psychiatric symptom(s) and/or disorders in light of the presenting concerns. Concluding clinical impressions presents another unique challenge for professionals working with elite athletes due to issues with the heterogeneity between clinically significant symptoms and normative behavior of athletes.[1] Some such examples would include an athlete presenting with symptoms of fatigue, decreased cognitive efficiency, weight change, as well as reduced appetite and motivation. The aforementioned symptoms characterize both over-training syndrome (OT) and depression which share some diagnostic criteria.[34] Athletes commonly engage in ritualistic behaviors that could alert a clinician to the possibility of obsessive-compulsive disorder (OCD); however, such are differentiated from OCD-related repetitive behaviors. Particularly, these behaviors are likely restricted to a limited range of settings

(e.g., locker room, playing field) and do not impact overall life functioning.[10,35]

Step 3b. With diagnostic impressions collected, the sports psychologist can initiate the process of examining what constitutes evidence-based practice for the target psychiatric symptoms (refer to guidelines outlined by the APA Presidential Task Force for Evidence-based Practice for further information).[36] The APA Society of Clinical Psychology (Division 12) offers resources for practitioners to refer to regarding evidence-based treatments for clinical presentations. Yet, this information must be considered in light of the aforementioned limiting athlete-specific factors. For example, although utilizing SSRIs and cognitive-behavioral psychotherapy is aligned with evidence-based practice, using SSRIs may be modified given risks that could be associated with impacting athlete performance. More concisely, regardless of what constitutes best practice for the athlete's clinical presentation, selection and modification of such will be informed by the assessment of factors outlined in Steps 1 and 2.

Step 3c. Once a proposed therapeutic approach is selected, the integrative team must view the selected methods within the context of the elite athlete, specifically, what is feasible and practical given any relevant factor. This could include time-related availability, personality factors, and level of impairment.[1] The clinician will aim to extract the most therapeutic benefit from the least degree of intervention. When working with the elite athlete population, the sports psychologist must, at times, forgo the aspiration to achieve the highest degree of therapeutic change in an effort to align with the minimally invasive yet clinically effective method. Nonetheless, attaining the goals of the athlete, coaches, and/or organization should remain at the forefront of therapy selection.

Step 3d. Next, we recommend that when the proposed treatment model (informed by Steps 3a-3c) is characterized by a combination approach (both pharmacotherapy and psychotherapy), the model should be viewed through the lens of the previously outlined conceptual models (i.e., additive, facilitate, synergistic). This lens will support the integrative team in understanding projected timelines and/or expected change that will be yielded when a combination approach is utilized. For example, a team of professionals may prescribe an SSRI class drug in combination with cognitive-behavioral psychotherapy. The team may hypothesize, depending on athlete-specific factors, that the interaction between the pharmacotherapeutic and psychotherapeutic arms of the intervention will lead to synergistic gains (i.e., the combination will lead to positive change that exceeds what either could have achieved independently). Conversely, the team could predict the relationship to be facilitative (i.e., a monotherapy unlocks the capacity for another monotherapy to have superior therapeutic effects). In this case, the cognitive-behavioral psychotherapeutic aspect will facilitate adherence to the SSRI class medication, which will permit the pharmacotherapeutic arm to engage its full expected effect. Assessing the proposed treatment model from a conceptual perspective will elucidate the intervention element expected to be most dependent on the other therapeutic form (e.g., an aim to have psychotherapy aid the effectiveness of an SSRI). This may provide information on expected timelines, especially when change is expected to be contingent on a specific, well-researched medication.

Step 3e. Finally, we invite the sports psychologist to encourage their team to reassert that all selected practices have been 1) screened through the recommended risk-benefit analysis informed by all information elaborated on in Steps 1-3, 2) is agreed upon by the athlete, coaches, and/or organization, and 3) the confidentiality, safety, and well-being of the athlete is prioritized, which should be clearly communicated to all parties involved, including any agreed upon limitations to confidentiality. We emphasize that we do not advocate for any one monotherapy or for combination therapy, but instead recommend that all practice be evidence-based, with the aforementioned adjustments being implemented where appropriate.

Execution

We have thus far outlined a stepwise guide for assessing the myriad of variables a sports psychologist and/or integrative team should be attune to as treatment plans are developed for elite athletes. When clinicians work with integrative teams, challenges may arise, including ascertaining clear communications between team members and team members demonstrating an understanding of each professional's roles. The sports psychologist may face unique challenges in such teams, especially within sports organizations. Adversities may include navigating hierarchies within the team, advocating for the player as the consumer of care within an environment in which the athlete is expected to "perform" at an elite level, and addressing discrepancies in expectations between players and the organization's other personnel.[37]

When executing the final, agreed-upon treatment approach, we advocate for consistent and regular consultation between the integrative team members which should be informed by progress monitoring relevant to the elite athlete's concerns. However, barriers may arise when implementing such an approach which has been discussed in prior literature, particularly in the context of organizational settings.[38,39] Nonetheless, the elite athlete's athletic performance will regularly be a relevant factor in the context of sports organizations, which will likely lead to performance-related metrics being an inevitable dimension to integrate into treatment team discussions. When the integrative team's client is the elite athlete, the licensed psychologist's core responsibilities do not change, despite one of their main roles serving the interests of the relevant sports organization. As we alluded to before, a balance will need to be achieved and maintained throughout therapeutic work with the elite athlete and organization to protect any confidentiality, expectations, modalities, or roles that were agreed upon prior to the initiation of the intervention. Regardless, we emphasize the instruction of Kendall et al[40] regarding "flexibility within fidelity" with adjustments to fit within the treatment protocols for elite athletes. Specifically, the clinician adheres to evidence-based practice that is feasible within the relevant sports setting and is simultaneously willing to adjust such practices as necessary to optimize "fit" for the client. For example, within the context of the pharmacotherapy arm of athlete-specific interventions, although lithium may be initially indicated as best-fit for the client experiencing mood concerns, their role as an elite athlete would demand flexibility for opting for an alternative (e.g., valproic acid) to avoid the expected side effects of lithium (i.e., weight gain, tremors, dehydration) that may impede their ability to perform on the playing field.[10,26-28] We suggest extending the notion of "flexibility within fidelity" to all steps in our stepwise guide, in that there can be fluidity and movement across the assessment stages to adjust recommendations as needed for the sake of optimizing the athlete's care and goals. For extension of "flexibility within fidelity", see discussion regarding its implementation into evidence-based practice.[41]

Conclusion

A range of research has suggested that elite athletes display a proneness to some pathology, as well as increased likelihoods of engaging in risky behaviors, compared to the general population.[3-7] There has been substantial work conducted to understand what therapeutic tools are at the disposal of clinicians working to address such concerns as well as to elucidate how these therapeutic tools can be used most optimally.[1,2,10,11] In our review, we sought to address a void in the literature that integrates knowledge from the body of work pertaining to the proper, systematic assessment of pharmacotherapeutic and psychotherapeutic modalities available to integrative teams working in sports settings, which can result in the utilization of either a monotherapy or combination therapy. We advocate for a risk-benefit assessment to guide the selection process.[1]

In Step 1: Pharmacotherapy, we provided a rationale for beginning this assessment with consideration of medication-based intervention options so as to provide an opportunity for what is potentially the least invasive, pragmatic option for intervention. Other concerns arise when medication is used in the context of elite athletes, which includes concerns for side effects (positive or negative) and caution for violating doping regulations.[26-29] In Step 2: Psychotherapy, we reiterated concerns regarding the implementation of psychotherapy with elite athletes, including stigma, time constraints, altered expectations of outcomes, and personality factors.[1,6,19] Once limiting factors were assessed, we directed consumers of our guide to Step 3: Selection, which echoed the core animus of providing therapeutic interventions to elite athletes. This involves engaging in evidence-based practice that aligns with a balance of both the athlete's and the organization's goals, with the added caveat that the clinician is ultimately held to the standards of the American Psychological Association[33] for preserving the well-being and rights of the athlete. Step 3: Selection also emphasized the importance of synthesizing the information gathering conducted in Steps 1 and 2 to project expected outcomes and timeline via additive, facilitative and synergistic conceptual models when combination therapy is utilized.[2] Finally, Step 4: Execution, asserted the need for the integrative team to work in synergy to flexibly pursue the common goal of addressing the elite athlete's presenting concerns and to achieve whatever goals are set collaboratively between the athlete, coaches, and other organization personnel.

We advocated for the recommendation of Kendall et al[40] to embrace "flexibility within fidelity" when utilizing the current stepwise guide. In this case, such is aimed at acknowledging that although a clinician and/or integrative team can aim to have their work guided by evidence-based practice, intervention in the elite athlete context must be tailored to address variables that are relevant to elite athletes (e.g., side effects impacting performance, altered expectations, doping regulations). Additionally, when utilizing our guide, we suggested extending

the ideas of Kendall et al[40] to have professionals embrace a willingness to fluidly explore the various steps in our guide, including revisiting steps that had been addressed priorly. Such a suggestion is aimed at augmenting opportunities for providing the elite athlete with the most efficient, least invasive, pragmatic, and simultaneously therapeutic intervention model. Although research is limited with regard to controlled clinical trials that would ascertain best practice when working with elite athletes, we hope that our review may contribute to the menu of literature that works on developing theoretical and conceptual models to implement care for elite athletes.[42] Regardless of what guide or models are utilized to dictate therapeutic interventions, we defend the elite athlete's needs and functioning as primary to any goals that are outlined at the outset of treatment.

Conflict of Interest Statement

The authors have no conflicts of interest to declare.

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