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About the author

Dr Amy Izycky is a clinical psychologist and a psychodynamic psychotherapist specialising in neuropsychology. She graduated from Durham University with an honours degree in psychology and a master's of science in developmental psychopathology. She later went on to complete her doctorate in clinical psychology at Newcastle University and more recently completed her postgraduate diploma in clinical neuropsychology at Glasgow University. Dr Izycky has trained with the North of England Association of Psychoanalytic Psychotherapists (NEAPP) to achieve her Psychodynamic Psychotherapy registration. She represented Durham University as a high-performance rower, competing at national level before going on to compete at club level for many years.

Dr Izycky has a well-established private practice in the North-East of England. She specialises in brain injury, sports-related presentations and adjustment to injury and disability. She works with a variety of international and professional sportspeople who present with mental health difficulties and struggle to adjust to injury and retirement. She has written for peer-reviewed journals, academic texts and *The Guardian*.

INTRODUCTION

Where it all began

Never before has a topic been of such interest to the sporting world and the general population. As more and more sports personalities talk about their own mental health difficulties and internal struggles, we are slowly starting to understand more about the psychology of the successful athlete. So far, many sportspeople have written biographies and have attempted to share their stories. This book intends to go one step further where, as a clinical psychologist, psychodynamic psychotherapist, and a sportsperson myself, I have sat down with athletes and had a conversation with them about their difficulties. They have courageously allowed me to explore these difficulties with them, play around with some ideas, and share them with you through a psychological lens. My ultimate aim, and theirs, is to increase awareness and to inspire further conversation and discussion. We hope that you may find enjoyment, compassion, and understanding in their stories.

I was first exposed to the world of high-performance sport at the age of 19. I was a young and vulnerable girl who was trying to develop into adulthood. I was living away from home for the first time and within two months of me leaving home my mother was diagnosed with breast cancer. I was told to stay at university and continue with my studies. I'd given rowing a go during freshers' week, and as the

year progressed I was doing well within the world of college rowing. At the end of my first academic year I won my first novice cup and was spotted by the university and GB development coach. I was approached by my college captain and asked if I wanted to go to trials. I was flattered and I went for it.

The next year I was thrust into what an onlooker, most likely, would have perceived to be an obsessive, masochistic, and socially isolated world that, to your average rower, was par for the course. Of most concern was the day when I was invited to consider being a lightweight rower. It became commonplace to watch girls weighing themselves and training multiple times each day, missing meals, taking laxatives and slimming pills, sweat running in bin bags, and sitting in scalding hot baths in hotel rooms throughout the night in an attempt to make the numbers on the scales correct the next morning. I lasted an academic year and after competing at Henley I returned home, soon to find myself in hospital with appendicitis. I recall waking the morning after emergency surgery and being spoken to in a rather stern way by the surgeon. He told me that if I had left it any longer my appendix would have burst and I would have succumbed to more significant complications. He advised that I should not have ignored the pain, something my rowing training had educated me to do and expected me to do in order to perform. My get well soon card from my then boyfriend was brief and suggested that perhaps this might put an end to "all that silly dieting". I returned to university for my final year and decided not to return to rowing.

My story is not extreme, far from it, but I share it with you as part of the journey that led me to writing this book. This was my first exposure to mental health difficulties in high-performance athletes. Even at such a young age, with an untrained eye, I had a sense that something didn't feel comfortable about what I was being exposed to. Almost 18 years on, I now work as a clinical psychologist and psychodynamic psychotherapist with a wide variety of people who are struggling with their mental health, including elite athletes, albeit to a limited amount, for various reasons that we will consider later in this book.

In 2012, within my role as a clinician, in a discussion with a rowing coach, I was informed that within one small university lightweight rowing team multiple girls and boys were presenting with self-harm

and eating disorders. I met with these athletes on a clinical basis, yet for some it was too late and physical intervention was required urgently before any thought could be given to their mental health. For others, meeting with a clinical psychologist was not wanted and conflicted with their sporting goals. I was avoided.

The university acknowledged that it had a duty of care to its students and needed to respond to what was happening. I was introduced to a sociologist, who was once a professional footballer. We worked together and proposed two research projects. One was to explore the specific experience and presentation of lightweight rowers and the other to profile a broad range of athletes across all sports at the university. This was to include assessments of personality and mental health. We only received funding to complete the work with the lightweight rowers and so this is what we did. I had to be careful not to be biased by my own experiences of being a lightweight rower and needed to ensure that the methodology we put in place was as open and unbiased as possible. We collected descriptive background information on each athlete and selected a broad range of assessments measuring personality, distress, alexithymia (inability to recognise and describe one's emotions), self-esteem, and eating-disordered behaviour. We both worked hard on a loose interview structure and themed our questions around what the rowers enjoyed, what they found difficult, and what motivated them. I then trained an assistant psychologist to administer the interview, once again to protect from any bias.

The findings were staggering. Out of the sample of eight lightweight rowers (which was 50% of the total lightweight squad), two athletes reported vomiting to control their weight, five reported bingeing to the point that they felt out of control, and one reported the use of laxatives. Three of these eight individuals presented with a combination of binging, vomiting, and excessive use of exercise to lose weight. In short, it is likely that they would have met the criteria for a diagnosis of an eating disorder. On personality assessment, our sample scored the highest on avoidant, obsessive-compulsive, and depressive personality traits with the most selected items on the personality questionnaire being "I am my own worst critic", "I worry a lot", "If others can't do things correctly, I would prefer to do them myself", "I put my work ahead of being with my family or friends or having fun", and "I am critical of others". The interview

identified themes of observing others struggling, extreme weight loss practices, discipline and control, the awareness of coaches judging, the awareness of teammates also being rivals, and self-criticism. If an individual was already in treatment for mental health difficulties (which we were aware some of the squad were) we recommended that they talk to their medical professional to seek advice on whether or not it was advisable for them to take part in the research. None of those that took part were already in treatment and hence our results were indicative of the "healthier" athletes in the squad.

We were seemingly faced with a sample of eight athletes where seven met the criteria for referral to an eating disorder service. Yet despite this, at the point of interview, they told us that "I would describe myself as one of the healthiest and happiest lightweights on the team." They also made reference to much more severe weight loss practices in other members of the squad. They were a highly critical, self-reliant group that perceived the need for little support or would struggle to approach their coaching team for help for fear of judgement. Of course, as with any piece of research, there is always much left open to interpretation, but I was concerned with the findings and I was concerned that this small yet informative group seemed to lack insight into the significance of what they were reporting and the extent of their own needs. Within this elite athlete population, where many were GB athletes or triallists, this behaviour seemed culturally acceptable. I am still astounded with the realisation of how, had these athletes not been in the sporting world and were seen at a doctor's surgery presenting with the symptoms they were reporting, they would be referred to mental health services. However, just because these sportsmen and women were expected to perform in weight-restricted sports, their symptoms were seen simply as a necessary means to an end.

Of course, we must be careful not to assign blame to the world of elite sport or weight-restricted sports. We have to consider if those with a predisposition or vulnerability to going on to develop eating difficulties are attracted to the world of weight-restricted sport as it makes eating-disordered behaviour socially acceptable. And, more generally, certain personality traits or vulnerabilities may well be the very reason why many individuals are attracted to their chosen sport. Perhaps sport maintains and even compounds an existing

predisposition for some individuals who need an arena that makes their presentation socially acceptable. For the patient who visits the clinic for assistance with anger management, this may be the pro boxer or MMA cage fighter. For the patient who visits the clinic for an eating disorder, this may be the weight-restricted sportsperson such as the jockey and the lightweight rower.

In psychology, our assessments are based on statistical phenomena. You may recall being taught about the normal distribution or bell curve many years ago in school. In short, it's the phenomenon that if you were to draw a graph showing the number of people that present with a certain characteristic, the majority of people would clump together somewhere in the middle, around average. The graph and the numbers would tail out at the two extremes where only a few people would be located. For example, if we look at height, only a few people would sit at one end around 2 foot tall and likewise only a few would sit at the top end around 8 foot tall but the majority would be somewhere in the middle around 5' 7"; hence, if drawn, this would give us our bell curve. I have used the example of height but psychologists administer personality assessments and a similar phenomenon is seen. Only those who sit two standard deviations (in the extremes) away from average would qualify for significant difference or clinical diagnosis (depending upon the assessment). After working with athletes, I have a theory. I believe that on many personality traits such as masochism, obsessionality, perfectionism, and avoidance, athletes score higher than the average member of the population, yet it is this that actually makes them damn good at what they do. If you look at the illustration below, I would suggest that many elite athletes are skewed to the right on a number of traits. This means they are well equipped to adhere obsessionally to a rigorous training regime and their somewhat greater levels of masochism allow them to push through the pain barrier and not to give up as early as many in the "normal" population might.

For the majority, the thought process is very different when experiencing pain during exercise. Instead of thinking "Push through it" they will more likely think, "This is getting a bit much now, I think I'll stop." If you stop at the first sign of pain, you're not going to make a good athlete. Similarly, if you push through too much pain, you're not going to make a good athlete. This slight difference in personality

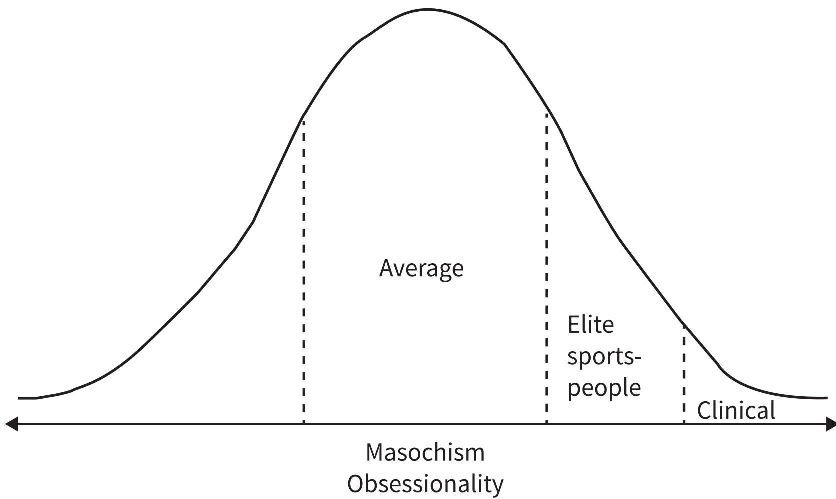

Figure 1 Skewed to the right

structure may be able to distinguish between the average and the elite. If you look at our illustration, however, you may well have already noted that by being skewed to the right on certain personality traits you move closer to the tail end of the curve where we would expect to see our clinical population. Therefore, by the very nature of being skewed on these personality traits, athletes may be more vulnerable to tipping into something that is of clinical significance. In other words, they may present with a clinically diagnosable mental illness. So, in turn, personality traits that help you to be an incredible athlete and may present as socially admirable qualities on the field or on the water—"he has such discipline, such control"—may tip you over into something unhelpful in everyday life.

The first section of the book explores weight-restricted sport and what has become socially acceptable in rowing and horse racing. I discuss with Kieren Emery, retired lightweight GB rower, how his chosen weight-making practices, including "functional vomiting", resulted in significant damage to his body. I then speak with Mark Enright, a professional jockey, who shares his own experiences of a culture whereby weight-control practices, such as sitting in saunas and dehydration, is common practice and widely spoken about. He also talks about his experience of taking Lasix or "piss pills" and the consequences of this. I speak with

Dr Dan Martin, performance nutritionist and researcher, and learn how, despite awareness of an evidence-based diet and exercise plan that will support jockeys to weight reduce and maintain in this healthy way, they are choosing not to. I explore why.

The next section presents a collection of chapters that explore the hypothesis of being skewed to the right. I start by exploring masochism with Michelle Bergstrand, a British cyclo-cross champion, and how experiencing pain becomes something that is habitual and unnoticed, yet satisfies and drives the individual to train and compete. Next, I explore the fine line between healthy and unhealthy obsessionality with Luke Stoltman, Scotland's strongest man, and how obsessions can function to provide control in a world that may be perceived as out of one's control. Finally, with Graeme Fowler, England cricketer, I look at focus. Graeme had developed a strong ability to focus to block out painful things in his past, which served him well in his early life and made him an incredible batsman on the field, allowing him to focus solely on the ball, but which later in life led to significant depression. I then explore the phenomenon of internal acceptance and worth and how conversely, this trait may well be skewed to the left in our elite sports population. In other words, if levels of acceptance and value are lower, this can also drive and motivate sportspeople to perform and achieve. The relationship between acceptance and mental health is explored with Nigel Owens, Welsh international rugby union referee, who talks openly about the impact of his struggles accepting his sexuality and the impact of this on his mental health.

It seems unfortunate that there is a culture of professional sportsmen and sportswomen being idolised and put on a pedestal in the public eye, seemingly with perfect lives. I respect the hard work and sacrifice that goes into becoming a professional sportsperson and I also respect that in our day-to-day lives we need individuals who have achieved and persisted in the face of defeat to inspire and influence us all. I just fear that this need in the general population to idolise our sporting heroes also prevents us from acknowledging their vulnerability and potential difficulties.

I wonder if it is that many athletes are frightened to fall off this pedestal in front of their adoring audiences as they inspire such hope for so many of us. It is no surprise that at times of injury or retirement

many of our athletes struggle. My hope in writing this book is not to shatter anyone's beliefs about their sporting hero but instead to enrich their understanding. Perhaps to give the sportsperson some breathing space to acknowledge that they too are human and may also be suffering in some way and may even be more susceptible to suffering because of their greatness and achievements. They should not have to feel that they have to silently present as grateful for what they have achieved. We can still hold them as heroes and hold their great achievements in high esteem as they so deserve, but we may also be able to hold a more balanced view of the person themselves.

The final section of the book dedicates itself to thinking about possible areas of vulnerability for the elite sportsperson. I speak with Jack Rutter, England cerebral palsy football captain, about his struggle through brain injury and his loss of identity as a professional footballer. I explore not only how injury can be a challenge to us all but also why it is that injury and retirement prove to be such a challenge for sportspeople. I explore why it is at retirement when, so very often, we see athletes collapse and struggle with their mental health and what the adjustment process is that must follow for healthy recovery.

We live in a society today that views it fashionable to have a sports psychologist but shaming to have a clinical psychologist. Yet, it is this clinical help that so many of our top athletes need. I am often exposed to professional clubs employing mind coaches with no professional registration and little more than a day's training in stress management or an "alternative" therapy to help athletes through diagnosable clinical difficulties. It is important to understand how both society and the athlete wish to collude with the idea that this is all that is required in an attempt to normalise what they are experiencing, rather than accepting and acknowledging the reality of their mental health.

For many who rely on how they relate to themselves, their body, and their sport to perform at such a high level in order to achieve, it may be incredibly difficult to visit a clinician. I am aware that some have met with me then avoided engaging any further for fear of what exploration and change may bring. Multiple conflicts are inherent in this process and I often feel that many coaches may struggle to send an athlete to a clinician who may work with them on, for example, their obsessionality to help them move closer to a position of health,

when it is the very fact that they are so obsessive that makes them an incredible athlete. I often jest with coaches that they do not wish to send their athletes to me in case once they achieve a position of health, they may no longer be motivated to achieve what they have done in the past. I joke but there is also a reality in this. I see it in so many patients. It is important that they themselves are ready before they meet with a clinician or a therapist. We all need our defence mechanisms and we possess them for good reason, because for a certain amount of time they work for us. It is at the point when the individual is able to recognise that this way of being is no longer working that I would encourage them to sit down with a clinician.

A final chapter is dedicated to thinking about how we may change our sports culture to support the next generation of sportspeople. I talk to Ruth Walczak, a GB lightweight rower and then leadership consultant who has specialised in organisational culture change. Ruth concludes that any changes must occur at a systemic level and with consistent messages from all coaching and team staff members. I also talk to Tanni Grey-Thompson, who authored *Duty of Care in Sport: Independent Report to Government*, a review requested by the minister of sport in December 2015. Baroness Grey-Thompson explains how there is a need for a sports ombudsman, along with many other changes, to start to elicit a cultural shift in sport. We also explore the possible barriers to this that include abuse of power and enforced compliance.

In conclusion, I want to acknowledge that I do not wish to suggest that all athletes present with mental health difficulties and/or unhealthy internal drives for engaging in sport, far from it. Some people engage in sport because they just enjoy it! The sporting population is similar to the general population in that it is heterogeneous in nature and consists of those that have physical health difficulties, mental health difficulties, and those with no difficulties. Hence, this is a reminder that just like the normal population it would be ludicrous to suggest that mental health difficulties do not exist within our sporting populations. If this book is successful in achieving one aim, it is to share with you the stories that have touched me and that I have been privileged to hear and to see, thereby to increase understanding and awareness that even those we idolise, those who are extremely successful in the sporting arena, are just like

you and me and that they have stories and histories and very present everyday struggles. I hope that you may understand, may empathise, and may open your eyes that little bit wider.

A note on language use

In each chapter I have interviewed a sportsperson. To ensure that the individual's story and personality is communicated accurately I have decided to include their own words which can frequently include the use of swear words and colloquialisms. I have included clarification in parenthesis for those terms that may be unfamiliar to some readers.