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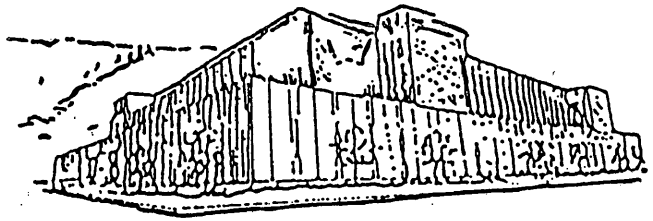
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**ATHLETE PREFERENCES FOR
SPORT PSYCHOLOGY INTERVENTIONS**

by

Sameep D. Maniar

B.A., Northwestern University, 1996

presented in partial fulfillment of the requirements


for the degree of


Master of Arts

The University of Montana

1998

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Athlete Preferences for Sport Psychology Interventions (62 pp.)

Director: John Sommers-Flanagan, Ph.D. 

Treatment acceptability is defined as: “judgments by laypersons, clients, and others of whether treatment procedures are appropriate, fair, and reasonable for the problem or client” (Kazdin, 1981, p. 493). Past research has shown that highly acceptable interventions are related to increased compliance and efficacy of treatment (e.g., Cross Calvert & Johnston, 1990). One aspect of treatment acceptability, willingness, is examined in the present study. Data were collected on 60 NCAA Division I athletes (32 men, 28 women) from ten sports to assess their willingness to: (a) seek help, (b) seek help from various professionals and non-professionals, (c) seek help if recommended by a coach, and (d) participate in performance enhancement interventions. Subjects were asked questions for three different athletic scenarios: midseason slump, return from injury, and desire to perform more optimally. Results of split-plot analyses of variance and Newman-Keuls post-hoc pairwise multiple comparison procedures indicated: (a) female athletes were more willing to seek help than male athletes, (b) athletes preferred seeking help from a coach over sport professionals and sport professionals were preferred over psychologists and counselors, and (c) goal setting, imagery, relaxation training, and talking in depth were preferred over hypnosis and medication for use with all three scenarios. These results suggest that education aimed at demystifying psychology and counseling and hypnosis are necessary for future work with athletes. Limitations of the study are discussed.

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**To all my teachers & professors that pushed me to
do more than was expected, to go the extra mile.**

1. Introduction and literature review

“They are asking participants in a behavioral treatment program how much they like it. Why, of course they should like it. After all, we are doing it to them for their own good aren’t we? And even if they say they don’t like it, we know what is best for them. Clearly, if the procedure is effective, its just not important whether anyone says they like it or not” (Wolf, 1978, p. 206).

Several studies have documented the positive effects of psychological interventions such as goal setting (Weinberg, Stitche, & Richardson, 1994), imagery (see Gould & Damarjian, 1996; Vealey & Greenleaf, 1998, for review), and hypnosis (see Morgan, 1996, for review) on athletic performance (see also Greenspan & Feltz, 1989; Meyers, Whelan, & Murphy, 1996; Vealey, 1994; Weinberg & Comar, 1994). These studies, similar to outcome research in psychotherapy, are designed to evaluate intervention efficacy. At this point, the literature suggests that there are various sport psychology interventions that can *potentially* be used by athletes for performance enhancement. However, in order for athletes to take advantage of available sport psychology interventions, they must be open and willing to seek help from a counselor, psychologist, sport psychologist, or other mental health professional.

For experts in the field of sport psychology or those working with elite athletes, convincing clients that psychological interventions are indeed successful may not pose a problem. But for those who are less well-known in the field of sport psychology or work with amateur athletes, it is all too common to experience difficulty in persuading athletes to take advantage of psychological services. In addition, sport psychology intervention effectiveness is only relevant if athletes are willing to utilize such interventions (Ievleva & Orlick, 1991).

Research indicates that athletes underutilize mental health services as compared to non-athletes (Bergandi & Wittig, 1984; Carmen, Zerman, & Blaine, 1968; Pierce, 1969; Pinkerton, Hinz, & Barrow, 1989; Reinhold, 1973; Segal, Weiss, & Sokol, 1965). One explanation for this discrepancy is that athletes are uncomfortable going outside of the

athletic department to seek help from service providers who may not understand special concerns, needs, and pressures faced by student-athletes (Greenspan & Andersen, 1995). This appears to be true for sport psychology services as well. Although the number of sport psychologists is steadily increasing, research indicates that athletes (and coaches) continue to be hesitant to take advantage of sport psychology services (Brewer, Van Raalte, Petitpas, Bachman, & Weinhold, 1998; Linder, Brewer, Van Raalte, & DeLange, 1991; Ravizza, 1988). According to Ravizza (1988) this may be due to perceptions that the services sport psychologists offer are predominantly for athletes with psychological problems. In other words, athletes may see sport psychologists as having a “shrink” image (Linder et al., 1991). Perhaps, the word “psychologist,” regardless of the context, deters athletes from seeking help of any kind. Thus, unless athletes perceive sport psychologists as effective in dealing with sport-related issues, athletes may be uninterested or unwilling to seek professional assistance.

Because unfavorable perceptions of psychotherapy and fears of mental health services are associated with avoidance of psychological services (Leaf & Bruce, 1987) and unwillingness to seek help (Deane & Chamberlain, 1994; Deane & Todd, 1996), perhaps further education about these procedures and their effectiveness can increase treatment acceptability. And if athletes view sport psychology interventions as more acceptable, they may become more willing to seek out and participate in such interventions.

In fact, several studies have shown that consumer education increases treatment compliance (Kazdin 1980b; Mudford, 1987; Singh & Katz, 1985). And, Dunbar and Agras (1980) found that a lack of knowledge about one’s treatment program was a major factor accounting for treatment nonadherence. With increased compliance and adherence, we can expect that more clients will be reached. And, if more clients are reached, chances of higher outcomes will increase as well. As Reimers, Wacker, and Koepl (1987) stated in describing Witt and Elliott’s (1985) findings, “Obviously if the treatment is not tried,

there is little or no chance the problem will be resolved” (p.218). (For a review of consumer education guidelines for health care professionals, see Meichenbaum & Turk, 1987.)

As Wolf (1978) points out in the opening quote, mental health professionals sometimes believe they know what is best for their clients, regardless of their clients’ perspectives. This attitude may lead to the development of insensitive professionals who do not ask their clients or athletes how acceptable a particular intervention is for them. In some extreme cases, mental health professionals may act as if they do not care how the client feels. For example, Wolf (1978) alludes to this issue by asking the following questions: “Do the ends justify the means? That is, do the participants, caregivers and other consumers consider the treatment acceptable?” (p. 207) and “...even if they say they don’t like it, we know what is best for them” (p.206). This insensitivity, however, may be due to clients’ perceptions. For example, Brody (1980) found that patients felt that doctors did not pay enough attention to their ideas. Whether this insensitivity exists in reality or is merely clients’ perceptions, it is an issue that must be addressed.

A large amount of research in counseling and psychology focuses on treatment efficacy. After all, we want to know if a treatment works or not. Although this outcome research is important, researchers discussed the need for more extensive criteria in evaluating treatment *in addition* to efficacy measures (Garfield, 1978; Kazdin & Wilson, 1978; Strupp & Hadley, 1977; Wolf, 1978). For example, these researchers suggested that treatment evaluation should include: (a) cost effectiveness, (b) efficiency of treatment, (c) discomfort and stress during treatment, (d) side effects of treatment, etc. In addition to efficacy, it was suggested that it is equally important for interventions to be viewed as potentially effective by the group of individuals for whom the treatment is designed (Wolf, 1978). For example, Wolf (1978) states: “...that if the participants don’t like the treatment then they may avoid it, or run away, or complain loudly. And thus, society will be less

likely to use our technology, no matter how potentially effective and efficient it might be” (p. 206). Moreover, it is ethically questionable for practitioners to use interventions that are deemed unacceptable by most of their clients. Out of these and other questions and concerns, the concept of *social validity* (Kazdin, 1977; Wolf, 1978) and later *treatment acceptability* (Kazdin, 1980a, 1980b) emerged to measure the attitudes of potential clients toward various forms of treatment.

1.1 Treatment acceptability

Treatment acceptability is commonly defined as “judgments by laypersons, clients, and others of whether treatment procedures are appropriate, fair, and reasonable for the problem or client” (Kazdin, 1981, p. 493). These “judgments of acceptability are likely to embrace evaluation of whether treatment is appropriate for the problem, whether treatment is fair, reasonable, and intrusive, and whether treatment meets with conventional notions about what the treatment should be” (Kazdin, 1980a, p. 259). One aspect of acceptability is willingness or openness to participate in a specific intervention (Brewer, Jeffers, Petitpas, & Van Raalte, 1994; Kazdin, 1980a; Tarnowski & Simonian, 1992). The concept of willingness is examined in the present study. Specifically, this study explores the question: from whom are athletes willing to seek help? And, should they seek help, which interventions are athletes most likely to view as desirable?

Two main reasons were initially given for investigating treatment acceptability. First, several authors have discussed legal and ethical issues associated with certain treatments (e.g., Kazdin, 1981; Witt & Elliott, 1985). For example, if the courts determine a treatment is unacceptable, it can not be considered for treatment (Budd & Baer, 1976). Second, if several effective treatments are available, acceptability research may show which treatments might be more associated with higher client compliance. And, increased treatment compliance may result in improved treatment outcomes (Kazdin, 1981).

In subsequent research, several more reasons for evaluating and studying treatment acceptability were noted. Specifically, highly acceptable treatments have been found to result in decreased attrition and increased compliance (O'Brien & Karsh, 1990). In addition, treatment acceptability has been found to directly affect treatment outcome and treatment satisfaction (Cross Calvert & Johnston, 1990; see also Elliott, 1988; Reimers, Wacker, & Koepl, 1987). As Tarnowski and Simonian (1992) state: "...treatment acceptability appears to be implicated in mediating negative clinical outcomes including treatment termination, noncompliance, and lack of improvement" (p. 101).

1.1a. Factors affecting treatment acceptability. Witt and Elliott (1985) suggested that three components affect acceptability of various treatments: (a) treatment use, (b) treatment compliance, and (c) treatment effectiveness. A fourth element, described as client "understanding" of treatment procedures, was later added by Reimers, Wacker, and Koepl (1987). Subsequent research has supported this model of acceptability; however, due to treatment use and treatment compliance being closely-related, these two components are often discussed concurrently. First, in their review of the literature, O'Brien and Karsh (1990) found that treatment use and compliance appeared to be inversely related to treatment complexity. Thus, complex interventions may require simplification in order for them to be considered acceptable (and thus effective) treatments. Likewise, clients who deem a treatment as unacceptable may be less likely to comply with the intended treatment (O'Brien & Karsh, 1990). Second, treatment effectiveness is sometimes a large determinant of acceptability. Although treatment effectiveness can increase acceptability, caution must be used when using outcomes to justify interventions. Clearly, in some cases—and especially in performance enhancement work with athletes—it is unethical for a practitioner to assume that the ends justify the means. Third, understanding of treatments is an integral part of acceptability. Unless a client has an understanding of what a proposed treatment includes, she/he may not consider the intervention acceptable. However, in

addition to compliance (discussed earlier), treatment acceptability can also be increased with consumer education (Foxx et al., 1996; Jensen, 1997; Jensen, Kennerley, LeJeune-Hall, & Bacon, 1992; Kazdin, 1980b; Mudford, 1987; Singh & Katz, 1985; Tingstrom, 1989).

Additional factors that affect acceptability have also been researched. First, in their review of the literature, Reimers, Wacker, and Koepl (1987) found that three main aspects of a proposed treatment plan affect acceptability: (a) severity of the problem, (b) time needed to implement the intervention, and (c) type of treatment approach employed. Furthermore, cost and side-effects may also influence acceptability ratings (Kazdin, 1981; Reimers, Wacker, & Koepl, 1987). Second, the influence of multiple demographic variables, such as income and race (Heffer & Kelly, 1987), knowledge of behavioral principles (Clark & Elliott, 1988; Rasnake, Martin, Tarnowski, & Mulick, 1996), and experience with the treatment (Witt & Martens, 1983; Witt & Robbins, 1985) have also been investigated.

Three therapist variables have also been found to affect clients' treatment acceptability ratings: (a) jargon used to describe treatments, (b) rationales given for various treatments, and (c) involvement in treatments. First, researchers have found that potential clients' treatment evaluations fluctuate depending on what the treatment is called and how it is described (Witt, Moe, Gutkin, & Andrews, 1984; Woolfolk, Woolfolk, & Wilson, 1977; Woolfolk & Woolfolk, 1979). For example, in their studies of preservice teachers, Woolfolk et al. (1977) and Woolfolk & Woolfolk (1979) showed a videotape of a teacher reinforcing appropriate behavior. The video was titled "behavior modification" for half of the sample and "humanistic education" for the other half. Subjects rated the personal capabilities of the teacher as well as the effectiveness of the teaching technique more positively if it was labeled humanistic education. Second, rationales for using a treatment have been shown to affect acceptability ratings (Cavell, Frentz, & Kelley, 1986a, 1986b). Third, the therapist's involvement in a treatment has been shown to affect a client's rating

of acceptability (Elliott, 1988). In addition, Kazdin (1980b) suggested that the context in which a treatment is used may influence acceptability.

1.1b. Treatment acceptability inventories. Several inventories have been developed to investigate the construct of acceptability. Initially, Kazdin (1980a) developed the Treatment Evaluation Inventory (TEI). The TEI is comprised of 15 items rated on a seven-point Likert-type scale. Subjects rate treatments in six main areas: (a) acceptability, (b) willingness, (c) suitability for individuals having other problems, (d) cruelty/fairness, (e) likely effectiveness, and (f) likeability. In addition, an overall acceptability index is calculated by summing scores from the 15 items.

Witt and Martens (1983) developed the Intervention Rating Profile (IRP) for judging teachers' acceptabilities of school interventions. The results of a factor analysis demonstrated that the IRP was comprised of one primary factor (general acceptability) and four secondary factors (risk, time, effects on children, and teacher skill). The IRP was later modified for use with a broader consumer population (e.g., parents, nurses, institutional staff). Of the original 20 items (rated on a six-point Likert-type scale), seven were modified and retained, while eight new items were added. The resulting new scale was entitled the IRP-15 (Witt & Elliott, 1985).

Because of subjects' dissatisfaction with the length of time required to complete the IRP and its derivatives, Tarnowski and Simonian (1992) simplified the IRP and developed the Abbreviated Acceptability Rating Profile (AARP). In addition, because investigators using the TEI were facing similar difficulties, Kelley, Heffer, Gresham, and Elliott (1989) simplified and provided statistical support for a shortened form of the TEI (TEI-SF).

In subsequent years, instruments targeted at more specific populations have been developed. Hunsley (1992) developed the Treatment Acceptability Questionnaire (TAQ) due to the need for an adult-specific acceptability measure, while Bourland and Lundervold (1989) developed the Geriatric Treatment Acceptability Survey (GTAS) for use with older

adults. Brewer et al. (1994) developed the Intervention Preference Questionnaire (IPQ) for use with sport psychology interventions, specifically for use with athletes returning to sports after suffering an injury. Also for use with sport psychology interventions, Jensen et al. (1992) developed the Treatment Questionnaire (TQ), a modification of the TEI. And, an instrument designed to measure athletes' attitudes toward seeking sport psychology consultation (ATSSPCQ; Martin et al., 1997) recently was developed.

Finally, in an effort to understand the relationship of acceptability to other variables, several scales were developed based upon modifications of the TEI or IRP. In order to assess the relationship of acceptability to effectiveness, Von Brock and Elliott (1987) added nine items to the IRP and labeled the new instrument the Behavior Intervention Rating Scale (BIRS). In addition, Reimers and Wacker (1988) modified the TEI to produce the Treatment Acceptability Rating Form (TARF). The TARF was further modified (Reimers, Cooper, Wacker, & DeRaad, 1989) to assess the relationship between acceptability and factors such as problem severity and compliance.

Recently, however, there has been some debate as to whether current instruments are accurately measuring the construct of treatment acceptability (i.e., there are concerns of validity). And, according to Spirrisson (1992), "agreement on what constitutes the *treatment acceptability* construct must necessarily precede agreement on how to measure it" (p. 259). This statement was in response to Irvin and Lundervold (1988), as discussed in Lundervold, Young, Bourland, and Jackson (1991), who "suggested that the TEI is not a 'pure' measure of acceptability since several questions refer to subjective discomfort of the treatment and efficacy, rather than simple endorsement of a treatment" (Lundervold et al., 1991, p. 98). Thus, there is some disagreement as to whether the broader, more general or the narrower approach should be employed when investigating treatment acceptability. There is also disagreement regarding which inventories are valid measurements of treatment acceptability.

Several current instruments such as the TAQ or IPQ would be relevant for the present study. However, the current research focuses on only one part of treatment acceptability: willingness. Furthermore, the currently-existing questionnaires are concerned with comparing a small number of interventions. For each intervention, each question (typically seven) must be answered. For the current study, seven questions for the six interventions across all three scenarios would be necessary, or 126 questions for each subject. Moreover, this would only address one aspect of the current study. No current treatment acceptability instrument assesses therapist preference for athlete subjects. Because of these concerns, a new instrument, the Athlete Preference Questionnaire (APQ), was designed for use in the present study.

1.1c. Research on acceptability. During the 1980s, treatment acceptability research focused predominantly on interventions for child behavior problems. The initial studies, conducted by Kazdin (1980a, 1980b, 1981), asked college students to rate the acceptability of treatment procedures when presented with scenarios of a normal and mentally retarded child who was demonstrating hyperactive, noncompliant, or aggressive behaviors. Evaluations were conducted using the TEI and the Semantic Differential (Osgood, Succi, & Tannenbaum, 1957). The results indicated that: (a) positive treatment procedures were generally more acceptable than negative methods, (b) case severity was a factor of acceptability, (c) nonexclusionary time-outs were more acceptable than exclusionary time-outs, and (d) aversive side effects reduced acceptability.

Following his initial studies with college students, Kazdin extended his research to acceptability ratings of children, parents, and treatment staff (Kazdin, 1984; Kazdin, French, & Sherick, 1981). Again, using an analogue design, results indicated that: (a) treatments described as having remarkable effects were rated as more acceptable than treatments producing weaker effects, (b) children rated medication as the most acceptable treatment, and (c) parents rated behavioral treatments higher than their children. Similar

analogue studies further extended Kazdin's research to parents of normal, autistic, and handicapped children (Pickering & Morgan, 1985), mothers of mentally retarded children (Singh, Watson, & Winton, 1987), and nurses and hospital staff working with mentally retarded children (Mudford, 1987).

As a result of Kazdin's initial studies, a second domain of acceptability research emerged in the school setting. In a study of preservice teachers, Witt and Martens (1983) found that five factors influenced acceptability of classroom interventions: (a) suitability of the intervention for a mainstreamed classroom, (b) risk to the child, (c) intervention time (for the teacher), (d) negative side effects on other children, and (e) skill of the teacher. And, a follow-up study by Witt, Martens, & Elliott (1984) found that behavior severity and type of intervention were additional factors that influenced teachers' treatment acceptability ratings. In subsequent studies, Epstein, Matson, Repp, and Helsel (1986) examined special education and regular teachers' treatment acceptability for mentally retarded and learning disabled students, and Irvin and Lundervold (1988) evaluated 58 special education teachers' ratings of acceptability, efficacy, intrusiveness, and restrictiveness for 18 treatments.

Recently, however, acceptability research has been expanded to many other areas of psychological treatment. For example, treatments for anorexia nervosa (Sturme, 1992), depression (Banken & Wilson, 1992), developmental disabilities (Epps, Prescott, & Horner, 1990), geriatric behavior problems (Lundervold, Lewin, & Bourland, 1990; Lundervold et al., 1991), marital therapy (Bornstein et al., 1983; Bornstein et al., 1987; Upton & Jensen, 1991; Wilson & Flammang, 1990), mental retardation (Rasnake, Martin, Tarnowski, & Mulick, 1996), panic disorder and agoraphobia (Aronson, Craig, Thomason, & Logue, 1987), paradoxical interventions (Betts & Remer, 1993; Cavell, Frenz, & Kelley, 1986b; Hunsley, 1993; Hunsley & Lefebvre, 1991), sex offenders (Lundervold & Young, 1992), sex therapy (Wilson & Wilson, 1991), and sport

psychology (Brewer et al., 1994; Jensen, 1997; Jensen et al., 1992) have all been evaluated with regard to acceptability.

In the area of sport psychology, a few treatment acceptability studies have recently been conducted. First, Brewer et al. (1994), using the IPQ, assessed undergraduate non-athletes' intervention preferences for a hypothetical injured athlete as well as injured athletes' perceptions directly following brief introductory sessions of goal setting, imagery, and counseling. All three interventions received positive ratings, with goal setting being the most preferred treatment. In addition, within the non-athlete sample, females perceived interventions as significantly more positive than males. Second, Jensen et al. (1992) found that golfers had a generally favorable view of relaxation, imagery, and cognitive restructuring as measured by the Treatment Questionnaire (TQ), a modification of the TEI. Third, Jensen (1997) found that soccer players preferred imagery and cognitive restructuring over relaxation training, while football players preferred relaxation training over imagery and cognitive restructuring.

Overall, the interest in treatment acceptability research over the past two decades may indicate that clients' preferences and attitudes for particular treatments are becoming more important to researchers and practitioners in psychology. The more recent onset of treatment acceptability studies with athletes represents an important shift in attitudes toward providing sport psychology interventions for athletes. Specifically, it suggests that sport psychology practitioners are paying greater attention to athletes' interests and preferences for performance enhancement interventions.

1.2 Therapist preference

Another major issue related to athlete unwillingness to consult a professional involves perceptions and preferences for working with various professionals. The body of research most directly pertinent to this issue is the literature on therapist preference.

In an effort to better understand public perceptions of therapists, the concepts of therapist preference (or preference for therapist) and client perceptions of therapists have been examined in several contexts. Researchers have investigated the effects of attire of therapist (Gass, 1984), ethnicity and acculturation of prospective client (Ruelas, Atkinson, & Ramos-Sanchez, 1998), fee charged (Bloom, Schroeder, & Babineau, 1981; Brigham & Brigham, 1985; Schneider & Watkins, 1990; Trautt & Bloom, 1992; Wong, 1994), gender of prospective client (Greenberg & Zeldow, 1980), gender of therapist (Campbell & Johnson, 1991; Furnham & Wardley, 1990; Greenberg & Zeldow, 1980; Wong, 1994), marital status of therapist (Campbell & Johnson, 1991), physical attractiveness of therapist (Cash, Begley, McCown, & Weise, 1975), seating arrangement (Gass, 1984), theoretical orientation/treatment modality (Schneider & Watkins, 1990; Wong, 1994), and title of therapist (Bass, 1986; Farberman, 1997; McGuire & Borowy, 1979; Murstein & Fontaine, 1993; Trautt & Bloom, 1982; Van Raalte et al., 1996; Van Raalte, Brewer, Linder, & DeLange, 1990; Warner & Bradley, 1991; Webb & Speer, 1985, 1986; Wollersheim & Walsh, 1993) on clients' perceptions of and preferences for therapists.

Research aimed at evaluating subjects' perceptions of various therapists has resulted in two main findings. First, counselors are generally rated more favorably than psychologists (Murstein & Fontaine, 1993; Trautt & Bloom, 1982; Warner & Bradley, 1991; Wollersheim & Walsh, 1993). For example, in a study by Warner and Bradley (1991), "counselors were rated as more aptly described by the words *helpful, caring, friendly, a good listener* than were psychologists" (p. 140). One explanation for the more favorable views of counselors is that the public may have less favorable attitudes toward professionals with the "psych" prefix (McGuire & Borowy, 1979). This stigma was presumed to be due to society's lack of information about the education, training, and role of psychologists (McGuire & Borowy, 1979; Warner & Bradley, 1991; Wollersheim &

Walsh, 1993); however, the reluctance to consult a psychologist may be due to the “shrink” connotations associated with the “psych” prefix.

Second, research suggests that the public lacks information regarding the education and training of psychologists (Farberman, 1997; Warner & Bradley, 1991; Webb & Speer, 1986; Wollersheim & Walsh, 1993; Wood, Jones, & Benjamin, 1986). For example, Warner and Bradley (1991) found that when asked multiple-choice questions regarding training and treatment-focus of counselors, psychologists, and psychiatrists, subjects averaged only 50 percent correct. In addition, subjects found it easier to classify the expertise of those who work with clients who have “mild” disorders (counselors) and “severe” disorders (psychiatrists), leaving a vague “middle-range” for psychologists (Warner & Bradley, 1991).

In the area of sport psychology, the limited research on therapist preference indicates that although sport psychologists are perceived as similar to mental health practitioners in general, they are “perceived to be more similar to sport-related practitioners than other mental health consultants” (Van Raalte, et al., 1996, pp. 106-107). In addition, in their study of three national newspapers in the United States during the period of 1985-1993, Brewer et al. (1998) found that “the vast majority of articles were neutral in tone toward sport psychology, portraying the field in objective terms” (p. 89). Also, in a study of 48 African American and 177 Caucasian NCAA Division I university athletes, Martin et al. (1997), found that Black athletes stigmatized sport psychology consultants (SPCs) significantly more and were less willing to seek help from SPCs than White athletes. Moreover, male athletes stigmatized SPCs significantly more than female athletes.

1.3 Statement of purpose

The purpose of this study is to examine athletes’ preferences for seeking help when encountering sport-specific problems. Little research has been conducted in this area. According to Brewer et al. (1994), this type of research is “critical because the

interventions are psychological and could conceivably be viewed with skepticism” (p. 177). Not only will the present research provide some initial information which performance enhancement interventions athletes view as most acceptable, but it will also reveal specific interventions which are viewed most negatively by athletes. This information is essential because, as stated previously, only treatments that are viewed as credible and acceptable are likely to be used by athletes (Ievleva & Orlick, 1991). The results will also indicate what type of professionals athletes are willing to approach for help. This information is crucial because knowing how mental health professionals are perceived by athletes “can facilitate the development of materials designed to educate the public about sport psychology” (Van Raalte, Brewer, Matheson, & Brewer, 1996, p. 102).

In the current study, several hypotheses were examined. First, it was hypothesized that women would be more likely to seek help for sport-specific problems. Because men, in general, are less likely to use mental health services (Brinson & Kottler, 1995; Gottesfeld, 1995), it was presumed that this trend would carry over to athletes with performance problems, and women would be more willing to seek help. Additional support for this hypothesis was derived from Martin, Wrisberg, Beitel, and Lounsbury (1997) who found that male athletes stigmatized sport psychologists more than female athletes. Second, it was hypothesized that individual sport athletes would be more willing to seek help. Athletes participating in team sports may be more likely to keep their problems within the team, whereas individual sport athletes may have less of a sense of dependence on teammates and therefore should be more likely to seek help from someone outside of the team. Third, it was hypothesized that athletes would be less willing to seek help from an individual in the mental health field—including sport psychologists—as compared to those not affiliated with the mental health field (e.g., coaches, friends, family, etc.). Support for this conjecture was derived from findings by Van Raalte, Brewer, Brewer, and Linder (1993) who found that “sport psychologists are perceived by the

public, athletes, and themselves to be more similar to mental health professionals than to coaches” (p. 231; see also Ravizza, 1988). Furthermore, because of negative connotations of “psychologist” it was thought that altering the name of “sport psychologist” to “performance enhancement specialist,” although they could involve the same training and background, would increase willingness to seek help. In other words, it was thought that the semantics of practitioner titles would have an effect on willingness to seek help. Fourth, it was hypothesized that athletes would be more willing to seek help from trained professionals if it was recommended by a coach. Although athletes may be generally disinclined to seek help, a recommendation from a coach should help reduce some of this reluctance. Fifth, it was hypothesized that goal setting, imagery, and relaxation interventions would be preferred over less *familiar* or more extreme interventions such as hypnosis and medication. Support for this hypothesis comes from Reimers, Wacker, and Koepl (1987) who argued that unless a client has an understanding for a proposed treatment, she may not consider the intervention acceptable. Thus, unfamiliar interventions may cause additional anxiety in an already anxiety-provoking setting.

Finally, the current study investigated athletes’ preferences for sport psychology interventions in three *different* scenarios. The rationale for including several scenarios was to investigate whether athletes’ preferences varied depending on the nature of the problem. For example, are athletes more likely to seek help from a clinical psychologist in the case of a slump than in the case of an injury? Also, perhaps athletes prefer one intervention for one problem and another for a different problem. The scenarios were chosen for their common occurrence in sports, and it was assumed that all athletes would be able to relate to, or at least imagine, all three of the scenarios.

1.4 Limitations

There are four main limitations to the present study. First, beyond the scope of team versus individual sports, this study does not examine differences between specific

sports. Thus, any difference as a function of sport will not be adequately evaluated. Second, due to low enrollment rates of minorities at the university from which the study took place, preferences conveyed may not generalize to non-Caucasian student-athletes. Third, the present study uses an analogue design which may not be an accurate representation of real-life events, thus compromising some ecological validity. However, the present study asked subjects to rate intervention acceptability for themselves, whereas some prior studies have asked subjects to rate acceptabilities for another, fictitious person. In some instances, these prior studies involved subjects having little or no experience with the issue (i.e., non-consumers). For example, studies have asked undergraduate college students about parenting, non-athletes asked about sport scenarios, etc. Moreover, these studies assumed that subjects would project their feelings and attitudes onto a fictional subject, while the current study asked athletes to rate their own feelings for *themselves* (i.e., what subjects would do if they were in a particular situation). Fourth, the current study's results were obtained with an unvalidated instrument. Until further research can validate the instrument used in this study, the results must be interpreted with caution.

1.5 Definitions of Terms

Individual Sport: Any sport in which athletes compete on their own against other individuals. In the present study, these sports were men's and women's cross country & track, women's golf, and men's and women's tennis.

Team Sport: Any sport in which athletes compete as part of a group against other groups. In the present study, these sports were men's and women's basketball, men's football, women's soccer, and women's volleyball.

Treatment Acceptability: "Judgments by laypersons, clients, and others of whether treatment procedures are appropriate, fair, and reasonable for the problem or client" (Kazdin, 1981, p. 493).

Willingness: Openness to seek help or participate in a specific intervention.

Note: The therapist/consultant titles in the present study were deliberately left undefined, as the intent was to investigate subjects' preconceived perceptions of mental health professionals and the effects of job title. In the present study, the job/consultant titles were: athletic trainer, clinical psychologist, coach (current or former), counselor, friend/family member, medical doctor/physician, minister/pastor, performance enhancement specialist, professor/teacher in sport psychology, sport counselor, and sport psychologist.

2. Methodology

2.1 Participants

The subjects were 60 University of Montana athletes.

2.1a. Criteria for inclusion in the study. All University of Montana current athletes who did not participate in the pilot study were included in the subject pool.

2.1b. Selection of subjects. At the time of the study, all potential subjects were assigned a number. Using a random number table, 50 male (25 team sport, 25 individual sport) and 50 female (25 team sport, 25 individual sport) athletes were selected, resulting in a stratified random sample by sport (team, individual) and gender (male, female). Due to incorrect and unlisted phone numbers as well as unwillingness to participate in the study, 60 (32 male, 28 female; 27 individual-sport, 33 team-sport) of the initial 100 subjects were included in the study, resulting in a participation rate of 60 percent.

2.1c. Recruitment of subjects. All selected subjects were contacted via telephone by the primary investigator (author) or a research assistant and asked for their voluntary participation. Informed consent was obtained from each athlete prior to taking part in the study (see Appendix A).

2.1d. Characteristics of subject population. Subjects represented all sports (basketball, football, golf, soccer, tennis, track/cross country, volleyball) and all academic years. No age data were collected.

2.2 Procedures and measures

Question content was determined by obtaining input from a panel including nine sport psychology graduate students, one counseling professor who is a licensed clinical psychologist, and one health and human performance professor who is a certified sport psychology consultant. All panel members read and answered each question, altering any ambiguous wording when necessary. The revised questionnaire was then reviewed and

pilot tested on 30 student-athletes enrolled in an undergraduate sport psychology course. These athletes suggested no further revisions.

The proposed changes resulted in the final version of the Athlete Preference Questionnaire (APQ; see Appendix C). The APQ is comprised of three scenarios, each followed by one page of four questions. When reading the scenarios, subjects were asked to imagine themselves in the given situation and how he or she would feel about if it were happening to them. The scenarios were concerned with: (a) a midseason slump, (b) returning from a serious injury, and (c) the desire to perform more optimally. These scenarios were presented to subjects in random order.

On a separate page, four questions were asked following each scenario. All questions were rated on a nine-point Likert-type scale anchored by the terms “Never” and “Definitely.” The first question asked how willing the subject would be “to seek help in finding a solution to the situation described.” The second question asked how willing the subject would be to seek help from several people (presented in alphabetical order): (a) athletic trainer, (b) clinical psychologist, (c) coach (current or former), (d) counselor, (e) friend or family member, (f) medical doctor/physician, (g) minister/pastor, (h) performance enhancement specialist, (i) professor/teacher in sport psychology, (j) sport counselor, and (k) sport psychologist. The third question asked how willing the subject would be to see a trained specialist who could help him or her find a solution to the situation described *if his or her coach recommended it*. The fourth question asked the subject if she or he did seek help for the given situation, how willing would she or he be to use the following suggested interventions (presented in alphabetical order): (a) goal setting, (b) hypnosis, (c) imagery/visualization, (d) medication, (e) relaxation training, and (f) talking to someone in depth.

Each subject took the questionnaire individually (i.e., with no other subjects present). The first page of the questionnaire (following the consent form) consisted of

demographic information including: (a) gender, (b) athletic year, (c) academic year , (d) sport, (e) whether or not redshirted, and (f) whether or not transferred. In addition, this page included the State Hope Scale (Snyder et al., 1996) which was included for future research purposes. The demographic information and APQ required approximately 10-15 minutes to complete.

3. Results

3.1 Validity check

In order to evaluate whether subjects responded to the questionnaire in a serious manner (e.g., distinguishing between the various occupations and scenarios), titles such as family/friend, medical doctor/physician, and minister/pastor were included in the study. If, as planned, subjects comprehended and responded differently to each scenario, it would be expected that ratings of willingness to consult a physician for intervention purposes would be notably higher for the injury scenario. This was the case, as physician ratings for the injury ($M = 7.00$) scenario were significantly higher than the slump ($M = 4.03$) and optimal performance ($M = 4.23$) scenarios. In addition, the friend/family item was rated high ($M = 7.44$), while the minister/pastor item was rated relatively low ($M = 3.36$).

3.2 Willingness to seek help

A 2 (gender) \times 2 (team: individual sport vs. team sport) \times 3 (scenario: slump vs. injury vs. optimal performance) split-plot analysis of variance (ANOVA) was performed on the willingness to seek help ratings. A significant main effect for gender was obtained, $F(1, 56) = 6.13$, $p = .0163$ (see Table 3.1).

3.3 Preference for consultant

A 2 (gender) \times 2 (team) \times 11 (consultant) \times 3 (scenario) split-plot analysis of variance (ANOVA) was performed on the consultant ratings. Two significant main effects were revealed. First, the main effect for scenario was significant, $F(2, 112) = 21.00$, $p < .0005$. With a single exception (coach), subjects rated all consultants higher for the injury scenario than the slump or optimal performance scenarios. Using Newman-Keuls post-hoc pairwise multiple comparison procedures, the consultant ratings (collapsed across all consultants) proved to be significantly higher for the injury scenario than either the slump or optimal performance scenarios, $p \leq .05$. Second, the main effect for consultant was also significant, $F(10, 560) = 64.85$, $p < .0005$.

Table 3.1**Willingness to Seek Help Categorized by Scenario**

	N	Slump		Injury		Optimal Performance		Average
		Mean	Std Dev	Mean	Std Dev	Mean	Std Dev	Mean
Female	28	8.07	1.25	7.86	1.46	7.75	1.11	7.89
Individual	14	8.43	0.65	7.79	1.31	7.64	1.39	7.95
Team	14	7.71	1.59	7.93	1.64	7.86	0.77	7.83
Male	32	6.94	1.83	7.44	1.68	6.88	1.64	7.18
Individual	13	7.69	1.25	7.85	1.21	7.31	1.25	7.62
Team	19	6.42	2.01	7.16	1.92	6.58	1.84	6.72
Total	60	7.47	1.67	7.63	1.58	7.28	1.47	7.46
Individual	27	8.07	1.04	7.81	1.24	7.48	1.31	7.79
Team	33	6.97	1.93	7.48	1.82	7.12	1.60	7.19
Total	60	7.47	1.67	7.63	1.58	7.28	1.47	7.46

The analysis also revealed two significant interactions: gender \times consultant, $F(10, 560) = 4.13$, $p < .0005$ (see Figure 3.1) and scenario \times consultant, $F(20, 1120) = 13.56$, $p < .0005$ (see Figure 3.2). For the gender \times consultant interaction, t-tests corrected by the Bonferroni inequality ($\alpha = .01$) were performed on differences between males' and females' ratings of clinical psychologist, physician, minister/pastor, sport counselor, and sport psychologist. All comparisons were significant ($p \leq .05$), with male subjects rating clinical psychologist, physician, and minister/pastor significantly higher than female subjects and female subjects rating sport counselor and sport psychologist significantly higher than male subjects. For the scenario \times consultant interaction, Newman-Keuls comparisons were performed on the consultant ratings for each scenario. Significant differences between selected professionals within each scenario are described in Table 3.2.

3.4 Willingness to seek help when recommended by a coach

No significant differences were found for willingness to seek help when recommended by a coach for either gender or for team.

3.5 Preference for treatment

A 2 (gender) \times 2 (team) \times 6 (treatment) \times 3 (scenario) split-plot ANOVA was conducted on the treatment ratings. The main effect for treatment was significant, $F(5, 280) = 87.76$, $p < .0005$ (see Table 3.3), as were the gender \times treatment, $F(5, 280) = 2.94$, $p = .013$ (see Figure 3.3), team \times treatment, $F(5, 280) = 2.63$, $p = .024$ (see Figure 3.4), and scenario \times treatment, $F(10, 560) = 10.73$, $p < .0005$ (see Figure 3.5) interactions. Post-hoc comparisons were then performed on the treatment ratings. First, overall (i.e., collapsed across scenario, gender, and team), goal setting ($M = 8.07$) was

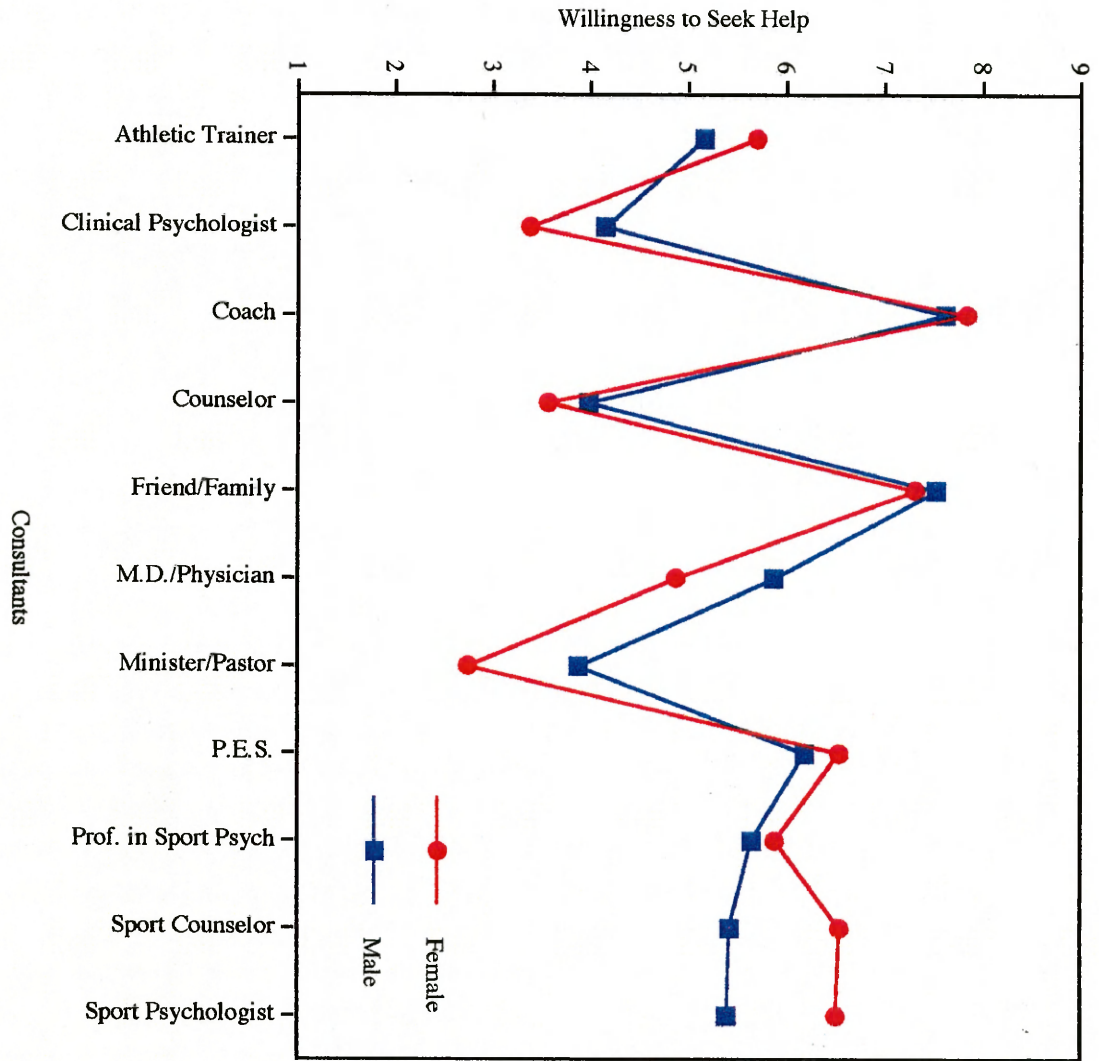


Figure 3.1

Figure 3.2

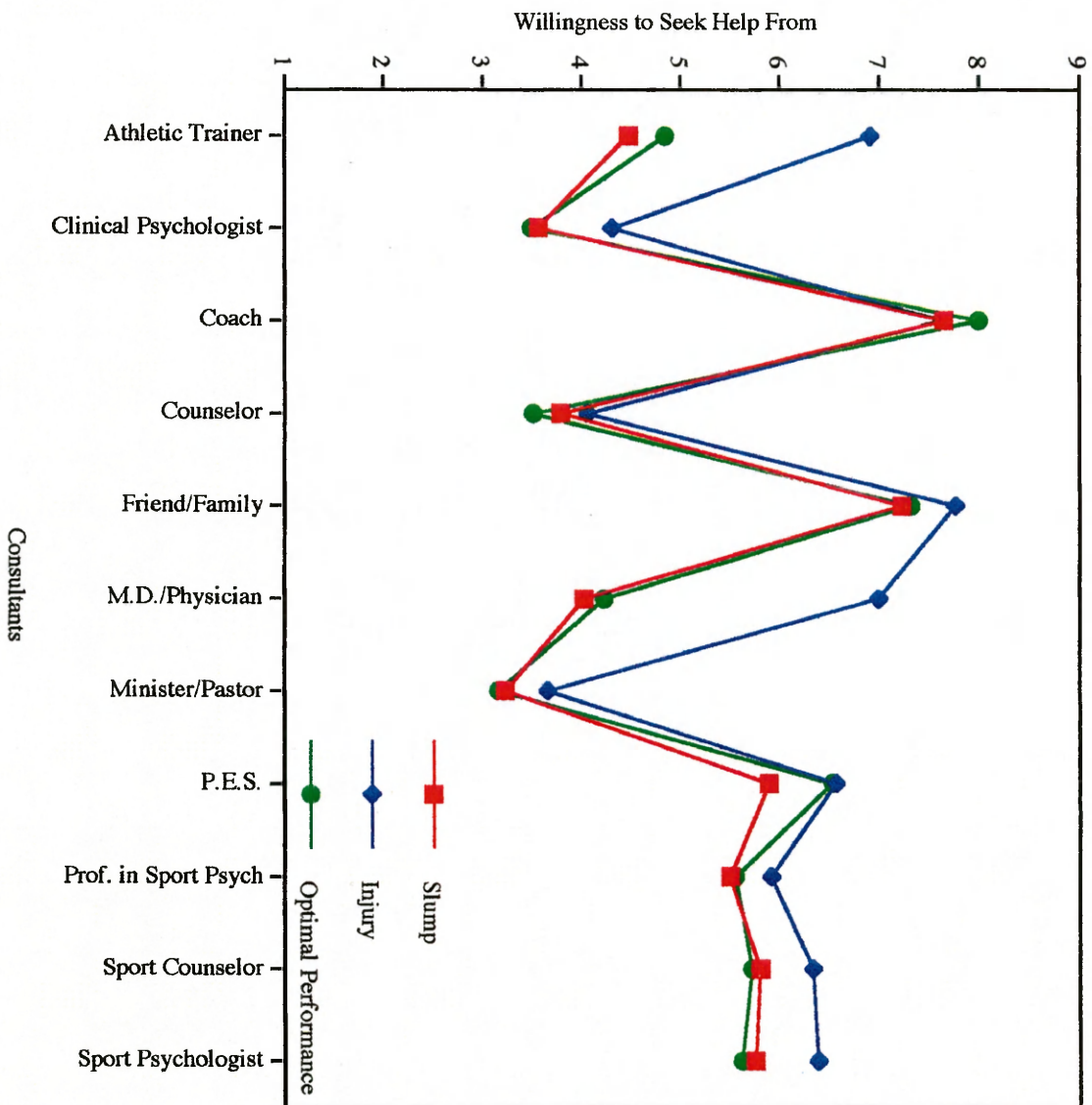


Table 3.2

Preference for Consultant Categorized by Scenario

Slump	Mean	Injury	Mean	Optimal	Mean	Average	Mean
1. Coach ^a	7.65	Friend/Family	7.77	Coach ^g	8.00	Coach ^k	7.76
2. Friend/Family	7.23	Coach ^a	7.64	Friend/Family	7.32	Friend/Family	7.44
3. P.E.S. ^b	5.89	M.D.	7.00	P.E.S. ^h	6.53	P.E.S. ^l	6.33
4. Sport Counselor ^b	5.80	Athletic Trainer ^d	6.92	Sport Counselor ⁱ	5.72	Sport Counselor ^m	5.95
5. Sport Psychologist ^b	5.75	P.E.S. ^e	6.57	Sport Psychologist ⁱ	5.62	Sport Psychologist ^m	5.92
6. Prof. in Sport Psych	5.50	Sport Psychologist ^f	6.38	Prof. in Sport Psych	5.55	Prof. in Sport Psych	5.66
		Sport Counselor ^f	6.33	Athletic Trainer ^j	4.85	Athletic Trainer ⁿ	5.42
7. Athletic Trainer ^c	4.48	Prof. in Sport Psych	5.92	Clinical Psychologist	4.32	M.D.	5.09
8. M.D.	4.03	Clinical Psychologist	4.32	Counselor	4.07	Clinical Psychologist	3.79
9. Counselor	3.80	Counselor	4.07	M.D.	4.23	Counselor	3.79
10. Clinical Psychologist	3.57	Minister/Pastor	3.67	Counselor	3.52	Minister/Pastor	3.36
11. Minister/Pastor	3.23			Clinical Psychologist	3.50		
				Minister/Pastor	3.17		

- ^a = significantly higher than values \leq 6.97**
- ^b = significantly higher than values \leq 5.13**
- ^c = significantly higher than values \leq 3.91**
- ^d = significantly higher than values \leq 6.28**
- ^e = significantly higher than values \leq 5.95**
- ^f = significantly higher than values \leq 5.76**
- ^g = significantly higher than values \leq 7.32**
- ^h = significantly higher than values \leq 5.88**
- ⁱ = significantly higher than values \leq 5.00**
- ^j = significantly higher than values \leq 4.28**
- ^k = significantly higher than values \leq 6.93**
- ^l = significantly higher than values \leq 5.53**
- ^m = significantly higher than values \leq 5.16**
- ⁿ = significantly higher than values \leq 4.72**

Table 3.3**Treatment Preference Categorized by Scenario**

<u>Slump</u>	<u>Mean</u>	<u>Injury</u>	<u>Mean</u>	<u>Optimal</u>	<u>Mean</u>	<u>Average</u>	<u>Mean</u>
1. Goal Setting	8.02	Goal Setting	7.88	Goal Setting	8.30	Goal Setting	8.07
2. Imagery	7.82	Imagery	7.83	Imagery	7.95	Imagery	7.87
3. Relaxation Training	7.20	Relaxation Training	7.33	Relaxation Training	7.28	Relaxation Training	7.27
4. Talking in depth	7.03	Talking in depth	7.30	Talking in depth	7.05	Talking in depth	7.13
5. Hypnosis	4.80	Medication	5.17	Hypnosis	4.50	Hypnosis	4.77
6. Medication	3.68	Hypnosis	5.02	Medication	3.53	Medication	4.13

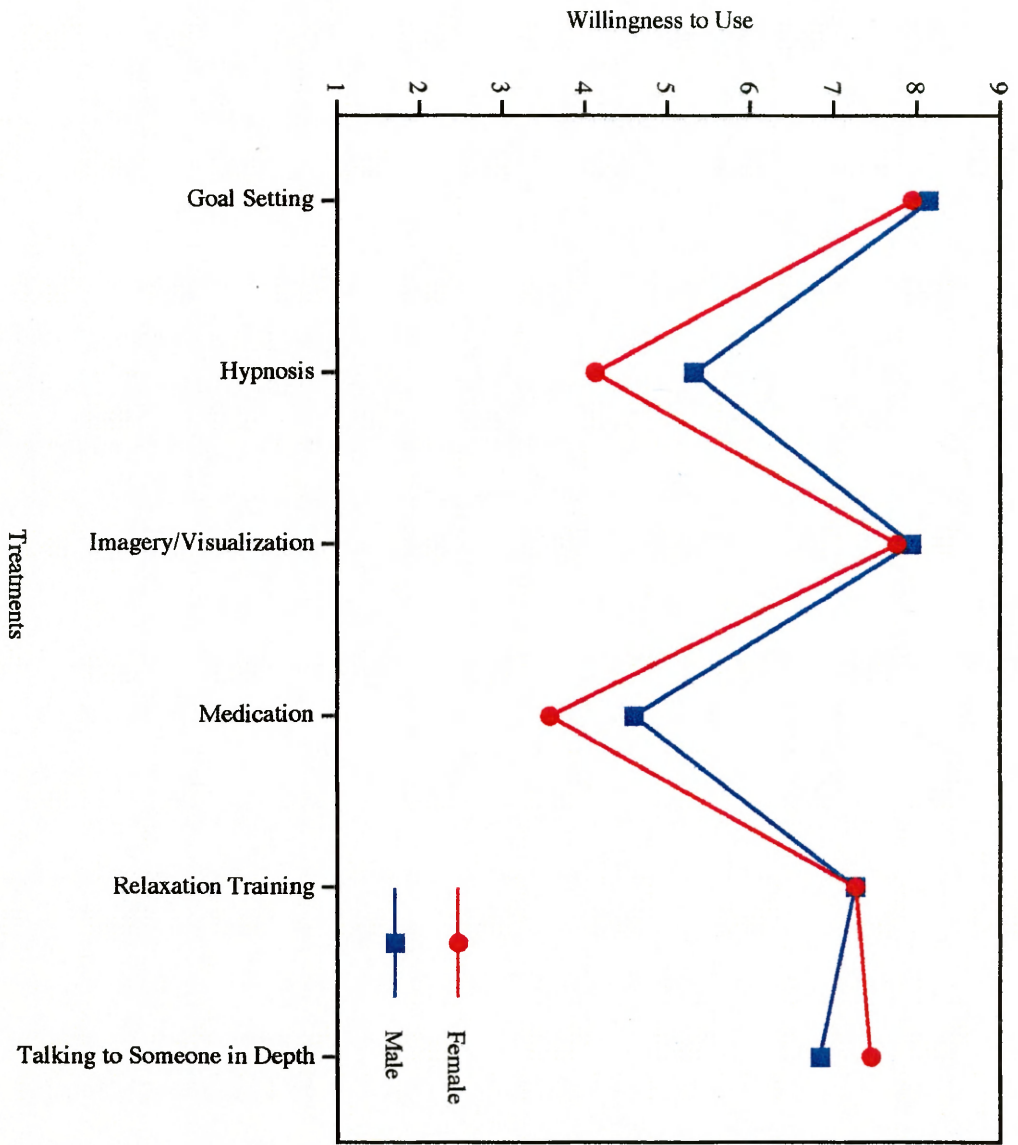


Figure 3.3

Figure 3.4

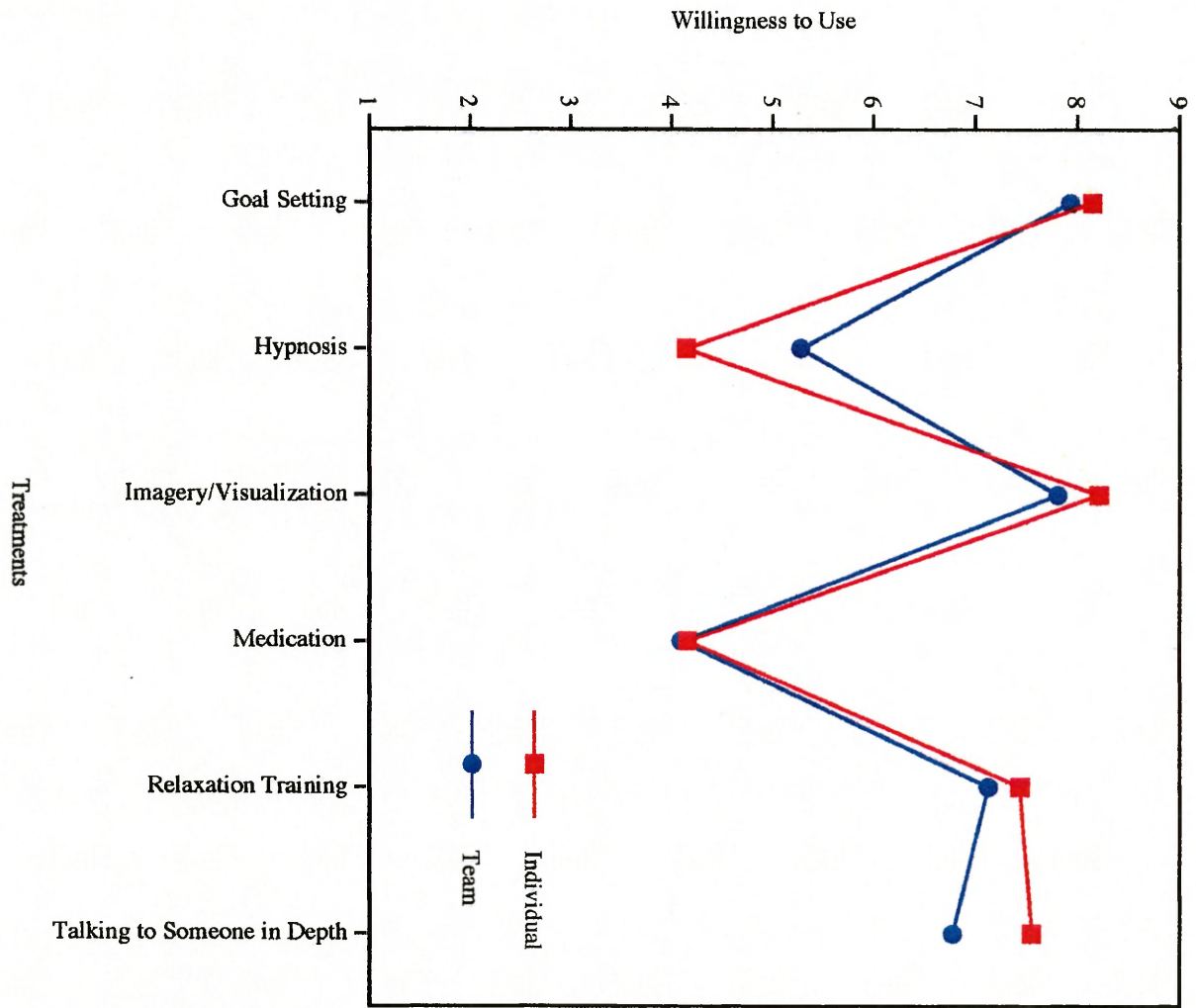
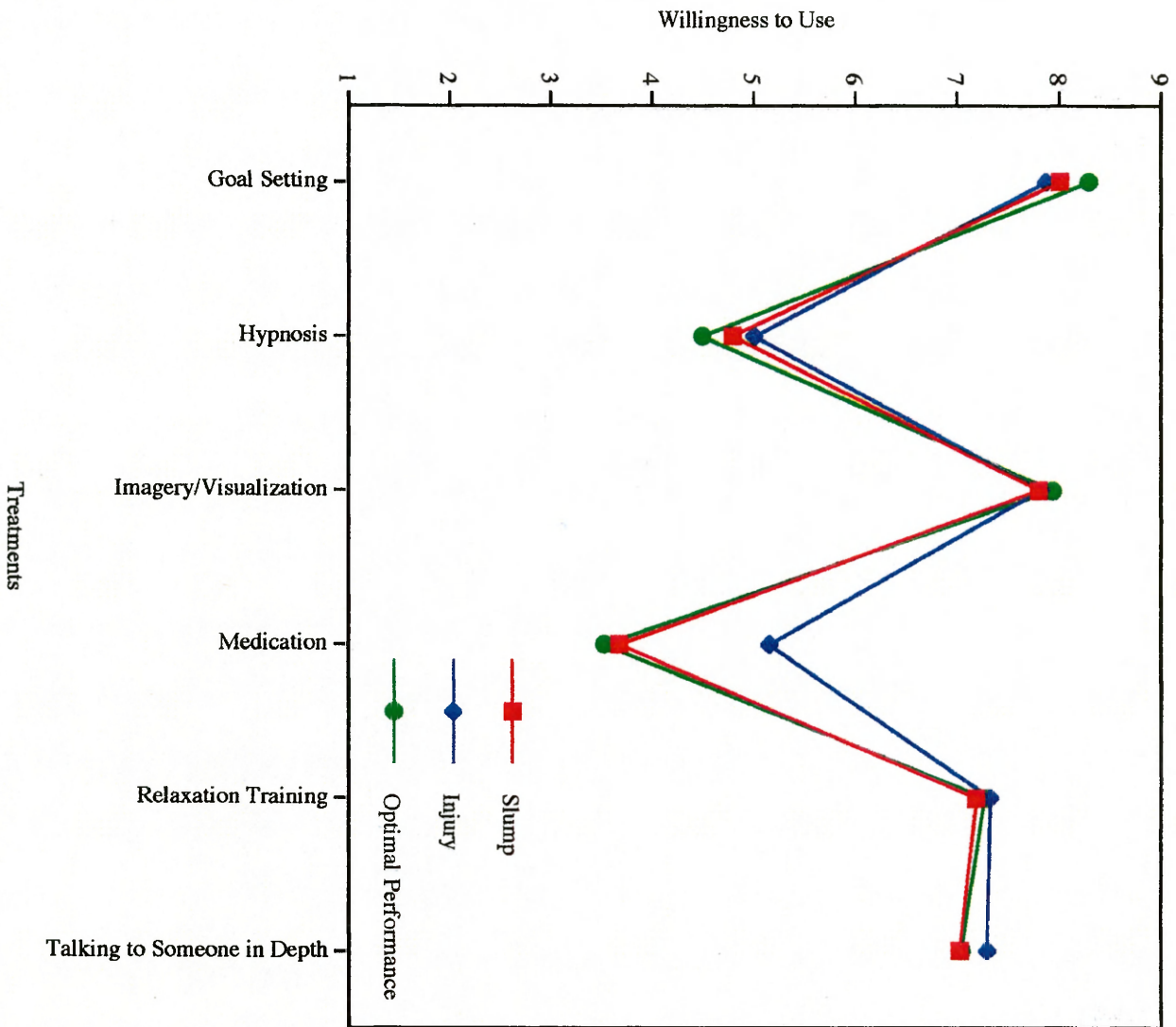


Figure 3.5



preferred over relaxation training ($M = 7.27$), talking in depth ($M = 7.13$), hypnosis ($M = 4.77$), and medication ($M = 4.13$); imagery/visualization ($M = 7.87$) was preferred over talking, hypnosis, and medication; relaxation and talking were both preferred over hypnosis and medication; and hypnosis was preferred over medication (Newman-Keuls, all $ps \leq .05$). Second, with respect to gender, males rated hypnosis ($M = 5.33$) and medication ($M = 4.60$) significantly higher than females ($M_s = 4.13$ and 3.58 , respectively), while females rated talking ($M = 7.45$) over males ($M = 6.84$; t-tests with Bonferroni correction, $ps \leq .05$). Third, with respect to team, team sport athletes rated hypnosis ($M = 5.28$) significantly higher than individual sport ($M = 4.15$) athletes, while individual sport athletes rated talking ($M = 7.56$) significantly higher than team sport ($M = 6.78$) athletes (Newman-Keuls, $ps \leq .05$). Fourth, with respect to scenario, medication was rated significantly higher for injury ($M = 5.17$) than for slump ($M = 3.68$) or optimal performance ($M = 3.53$; Newman-Keuls, $ps \leq .05$).

4. Discussion

4.1 Gender differences in willingness to seek help

In the current study, female athletes were more willing to seek help for performance-related concerns than male athletes. Overall, female athletes rated their willingness to seek help between “Probably” and “Definitely” ($M = 7.89$), while male athletes rated their willingness to seek help at approximately “Probably” ($M = 7.18$). These results correspond with research conducted with non-athletes that found a higher utilization rate of mental health services for women as compared to men (Brinson & Kottler, 1995; Gottesfeld, 1995).

Given the gender differences in willingness to seek help, it may be appropriate to target male athletes with educational programs. However, it remains to be seen as to whether males or females will be more receptive to educational experiences regarding the benefits of sport psychology interventions. In addition, although *statistically* significant, this difference does not appear to be of *practical* significance. In other words, a difference of 0.71 on a nine-point scale may not warrant any special concerns or considerations. Overall, both male and female athletes were generally willing to seek help for all three scenarios.

4.2 Team differences in willingness to seek help

Contrary to initial expectations, no significant difference was found between team and individual sport athletes in terms of willingness to seek help. Both team and individual sport athletes indicated they were “probably” willing to seek help. This finding suggests that athletes from all sports are equally likely to seek help.

4.3 Consultant preferences

Athletes in the current study indicated that they would be more willing to seek help from all consultant types in the case of an injury scenario. This was true with one single exception. Specifically, athletes were not more likely to consult with their coach in the

injury scenario. This suggests that athletes are more likely to seek help from consultants outside of their coach when injured in contrast to when in a slump or when they desire to perform more optimally. The athlete's motivation to seek professional assistance in the case of an injury may be due to limitations of the coaching staff. It may be perfectly reasonable to approach a coach for guidance and assistance when an athlete is in a slump or when he/she desires to perform at a higher level. However, this may have been due to a ceiling effect, as the ratings for coach were already quite high in the case of slump or desire to perform more optimally.

Across all scenarios, subjects indicated they were more willing to consult with their coach than both traditional mental health professionals (clinical psychologist, counselor) and sport professionals (performance enhancement specialist, sport counselor, sport psychologist). In addition, having the word "sport" imbedded in the professional title of counselors or psychologists appeared to increase athlete willingness to consult professionals. Moreover, professional titles without any reference to psychology or counseling (e.g., "performance enhancement specialist") were viewed as more attractive by subjects within the context of the optimal performance scenario. As noted below, these findings may suggest that professionals consider obtaining some sport science training in order to justify using the term "sport" when offering professional services.

In addition, women were more willing to seek help from sport professionals, whereas men were more willing to seek help from mental health professionals, physicians, and religious persons. One possible explanation for this difference may be because males have more traditional beliefs in who to seek help from. Perhaps, men are more comfortable in seeking help from the traditional, established professions of mental health, medicine, and religion. Women, on the other hand, may be more comfortable seeking help from nontraditional, or "new", professionals, such as sport psychologists. However, because there is little research on this topic, any interpretation of the results must be speculative.

4.4 Willingness to seek help when recommended by a coach

Again, contrary to initial expectations, a coach's recommendation had no significant effect on an athlete's willingness to seek help. Although athletes rated their coach as the person they were most willing to seek help from, in this study, a hypothetical coach's recommendation had no effect on willingness to seek help from a consultant. However, because the initial willingness to seek help ratings were already quite high without coach-recommendations, the absence of an effect in this case may be due to ceiling effects.

4.5 Treatment preferences

As expected, goal setting, imagery, and relaxation were preferred over hypnosis and medication. This may be due to goal setting, for example, being the least psychological and most common (i.e., well-known) intervention. In addition, talking in depth was also preferred over hypnosis and medication. This finding suggests that athletes may prefer counseling, at least when it is not referred to as "counseling," over less familiar or extreme interventions such as hypnosis and medication, respectively. And, goal setting was preferred over relaxation training. This preference was interesting because previous studies had found high ratings for relaxation training (Jensen, 1997; Jensen et al., 1992) and goal setting (Brewer et al., 1994); however, these studies did not compare *both* interventions. Again, though, it must be noted that the difference between goal setting and relaxation training may be of statistical significance but not practical significance, as relaxation training was rated generally high.

In examining the different treatment preferences of team and individual sport athletes, relatively little difference emerged except for hypnosis (higher for team) and talking (higher for individual). This result was surprising; however, the difference may be due to psychological skills training sessions that have been conducted with the soccer team over the past two years. Perhaps, the soccer players in the current study, who were introduced to hypnosis and self-hypnosis, contaminated the team sport ratings for the

hypnosis intervention. The differences for the talking intervention, however, may be due to uneasiness on team sports to consult someone outside of their sport. For example, “talking in depth” may be interpreted as “talking to someone other than my coach or teammates in depth.” As stated earlier, team sport athletes may have a greater sense of team unity and thus may be less likely to go outside the team for assistance. This tendency may not have been accurately reflected in the overall willingness to seek help ratings, as coach or friend could have been considered as possible helpers. However, when it was asked if the athlete would be willing to talk in depth with someone, she/he may have inferred that the talking would be with a non-sport professional.

With respect to gender, relatively little difference emerged except for hypnosis and medication (higher for men) and talking (higher for women). And, with respect to scenario, relatively little difference emerged except for medication in the case of injury.

4.6 Summary and recommendations for further research

Athletes appear quite willing to seek help for sport-specific performance concerns. For example, on a nine-point Likert-type scale, athletes rated their willingness above “Probably” ($M = 7.49$). However, their willingness to seek help appears to decrease as the professional with whom they might work is viewed as more closely associated to the mental health field. Athletes in the current study preferred a coach over a sport psychologist (and related titles), which was in turn preferred over a clinical psychologist (and related fields). Because of social stigmas of psychology and psychotherapy, athletes may fear being seen as defective. Psychologists and counselors must work harder to establish in-roads with athletes. Should clinical psychologists or counselors desire to work with athletic populations, it may be necessary for them to add the word “sport” to their title (e.g., “sport psychologist) or remove any affiliation with psychology altogether (e.g., performance consultant). (For further suggestions on this topic, see Lesyk, 1998.) Of

course, this should only be done after completing additional coursework in sport science and receiving supervision with athletes and/or performance enhancement, if necessary.

For whatever reason, athletes seemed non-responsive to an imagined coach's recommendation to seek professional help. This could indicate, in cases where athletes do not want to seek consultation, that their opposition to consultation is resistant to a coach's recommendation. Perhaps, athletes are distrustful of psychologists and counselors. And when someone is distrustful of a professional group, they are often resistant to rational argument (Alloy, Acocella, & Bootzin, 1996).

Consumer education may be one effective way to help the public understand the roles of psychology and psychologists. Essentially, sport psychology must be normalized. And, according to a study by Brewer et al. (1998), one way that this can be done is through the media. For example, Rick Wolff writes an advertisement "column" regularly in *Sports Illustrated* to inform the public about issues in sport psychology and to normalize sport psychology (in addition to advertising his publications). In addition, psychology currently has a public education campaign focused on educating the public about psychologists and mental health care (see Farberman, 1997). This campaign could easily be extended to include sport psychology.

The current study's results also reveal some hesitation on the part of athletes to employ hypnosis as a performance enhancement intervention. Should a practitioner (with the appropriate training) choose to use hypnosis with an athlete, education pertaining to its use and benefits may prove to be advantageous. As stated earlier, complex interventions (such as hypnosis, for example) may require simplification in order to be effective treatments (O'Brien & Karsh, 1990). In addition, athletes in general may benefit from any education aimed at demystifying the process of hypnosis.

As a final note, results from the present study should be interpreted with caution, as the APQ has not yet been proven to be a statistically accurate (i.e., valid) measure of athlete

preferences for seeking sport performance help. However, the APQ did appear to be valid, as the results of the current study corresponded with similar studies (Brewer et al., 1994; Jensen, 1997; Jensen et al., 1997; Martin et al., 1997). In addition, factor analyses and concurrent validity studies for the APQ are in progress.

5. References

- Alloy, L.B., Acocella, J., & Bootzin, R.F. (1996). Abnormal psychology: Current perspectives (7th ed.). New York: McGraw-Hill.
- Aronson, T.A., Craig, T.J., Thomason, S., & Logue, C. (1987). Health care utilization patterns in panic disorder and agoraphobia: A naturalistic study in secondary prevention. Journal of Anxiety Disorders, *1*, 283-293.
- Banken, D.M., & Wilson, G.L. (1992). Treatment acceptability of alternative therapies for depression: A comparative analysis. Psychotherapy, *29*, 610-619.
- Bass, B.A. (1986). Effects of professional title and degree upon the perceived credibility of a sex therapist. Journal of Sex Education and Therapy, *12*, 47-50.
- Bergandi, T., & Wittig, A. (1984). Availability of and attitudes toward counseling services for the collegiate athlete. Journal of College Student Personnel, *25*, 557-558.
- Betts, G.R., & Remer, R. (1993). The impact of paradoxical interventions on the perceptions of the therapist and ratings of treatment acceptability. Professional Psychology: Research and Practice, *24*, 164-170.
- Bloom, L.J., Schroeder, D.H., & Babineau, W. (1981). Reputation, training, fee, and androgyny: Their comparative effects on impressions of therapist credibility. Journal of Clinical Psychology, *37*, 90-95.
- Bornstein, P.H., Ballweg, B.J., Weisser, C.E., Fox, S.G., Kirby, K.L., Andre, J.C., Sturm, C.A., Wilson, G.L., & McLellarn, R.W. (1983). Treatment acceptability of alternative marital therapies: A comparative analysis. Journal of Marital and Family Therapy, *9*, 205-208.
- Bornstein, P.H., Stube, D., Wilson, G.L., Horstman, A.M., Sheets, D.R., Zulauf, J.R., Brier, K.L., & Cogswell, K.A. (1987). Egalitarian versus traditional behavioral marital therapy: A test of preference. Behavior Therapy, *18*, 279-282.

Bourland, G., & Lundervold, D.A. (1989). Acceptability ratings for interventions on problematic behavior of older adults. Journal of Clinical and Experimental Gerontology, 11, 105-114.

Brewer, B.W., Jeffers, K.E., Petitpas, A.J., & Van Raalte, J.L. (1994). Perceptions of psychological interventions in the context of sport injury rehabilitation. The Sport Psychologist, 8, 176-188.

Brewer, B.W., Van Raalte, J.L., Petitpas, A.J., Bachman, A.D., & Weinhold, R.A. (1998). Newspaper portrayals of sport psychology in the United States, 1985-1993. The Sport Psychologist, 12, 89-94.

Brigham, K.S., & Brigham, J.C. (1985). The influence of psychotherapy fees on observers' evaluations of therapists and clients. Journal of Social and Clinical Psychology, 3, 224-231.

Brinson, J.A., & Kottler, J.A. (1995). Minorities' underutilization of counseling centers' mental health services: A case for outreach and consultation. Journal of Mental Health Counseling, 17, 371-385.

Brody, D.S. (1980). Feedback from patients as means of teaching the non-technological aspects of medical care. Journal of Medical Education, 55, 34-41.

Budd, K.S., & Baer, D.M. (1976). Behavior modification and the law: Implications of recent judicial decisions. Journal of Psychiatry and Law, 4, 171-244.

Campbell, J.L., & Johnson, M.E. (1991). Marital status and gender similarity in marital therapy. Journal of Counseling and Development, 69, 363-368.

Carmen, L., Zerman, J., & Blaine, G. (1968). Use of the Harvard Psychiatric Service by athletes and nonathletes. Mental Hygiene, 52, 134-137.

Cash, T.F., Begley, P.J., McCown, D.A., & Weise, B.C. (1975). When counselors are heard but not seen: Initial impact of physical attractiveness. Journal of Counseling Psychology, 22, 273-279.

Cavell, T.A., Frentz, C.E., & Kelley, M.L. (1986a). Consumer acceptability of the single case withdrawal design: Penalty for early withdrawal? Behavior Therapy, *17*, 82-87.

Cavell, T.A., Frentz, C.E., & Kelley, M.L. (1986b). Acceptability of paradoxical interventions: Some nonparadoxical findings. Professional Psychology: Research and Practice, *17*, 519-523.

Cross Calvert, S., & Johnston, C. (1990). Acceptability of treatments for child behavior problems: Issues and implications for future research. Journal of Child Clinical Psychology, *19*, 61-74.

Deane, F.P., & Chamberlain, K. (1994). Treatment fearfulness and distress as predictors of professional psychological help-seeking. British Journal of Guidance and Counseling, *22*, 207-217.

Deane, F.P., & Todd, D.M. (1996). Attitudes and perceived likelihood of seeking professional help for personal problems or suicidal thinking. Journal of College Student Psychotherapy, *10*, 45-59.

Dunbar, J.M., & Agras, W.S. (1980). Compliance with medical instructions. In J.M. Ferguson & C.B. Taylor (Eds.), Comprehensive handbook of behavioral medicine (Vol. 3). New York: Spectrum.

Elliott, S.N. (1988). Acceptability of behavioral treatments: Review of variables that influence treatment selection. Professional Psychology: Research and Practice, *19*, 68-80.

Epps, S., Prescott, A.L., & Horner, R.H. (1990). Social acceptability of menstrual-care training methods for young women with developmental disabilities. Education and Training in Mental Retardation, *25*, 33-44.

Epstein, M.H., Matson, J.L., Repp, A.C., & Helsel, W.J. (1986). Acceptability of treatment alternatives as a function of teacher status and student level. School Psychology Review, 15, 84-90.

Farberman, R.K. (1997). Public attitudes about psychologists and mental health care: Research to guide the American Psychological Association Public Education Campaign. Professional Psychology: Research and Practice, 28, 128-136.

Foxx, R.M., Bremer, B.A., Shultz, C., Valdez, J., & Johndrow, C. (1996). Increasing treatment acceptability through video. Behavioral Interventions, 11, 171-180.

Furnham, A., & Wardley, Z. (1990). Lay theories of Psychotherapy I: Attitudes to and beliefs about psychotherapy and therapists. Journal of Clinical Psychology, 46, 878-890.

Garfield, S.L. (1978). Research problems in clinical diagnosis. Journal of Consulting and Clinical Psychology, 46, 596-607.

Gass, C.S. (1984). Therapeutic influence as a function of therapist attire and seating arrangement in an initial interview. Journal of Clinical Psychology, 40, 52-57.

Gottesfeld, H. (1995). Community context and the underutilization of mental health services by minority patients. Psychological Reports, 76, 207-210.

Gould, D., & Damarjian, N. (1996). Imagery training for peak performance. In J.L. Van Raalte & B.W. Brewer (Eds.), Exploring sport and exercise psychology (pp. 25-50). Washington, DC: American Psychological Association.

Greenberg, R.P., & Zeldow, P.B. (1980). Sex differences for an ideal therapist. Journal of Personality Assessment, 44, 474-478.

Greenspan, M., & Andersen, M.B. (1995). Providing psychological services to student athletes: A developmental psychology model. In S. M. Murphy (Ed.), Sport psychology interventions (pp. 177-191). Champaign, IL: Human Kinetics.

Greenspan, M.J., & Feltz, D.F. (1989). Psychological interventions with athletes in competitive situations: A review. The Sport Psychologist, *3*, 219-236.

Hunsley, J. (1992). Development of the Treatment Acceptability Questionnaire. Journal of Psychopathology and Behavioral Assessment, *14*, 55-64.

Hunsley, J. (1993). Treatment acceptability of symptom prescription techniques. Journal of Counseling Psychology, *40*, 139-143.

Hunsley, J. & Lefebvre, M. (1991). Clinical psychologists' views of the acceptability of paradoxical techniques. Psychotherapy, *28*, 580-587.

Ievleva, L., & Orlick, T. (1991). Mental links to enhanced healing: An exploratory study. The Sport Psychologist, *5*, 25-40.

Irvin, L.K., & Lundervold, D.A. (1988). Social validation of decelerative (punishment) procedures by special educators of severely handicapped students. Research in Developmental Disabilities, *9*, 331-350.

Jensen, B.J. (1997, August). Treatment acceptability of sport psychology interventions: Findings from multiple sports. Poster presented at the annual meeting of the American Psychological Association, Chicago, IL.

Jensen, B.J., Kennerley, R.J., LeJeune-Hall, A.R., & Bacon, T.J. (1992, October). Treatment acceptability of sport psychology interventions with golfers. Paper presented at the annual meeting of the Association for the Advancement of Applied Sport Psychology, Colorado Springs, CO.

Kazdin, A.E. (1977). Assessing the clinical or applied importance of behavior change through social validation. Behavior Modification, *1*, 427-452.

Kazdin, A.E. (1980a). Acceptability of alternative treatments for deviant child behavior. Journal of Applied Behavior Analysis, *13*, 259-273.

Kazdin, A.E. (1980b). Acceptability of time-out from reinforcement procedures for disruptive child behavior. Behavior Therapy, *11*, 329-344.

Kazdin, A.E. (1981). Acceptability of child treatment techniques: The influence of treatment efficacy and adverse side effects. Behavior Therapy, *12*, 493-506.

Kazdin, A.E. (1984). Acceptability of aversive procedures and medication as treatment alternatives of deviant child behavior. Journal of Abnormal Child Psychology, *12*, 289-302.

Kazdin, A.E., French, N.H., & Sherick, R. (1981). Acceptability of alternative treatments for children: Evaluations by inpatient children, parents, and staff. Journal of Consulting and Clinical Psychology, *49*, 900-907.

Kazdin, A.E., & Wilson, G.T. (1978). Evaluation of behavior therapy: Issues, evidence, and research strategies. Cambridge, MA: Ballinger.

Kelley, M.L., Heffer, R.W., Gresham, F.M., & Elliott, S.N. (1989). Development of a modified Treatment Evaluation Inventory. Journal of Psychopathology and Behavioral Assessment, *11*, 235-247.

Leaf, P.J., & Bruce M.L. (1987). Gender differences in the use of mental-health-related services: A re-examination. Journal of Health and Social Behavior, *28*, 171-183.

Lesyk, J.L. (1998). Developing sport psychology within your clinical practice. San Francisco: Jossey-Bass.

Linder, D.E., Brewer, B.W., Van Raalte, J.L., & DeLange, N. (1991). A negative halo for athletes who consult sport psychologists: Replication and extension. Journal of Sport & Exercise Psychology, *13*, 133-148.

Lundervold, D., Lewin, L.M., & Bourland, G. (1990). Older adults' acceptability of treatments for behavior problems. Clinical Gerontologist, *10*, 17-28.

Lundervold, D.A., & Young, L.G. (1992). Treatment acceptability ratings for sexual offenders: Effects of diagnosis and offense. Research in Developmental Disabilities, *13*, 229-237.

Lundervold, D., Young, L., Bourland, G., & Jackson, T. (1991). Psychometric properties of attitudinal measures of behavior treatment in geriatric settings. Behavioral Residential Treatment, 6, 97-106.

Martin, S.B., Wrisberg, C.A., Beitel, P.A., & Lounsbury, J. (1997). NCAA Division I athletes' attitudes toward seeking sport psychology consultation: The development of an objective instrument. The Sport Psychologist, 11, 201-218.

McGuire, J.M., & Borowy, T.D. (1979). Attitudes toward mental health professionals. Professional Psychology, 10, 74-79.

Meichenbaum, D., & Turk, D.C. (1987). Facilitating treatment adherence: A practitioner's guidebook. New York: Plenum.

Meyers, A.W., Whelan, J.P., & Murphy, S.M. (1996). Cognitive behavioral strategies in athletic performance enhancement. In M. Hersen, R.M. Miller, & A.S. Belack (Eds.), Handbook of behavior modification, Vol. 30 (pp. 137-164). Pacific Grove, CA: Brooks/Cole.

Morgan, W.P. (1996). Hypnosis in sport and exercise psychology. In J.L. Van Raalte & B.W. Brewer (Eds.), Exploring sport and exercise psychology (pp. 107-130). Washington, DC: American Psychological Association.

Mudford, O.C. (1987). Acceptability of a visual screening procedure for reducing stereotypy in mentally retarded children: Evaluation by New Zealand institutional staff. Behavior Change, 4, 4-13.

Murstein, B.I., & Fontaine, P.A. (1993). The public's image about psychologists and other mental health professionals. American Psychologist, 48, 839-845.

O'Brien, S., & Karsh, K.G. (1990). Treatment acceptability: Consumer, therapist, and society. In A.C. Repp & N.N. Singh (Eds.), Nonaversive and aversive interventions for persons with developmental disabilities (pp. 503-516). Sycamore, IL: Sycamore.

- Osgood, C.E., Succi, G.J., & Tannenbaum, P.H. (1957). Measurement of meaning. Urbana, IL: University of Illinois.
- Pickering, D., & Morgan, S.B. (1985). Parental ratings of treatments of self-injurious behavior. Journal of Autism and Developmental Disorders, *15*, 303-314.
- Pierce, R. (1969). Athletes in psychiatry: How many, how come? Journal of American College Health Association, *17*, 244-249.
- Pinkerton, R.S., Hinz, L.D., Barrow, J.C. (1989). The college student-athlete: Psychological considerations, and interventions. Journal of American College Health, *37*, 218-226.
- Rasnake, L.R., Martin, J., Tarnowski, K.J., & Mulick, J.A. (1996). Acceptability of behavioral treatments: Influence of knowledge of behavioral principles. Mental Retardation, *31*, 247-251.
- Ravizza, K. (1988). Gaining entry with athletic personnel for season-long consulting. The Sport Psychologist, *2*, 243-254.
- Reimers, T.M., & Wacker, D.P. (1988). Parents' ratings of the acceptability of behavioral treatment recommendations made in an outpatient clinic: A preliminary analysis of the influence of treatment effectiveness. Behavioral Disorders, *14*, 7-15.
- Reimers, T.M., Wacker, D.P., Cooper, L., & DeRaad, A. (1989). Acceptability of behavioral treatments for children: Analog and clinical evaluations by parents. Unpublished manuscript.
- Reimers, T.M., Wacker, D.P., & Koepl, G. (1987). Acceptability of behavioral interventions: A review of the literature. School Psychology Review, *16*, 212-227.
- Reinhold, J.E. (1973). Users and nonusers of college counseling and psychiatric services. Journal of American College Health, *21*, 201-208.

Ruelas, S.R., Atkinson, D.R., & Ramos-Sanchez, L. (1998). Counselor helping model, participant ethnicity and acculturation level, and perceived counselor credibility. Journal of Counseling Psychology, 45, 98-103.

Schneider, L.J., & Watkins, E., Jr. (1990). Perceptions of therapists as a function of professional fees and treatment modalities. Journal of Clinical Psychology, 46, 923-927.

Segal, B.E., Weiss, R.J., & Sokol, R. (1965). Emotional adjustment, social organization, and psychiatric treatment rates. American Sociological Review, 30, 548-556.

Singh, N.N., & Katz, R.C. (1985). On the modification of acceptability ratings for alternative child treatment. Behavior Modification, 9, 375-386.

Singh, N.N., Watson, J.E., & Winton, A.S. (1987). Parents' acceptability ratings of alternative treatments for use with mentally retarded children. Behavior Modification, 11, 17-26.

Snyder, C.R., Sympson, S., Ybasco, F., Borders, T., Babyak, M., & Higgins, R. (1996). Development and validation of the state hope scale. Journal of Personality and Social Psychology, 70, 321-335.

Spirrison, C.L. (1992). Measurement and meaning: The treatment acceptability construct and comments on Lundervold et al. (1991). Behavioral Residential Treatment, 7, 259-264.

Strupp, H.H., & Hadley, S.W. (1977). A tripartite model of mental health and therapeutic outcomes. American Psychologist, 32, 187-196.

Sturmey, P. (1992). Treatment acceptability for anorexia nervosa: Effects of treatment type, problem severity, and treatment outcome. Behavioural Psychotherapy, 20, 91-93.

Tarnowski, K.J., & Simonian, S.J. (1992). Assessing treatment acceptance: The Abbreviated Acceptability Rating Profile. Journal of Behavior Therapy and Experimental Psychiatry, 23, 101-106.

Tingstrom, D.H. (1989). Increasing acceptability of alternative behavioral interventions through education. Psychology in the Schools, 26, 188-194.

Trautt, G.M., & Bloom, L.J. (1982). Therapeugenic factors in psychotherapy: The effects of fee and title on credibility and attraction. Journal of Clinical Psychology, 38, 274-279.

Upton, L.R., & Jensen, B.J. (1991). The acceptability of behavioral treatments for marital problems: A comparison of behavioral exchange and communication skills training procedures. Behavior Modification, 15, 51-63.

Van Raalte, J.L., Brewer, D.D., Brewer, B.W., Linder, D.E. (1993). Sport psychologists' perceptions of sport and mental health practitioners. Journal of Applied Sport Psychology, 5, 222-233.

Van Raalte, J.L., Brewer, B.W., Linder, D.E., & DeLange, N. (1990). Perceptions of sport-oriented professionals: A multidimensional scaling analysis. The Sport Psychologist, 4, 228-234.

Van Raalte, J.L., Brewer, D.D., Matheson, H., & Brewer, B.W. (1996). British athletes' perceptions of sport and mental health practitioners. Journal of Applied Sport Psychology, 8, 102-108.

Vealey, R.S. (1994). Current status and prominence issues in sport psychology interventions. Medicine and Science in Sport and Exercise, 26, 495-502.

Vealey, R.S., & Greenleaf, C.A. (1998). Seeing is believing: Understanding and using imagery in sport. In J.M. Williams (Ed.), Applied sport psychology: Personal growth to peak performance (3rd ed., pp. 237-260). Mountainview, CA: Mayfield.

Von Brock, M.B., & Elliott, S.N. (1987). The influence of treatment effectiveness information on the acceptability of classroom interventions. Journal of School Psychology, 25, 131-144.

Warner, D.L., & Bradley, J.R. (1991). Undergraduate psychology students' views of counselors, psychiatrists, and psychologists: A challenge to academic psychologists. Professional Psychology: Research and Practice, 22, 138-140.

Webb, A.R., & Speer, J.R. (1985). The public image of psychologists. American Psychologist, 40, 1063-1064.

Webb, A.R., & Speer, J.R. (1986). Prototype of a profession: Psychology's public image. Professional Psychology: Research and Practice, 17, 5-9.

Weinberg, R.S., & Comar, W. (1994). The effectiveness of psychological interventions in competitive sport. Sports Medicine Journal, 18, 406-418.

Weinberg, R.S., Stitche, T., & Richardson, P. (1994). Effects of a seasonal goal setting program on lacrosse performance. The Sport Psychologist, 8, 166-175.

Wilson, G.L., & Flammang, M.R. (1990). Treatment acceptability of alternative formats of behavioral marital therapy. Scandinavian Journal of Behaviour Therapy, 19, 87-99.

Wilson, G.L., & Wilson, L.J. (1991). Treatment acceptability of alternative sex therapies: A comparative analysis. Journal of Sex and Marital Therapy, 17, 35-44.

Witt, J.C., & Elliott, S.N. (1985). Acceptability of classroom management strategies. In T.R. Kratochwill (Ed.), Advances in school psychology (Vol. 4, pp. 251-288). Hillsdale, NJ: Lawrence Erlbaum.

Witt, J.C., & Martens, B.K. (1983). Assessing the acceptability of behavioral interventions. Psychology in the Schools, 20, 510-517.

Witt, J.C., Martens, B.K., & Elliott, S.N. (1984). Factors affecting teachers' judgments of the acceptability of behavioral interventions: Time involvement, behavior problem severity and the type of intervention. Behavior Therapy, 15, 204-209.

Witt, J.C., Moe, G., Gutkin, T.B., & Andrews, L. (1984). The effect of saying the same thing in different ways: The problem of language and jargon in school-based consultation. Journal of School Psychology, 22, 361-367.

Wolf, M.M. (1978). Social validity: The case for subjective measurement or how applied behavior analysis is finding its heart. Journal of Applied Behavior Analysis, 11, 203-214.

Wollersheim, D.M., & Walsh, J.A. (1993). Clinical psychologists: Professionals without a role? Professional psychology: Research and Practice, 24, 171-175.

Wong, J.L. (1994). Lay theories of psychotherapy and perceptions of therapists: A replication and extension of Furnham and Wardley. Journal of Clinical Psychology, 50, 624-632.

Wood, W., Jones, M., & Benjamin, L.T., Jr. (1986). Surveying psychology's public image. American Psychologist, 41, 947-953.

Woolfolk, A.E., Woolfolk, R.C., & Wilson, G.T. (1977). A rose by any other name ...: Labeling bias and attitudes toward behavior modification. Journal of Consulting and Clinical Psychology, 45, 184-191.

Woolfolk, R.C., & Woolfolk, A.E. (1979). Modifying the effect of the behavior modification label. Behavior Therapy, 10, 575-578.

Figure Captions

Figure 3.1. Consultant × Gender interaction

Figure 3.2. Consultant × Scenario interaction

Figure 3.3. Treatment × Gender interaction

Figure 3.4. Treatment × Team interaction

Figure 3.5. Treatment × Scenario interaction

6. Appendixes

The following are included as part of the appendix:

A. Informed Consent

B. Demographic Questionnaire

C. Athlete Preference Questionnaire (APQ)

D. Institutional Review Board Approval

Appendix A

Informed Consent Statement

The Counselor Education Department at The University of Montana supports the practice of protection for human subjects participating in research. The following information is provided so that you can decide whether or not you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time without penalty.

The study is concerned with how student-athletes feel about certain approaches to problems in sport performance. You will be asked to read three different sport performance situations. We will then ask you four questions about how you would handle each specific series of events. Your answers will help us to learn more about how athletes handle performance problems and where athletes may seek help in times of need.

Your participation is encouraged, but it is strictly voluntary. Be assured that your name will not be associated in any way with the research findings. No one, including your coaches, will know who participated in this survey process. Upon completion of the survey, this front page will be removed from the questionnaire and replaced by a coded number. The informed consent form will be kept at a separate location from the completed questionnaire. Do not hesitate to ask any questions about this study. If you would like additional information concerning this study before, during, or after it is completed, please feel free to contact us by phone or mail. Also, if you would like to receive a summary of this study's results, check the appropriate box at the bottom of this page and include your mailing address. A copy of this consent form will be given to you.

Although we do not anticipate any injuries associated with this study, we are required to include the following paragraph in the informed consent:

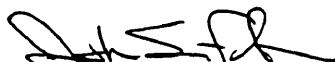
In the event that you are injured as a result of this research you should individually seek appropriate medical treatment. If the injury is caused by the negligence of the University or any of its employees, you may be entitled to reimbursement or compensation pursuant to the Comprehensive State Insurance Plan established the Department of Administration under the authority of M.C.A., Title 2, Chapter 9. In the event of a claim for such injury, further information may be obtained from the University's Claims representative or University Legal Counsel.

We appreciate your cooperation and thank you for your participation.

Sincerely,



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Name (please print): _____ Date: _____

Signature of Subject
agreeing to participate: _____

By signing, the subject certifies that he or she is at least 18 years of age

Please send me a copy of the results when it is available. Yes No
(If yes, please write your address below)

Appendix B

I. Directions: Please complete the following demographic information.

Gender: _____ Female
 _____ Male

Athletic standing: _____ Freshman
 _____ Sophomore
 _____ Junior
 _____ Senior

Current year at UM: _____ 1st year
 _____ 2nd year
 _____ 3rd year
 _____ 4th year
 _____ Beyond 4th year

Sport: _____ Football
 _____ Basketball
 _____ Volleyball
 _____ Soccer
 _____ Tennis
 _____ Golf
 _____ Track & Field (or Cross Country)

Have you been redshirted: _____ Yes
 _____ No
 _____ Currently

Did you transfer to UM: _____ Yes
 _____ No

II. Directions: Read each item carefully. Using the scale shown below, please select the number that best describes YOU and put that number in the blank provided.

1	2	3	4	5	6	7	8
Definitely	Mostly	Somewhat	Slightly	Slightly	Somewhat	Mostly	Definitely
False	False	False	False	True	True	True	True

- _____ 1. I can think of many ways out of a jani.
- _____ 2. I energetically pursue my goals.
- _____ 3. I feel tired most of the time.
- _____ 4. There are many ways around any problem.
- _____ 5. I am easily downed in an argument.
- _____ 6. I can think of many ways to get the things in life that are most important to me.
- _____ 7. I worry about my health.
- _____ 8. Even when others get discouraged, I know I can find a way to solve the problem.
- _____ 9. My past experiences have prepared me well for my future.
- _____ 10. I've been pretty successful in my life.
- _____ 11. I usually find myself worrying about something.
- _____ 12. I meet the goals I set for myself.

Appendix C

.....

SITUATION P

III. Directions: Please read the following passage. Think about how you would feel if you were experiencing what is being described. As best you can, try to imagine yourself in the situation below and how you would feel about it.

After performing well in your sport for the first part of the season, you are beginning to struggle with some basic skills that a few weeks ago were automatic. For no reason that you can see, you are experiencing a midseason slump. You are healthy and in shape, yet for some reason you cannot perform at the level you were able to just a short time ago. It seems that no matter what you do, you cannot break the pattern of performing the basic skills of your sport below what you are capable of. Your coach has not said anything to you (yet), nor has your participation been reduced, but you know something is wrong. You know that you are in a performance slump and that you are suffering because of it.

**Please answer the questions on the following page
specific to the above passage**

SITUATION P

1. How willing would you be to seek help in finding a solution to the situation described:

(circle number)	NEVER	DOUBTFUL		MAYBE	PROBABLY	DEFINITELY			
	1	2	3	4	5	6	7	8	9

2. If you did seek help, how willing would you be to seek help from the following people:

(circle number)	NEVER	DOUBTFUL		MAYBE	PROBABLY	DEFINITELY			
	1	2	3	4	5	6	7	8	9
a. Athletic Trainer	1	2	3	4	5	6	7	8	9
b. Clinical Psychologist	1	2	3	4	5	6	7	8	9
c. Counselor	1	2	3	4	5	6	7	8	9
d. Coach (current or former)	1	2	3	4	5	6	7	8	9
e. Friend or Family Member	1	2	3	4	5	6	7	8	9
f. Medical Doctor/Physician	1	2	3	4	5	6	7	8	9
g. Minister/Pastor	1	2	3	4	5	6	7	8	9
h. Performance Enhancement Specialist	1	2	3	4	5	6	7	8	9
i. Professor/Teacher in Sport Psychology	1	2	3	4	5	6	7	8	9
j. Sport Counselor	1	2	3	4	5	6	7	8	9
k. Sport Psychologist	1	2	3	4	5	6	7	8	9

3. If your coach recommended that you see a trained specialist that could help you find a solution with the situation described, how willing would you be to visit with this individual:

(circle number)	NEVER	DOUBTFUL		MAYBE	PROBABLY	DEFINITELY			
	1	2	3	4	5	6	7	8	9

4. If you did seek help for this situation, how willing would you be to use the following suggested intervention:

	NEVER	DOUBTFUL		MAYBE	PROBABLY	DEFINITELY			
	1	2	3	4	5	6	7	8	9
a. Goal setting	1	2	3	4	5	6	7	8	9
b. Hypnosis	1	2	3	4	5	6	7	8	9
c. Imagery/Visualization	1	2	3	4	5	6	7	8	9
d. Medication	1	2	3	4	5	6	7	8	9
e. Relaxation training	1	2	3	4	5	6	7	8	9
f. Talking to someone in depth	1	2	3	4	5	6	7	8	9

SITUATION Y

IV. Directions: Please read the following passage. Think about how you would feel if you were experiencing what is being described. As best you can, try to imagine yourself in the situation below and how you would feel about it.

Last season you sustained a season-ending injury in your sport that required reconstructive surgery. The experience was painful in many ways, yet rehabilitation went better than expected and you feel good about the progress you have been able to make. As you enter the new season, your doctor has given you the green light to return to full participation in your sport. However, you are struggling with your performance. With basic skills, you feel confident and seem to be fully recovered. Yet in “live” competition, you are hesitant and unwilling to fully engage. Even though you tell yourself that you are 100% ready, you are holding something back and you are not sure why. It seems you cannot help but feel that you will never again perform at the level you were able to before your injury and you are concerned that if you try, you’ll suffer the same season-ending injury again.

**Please answer the questions on the following page
specific to the above passage**

SITUATION Y

1. How willing would you be to seek help in finding a solution to the situation described:

(circle number)	NEVER	DOUBTFUL			MAYBE	PROBABLY		DEFINITELY	
	1	2	3	4	5	6	7	8	9

2. If you did seek help, how willing would you be to seek help from the following people:

(circle number)	NEVER	DOUBTFUL			MAYBE	PROBABLY		DEFINITELY	
a. Athletic Trainer	1	2	3	4	5	6	7	8	9
b. Clinical Psychologist	1	2	3	4	5	6	7	8	9
c. Counselor	1	2	3	4	5	6	7	8	9
d. Coach (current or former)	1	2	3	4	5	6	7	8	9
e. Friend or Family Member	1	2	3	4	5	6	7	8	9
f. Medical Doctor/Physician	1	2	3	4	5	6	7	8	9
g. Minister/Pastor	1	2	3	4	5	6	7	8	9
h. Performance Enhancement Specialist	1	2	3	4	5	6	7	8	9
i. Professor/Teacher in Sport Psychology	1	2	3	4	5	6	7	8	9
j. Sport Counselor	1	2	3	4	5	6	7	8	9
k. Sport Psychologist	1	2	3	4	5	6	7	8	9

3. If your coach recommended that you see a trained specialist that could help you find a solution with the situation described, how willing would you be to visit with this individual:

(circle number)	NEVER	DOUBTFUL			MAYBE	PROBABLY		DEFINITELY	
	1	2	3	4	5	6	7	8	9

4. If you did seek help for this situation, how willing would you be to use the following suggested intervention:

	NEVER	DOUBTFUL			MAYBE	PROBABLY		DEFINITELY	
a. Goal setting	1	2	3	4	5	6	7	8	9
b. Hypnosis	1	2	3	4	5	6	7	8	9
c. Imagery/Visualization	1	2	3	4	5	6	7	8	9
d. Medication	1	2	3	4	5	6	7	8	9
e. Relaxation training	1	2	3	4	5	6	7	8	9
f. Talking to someone in depth	1	2	3	4	5	6	7	8	9

SITUATION L

V. Directions: Please read the following passage. Think about how you would feel if you were experiencing what is being described. As best you can, try to imagine yourself in the situation below and how you would feel about it.

Upon completing your junior year of eligibility, you have performed relatively well in your sport. Your coach and teammates appear to be pleased with your performance. However, you feel that there is something missing. Although you have performed at an acceptable level of accomplishment, you feel that you can perform better. You have dreams of performing at optimal levels, and you feel that you have not reached the performance potential that lies within your grasp. Even though no one is pushing you to improve your performance beyond what you've done in the past, you feel you must try something to help reach the highest levels of optimal performance you feel you are capable of achieving for your senior season.

**Please answer the questions on the following page
specific to the above passage**

SITUATION L

1. How willing would you be to seek help in finding a solution to the situation described:

(circle number)	NEVER	DOUBTFUL	MAYBE	PROBABLY	DEFINITELY				
	1	2	3	4	5	6	7	8	9

2. If you did seek help, how willing would you be to seek help from the following people:

(circle number)	NEVER	DOUBTFUL	MAYBE	PROBABLY	DEFINITELY				
a. Athletic Trainer	1	2	3	4	5	6	7	8	9
b. Clinical Psychologist	1	2	3	4	5	6	7	8	9
c. Counselor	1	2	3	4	5	6	7	8	9
d. Coach (current or former)	1	2	3	4	5	6	7	8	9
e. Friend or Family Member	1	2	3	4	5	6	7	8	9
f. Medical Doctor/Physician	1	2	3	4	5	6	7	8	9
g. Minister/Pastor	1	2	3	4	5	6	7	8	9
h. Performance Enhancement Specialist	1	2	3	4	5	6	7	8	9
i. Professor/Teacher in Sport Psychology	1	2	3	4	5	6	7	8	9
j. Sport Counselor	1	2	3	4	5	6	7	8	9
k. Sport Psychologist	1	2	3	4	5	6	7	8	9

3. If your coach recommended that you see a trained specialist that could help you find a solution with the situation described, how willing would you be to visit with this individual:

(circle number)	NEVER	DOUBTFUL	MAYBE	PROBABLY	DEFINITELY				
	1	2	3	4	5	6	7	8	9

4. If you did seek help for this situation, how willing would you be to use the following suggested intervention:

	NEVER	DOUBTFUL	MAYBE	PROBABLY	DEFINITELY				
a. Goal setting	1	2	3	4	5	6	7	8	9
b. Hypnosis	1	2	3	4	5	6	7	8	9
c. Imagery/Visualization	1	2	3	4	5	6	7	8	9
d. Medication	1	2	3	4	5	6	7	8	9
e. Relaxation training	1	2	3	4	5	6	7	8	9
f. Talking to someone in depth	1	2	3	4	5	6	7	8	9

Appendix D

For Internal Use Only

Form RA-108
(Rev. 2/95)

RECEIVED

THE UNIVERSITY OF MONTANA INSTITUTIONAL REVIEW BOARD (IRB) CHECKLIST

Submit one completed copy of this Checklist, including any required attachments, for each project involving human subjects. The IRB meets monthly to evaluate proposals, and approval is granted for one academic year. See IRB Guidelines and Procedures for details.

Project Director: SAMEEP D. MANIAR Dept.: COUNSELOR ED. Phone: x2600
Signature: [Signature] Date: 12/1/97

Co-Director(s): _____ Dept.: _____ Phone: _____

Project Title: Division I Athletes' Preferences for Sport Psychology Interventions

Project Description: Assessing athletes' willingness to ^{participate in} sport psychology interventions ?
(in nontechnical language)
willingness to see various individuals across three different scenarios.

Please provide the dates requested below:

Date Submitted to IRB	Projected Start Date	Ending Date
12/2/97	2/2/98	6/1/98

Students only: Faculty Supervisor: John Still Dept.: COUN Phone: 5126
Signature: John Sommers-Flanagan

(My signature confirms that I have read the IRB Checklist and attachments and agree that it accurately and adequately represents the planned research and that I will supervise this research project.)

Project Director: Please complete page 2 of IRB Checklist, on back.

For IRB Use Only

IRB Review and Determination:

Exempt from Review Expedited/Administrative Review Approved

Conditional approval: _____

Resubmit proposal: _____

Disapproved: _____

Signature/IRB Chair: Larry Laydock Date: 12/10/97

Project Information

1. In your opinion, does this project meet the requirements for *Research Exempt from Review* as outlined in Section B of the IRB Guidelines and Procedures?

- YES (Complete information below and attach questionnaire/instrument) NO (Complete information below and attach IRB Summary, eleven items)

2. Human Subjects. Describe briefly: 100 University of Montana student-athletes (50 women, 50 men)

Are any of the following included? Check all that apply.

- Minors (under age 18) _____ If YES, specify age range(s): _____
 Members of physically, psychologically, or socially vulnerable population?

3. How are subjects selected/recruited? Explain briefly: They will be randomly selected from a list of all athletes; recruited via telephone.

4. Identification of subjects in data.

- Anonymous, no identification Identified by name and/or address or other

5. Subject matter or kind(s) of information to be compiled from/about subjects.

Describe briefly: Athletes will be asked how willing they are to seek help & from who for three different scenarios.

Is information on any of the following included? Check all that apply.

- Sexual behavior Illegal conduct
 Alcohol use/abuse Drug use/abuse
 Information about the subject that, if it became known outside the research, could reasonably place the subject at risk of criminal or civil liability or be damaging to the subject's financial standing or employability.

6. Means of obtaining the information. Check all that apply.

- Field/Laboratory observation Mail survey (Attach questionnaire/instrument)
 Tissue/Blood sampling On-site survey (Attach questionnaire/instrument)
 Measurement of motions/actions Examine public documents, records, data, etc.
 In-person interviews/survey (Attach questionnaire/instrument) Examine private documents, records, data, etc.
 Telephone interviews/survey (Attach questionnaire/instrument) Use of standard educational tests, etc.
 Other means (specify): _____

7. Is a written consent form being used: YES (Attach copy) No

8. Will subject(s) receive an explanation of the research before and/or after the project?

YES (Attach copy) No If subjects request an explanation other than what is given on the informed consent, it will be provided either during or following the questionnaire. Results will be mailed to all interested parties.

9. Is this part of your thesis or dissertation? Yes No

If YES _____ date you successfully presented your proposal to your committee: John E. Manian, PhD
Nov 26, 1997

Mr. Manian's Committee
Approves this project.
John E. Manian, PhD
Nov 26, 1997