



Empirical Justification for the Involvement of Athletes' Supportive Others When Conducting Sport Specific Mental Health Interventions

Elena Gavrilova

Department of Psychology, University of Nevada

Brad Donohue

Department of Psychology, University of Nevada, Las Vegas

JoHannah Kalita

Department of Psychology, University of Nevada, Las Vegas

Michelle Paul

Department of Psychology, University of Nevada, Las Vegas

Jennifer Pharr

Department of Environmental and Occupational Health, University of Nevada, Las Vegas

Daniel Allen

Department of Psychology, University of Nevada, Las Vegas

Collegiate athletes experience similar severity of mental health symptoms as non-athlete peers, but lower mental health treatment engagement. Only one randomized clinical trial has occurred in collegiate athletes who have been assessed for mental health disorders. In this study collegiate athletes who received sport-specific psychological intervention that was supported by the athletes' significant others showed decreased severity of psychiatric symptoms and interferences in sport performance up to 8-months post-randomization. The influence of collegiate athletes' significant others on outcomes was not examined in this study and is the aim of the current study. Results indicated the number of significant other types involved in treatment was associated with decreased psychiatric symptoms but not interferences with sport performance. Session attendance of collegiate athletes was associated with reduced interferences in sport performance but not decreased psychiatric symptomology; suggesting collegiate athletes are more likely to improve mental health when a variety of significant others are engaged in psychological intervention.

Keywords: athlete, mental wellness, mental health, family therapy, sport performance

Collegiate students in the United States formally participate in three levels of sport competition that are affiliated with universities (National Collegiate Athletics Association/ NCAA, Club, Intramural), with each having its own culture and challenges (Marzell et al., 2015). Across these levels of competition, athletes are united in their passion for sport while responding similarly to interventions that concurrently target sport performance and mental health (Donohue et al., 2018). With growing interest in athletes' mental health, extant studies have been conducted to understand the influence support systems have on athletes' mental health (Ullrich-French & Smith, 2006). Indeed, various relationships have been shown to influence the mental health of athletes (Eisenberg et al., 2012), including parents (Hussey et al., 2019), members of the athletic system (Moreland et al., 2017), coaches (Donovan et al., 2002; Ferguson et al., 2018; Rice et al., 2016; Vaughan et al., 2004; Zourbanos et al., 2010), and teammates (Dams-O'Connor et al., 2007; Hagiwara et al., 2017; Raabe et al., 2016).

Results from the aforementioned studies suggest interventions aimed at improving the mental health of athletes may be positively augmented with the incorporation of parents, coaches, teammates and other supportive others (Gill 2008; Stillman et al., 2013). Along this vein, Zimmerman and Protinsky (1993) recommended the inclusion of coaches in family system interventions with athletes, yet until recently family-based mental health interventions have not been evaluated in collegiate athletes. Donohue et al. (2018) compared campus counseling services as usual (SAU) with a sport specific family behavior therapy (coined The Optimum Performance Program in Sports; TOPPS). Results showed greater improvements in sport performance, psychiatric symptom severity, and sport-specific relationships with teammates, coaches and family for participants who received TOPPS ($n = 36$) as compared with participants in SAU ($n = 38$) up to 8-months post-randomization. Persons who were invited by student-athletes to participate in the TOPPS sessions included parents, non-parent family members, intimate partners, coaches, teammates, and non-teammate friends. The role of these persons during sessions included brainstorming solutions to problems, developing goals, modeling skills, and providing encouragement. Attendance of supportive others varied based on availability and desire of student-athlete participants and occurred through in-person and tele- and/or video-conference technologies. Indeed, tele- and video-technologies were encouraged throughout intervention when supportive others lived remotely from campus. In this study, the influence of supportive other types (e.g., parents) on treatment outcomes was not examined.

Therefore, the current study involves an examination of data that was collected but not disseminated in in Donohue et al. (2018). The aims of this study are threefold: (a) determine if the athletes' session attendance, (b) the session attendance of athletes' supportive others (piecing out athlete session attendance), and (c) the number of supportive other types (e.g., parents, coaches, teammates) involved throughout intervention (in-person, tele-therapy, video-therapy), is positively associated with athletes' outcome improvements (reductions in psychiatric symptomology and factors reported to interfere with sport performance).

Method

Participants

Participants were 36 collegiate student-athletes from a Division I university in the United States who were interested in participating in goal-oriented programming to assist sport performance and performance in life in general. Most were NCAA athletes ($n = 22$; 61%), single ($n = 35$; 97%), male ($n = 19$; 53%), and White ($n = 15$; 42%). Participants were not required to evidence psychiatric diagnoses, although according to the results of a validated semi-structured interview for the DSM-IV¹⁸ 29 (81%) evidenced current or past psychiatric diagnoses, and 15 (42%) of the participants evidenced current psychiatric diagnoses.

Inclusionary Criteria

Inclusionary criteria for participants: (a) at least 18 years old; (b) enrolled in the university while formally participating in sports (i.e., NCAA, Club, Intramural); (c) identified as having used illicit drugs or alcohol in the past 4 months; (d) expected to be enrolled for 8 months; (e) not currently receiving psychotherapy; (f) athlete had at least one adult supportive other (e.g., parent, teammate) who could be invited to at least one of intervention sessions to assist the athlete during intervention.

Procedures

Data was obtained from a subset of participants who were randomly assigned to receive the TOPPS experimental arm in the aforementioned clinical trial; Donohue et al., 2018). Participants were recruited through the university athletic department ($n = 4$; 11%), class presentations promoting goal-oriented programming for student athletes ($n = 14$; 39%), coaches and teammates ($n = 10$; 28%), and to obtain research credit for study participation ($n = 8$; 22%). During intake examination if the athlete was interested in participating in a goal-oriented program aimed at improving sport and life performance they were screened for inclusionary/exclusionary criteria, invited to consent to the study, and scheduled for baseline assessment approximately one week later. Following baseline assessment, participants were randomly assigned to either TOPPS or campus counseling SAU. Only participants who were assigned to the TOPPS were included in this study because SAU was an individually-based treatment. The study was approved by the university's Institutional Review Board, and no adverse events were reported to occur.

Intervention

The Optimum Performance Program in Sports was developed with support from the National Institute on Drug Abuse (see Donohue et al., 2018 for a review of some of these studies). Although participants were permitted to attend sessions on practice fields, almost all sessions occurred in offices decorated to celebrate sport, culture and healthy lifestyle. During the first session, participants received an orientation, including the structure and format of meetings (e.g., 12 sessions of 60 minutes each occurring within 4 months), brainstorming goals for sport and life, participation in semi-structured interviews to address sport/ethnic culture, reviewing intervention components, determining how supportive others would be involved.

Supportive others were conceptualized to be change agents to assist participants' goal accomplishment. Supportive others were engaged during sessions through in-person contact, through telephone contact, and/or through video-conference contact based on their availability

and the desire of participating athletes. One week prior to each intervention session providers were prescribed to encourage the participating athletes to attempt to engage supportive others. They were encouraged to attempt to involve their supportive others in-person whenever possible, but when supportive others were unable to attend sessions in person (e.g., lived remotely from campus, employment, lack of transportation) the participants were encouraged to engage their supportive others through telephone or video-conferencing.

During the orientation session providers reviewed who participants would most want respect from, and who some of the people are that would most likely have the participants' back in crisis. They were informed that these supportive others (i.e., family, intimate partner, coaches, teammates, non-teammate friends) are important in assisting goal accomplishment, and that they could be involved in all or some sessions to model skills, generate solutions, reward and encourage goal accomplishment, and provide motivation. Athletes were informed that they could be involved strategically in particular exercises and might need to be excluded in some sessions, or parts of sessions. They were prompted to brainstorm how others might be valuable contributors to skill development during sessions. Guidelines and confidentiality limits were reviewed prior to participation of supportive others. Participants were assured content from providers would not reflect past events unless requested explicitly by participants. Participants were asked to sign releases of information for providers to communicate with engaged supportive others, and supportive others provided verbal consents for their role as supportive others to participants after formally reviewing the role of supportive others at the start of their first session. Supportive others and participants were prompted to review how supportive others could assist the athlete at the start of each session, and participants were prompted to indicate who, if anyone, they would like to involve during the upcoming session. Participants were also encouraged to invite supportive others with whom they may have experienced difficulties to facilitate conflict resolution. When supportive others disclosed psychopathology, a referral was provided. There were no limits on the number of supportive others participants could include during intervention sessions.

At the start of each session planned intervention components were reviewed, including expected duration and how each component was expected to optimize the participants' performance plan, and athletes engaged in cognitive and behavioral skills to prepare for upcoming supportive events.

Participants' assessment results were reviewed to determine goal worthy areas. Participants and supportive others engaged in brainstorming to determine how supportive others could assist participants in goal accomplishment. Goals were relevant to optimum sport performance enhancement, mental health, relationships, academic performance, service to others, and optimum intake. Supportive others were encouraged to support participants any time and provide rewards contingent on goal completion.

A motivation enhancement exercise involved reviewing negative consequences for not achieving goals, and positive consequences associated with goal achievement. Supportive others helped brainstorm consequences.

Participants and supportive others were taught to identify and monitor goal consistent and inconsistent stimuli in the environment. Participants identified ways to manage these environmental stimuli to enhance optimum performance in sports and in life throughout intervention. Supportive others assisted in generating solutions, modeling skills, and providing encouragement. Participants learned to identify antecedents to problem behaviors, refocus disruptive thinking, diaphragmatic breathing, solution generation, review consequences to

potential solutions, imagine optimal performance, and imagine optimal reactions from others. Supportive others assisted in modeling, solution generation and encouragement. Participants were taught to make positive requests and express appreciation. Supportive others were involved as providers or recipients of requests or portrayed the role of others to assist athletes' practice.

Standard prompts were used to generate plans to improve income and decrease expenses. Supportive others assisted brainstorming and provided support. Skills were taught to solicit and prepare for job interviews. Supportive others assisted networking and interviewing skill development. Participants were encouraged to self-generate life aspirations, and brainstorm qualifications, resources and skills necessary to accomplish their dream job. Supportive others provided encouragement and supported brainstorming exercises.

Measures

A large battery of measures was administered during baseline assessment, 4-months post-baseline assessment, and 8-months post-baseline assessment. In this study only participant and supportive other session attendance and the primary outcome measures were examined.

Session Attendance

The participants' session attendance to TOPPS meetings was examined. The supportive others' session attendance was examined for in-person, telephone, and video conference across six relationship types: (a) parent; (b) non-parent family members; (c) intimate partners; (d) teammates; (e) coaches; and (f) non-teammate peers.

Psychiatric Symptoms

The Global Severity Index of Symptom Checklist 90 – Revised (SCL-90-R GSI; Derogatis et al., 1976) consists of ninety items measuring overall psychological distress during the past seven days. Each item is rated from zero (Not at all) to four (Extremely); higher scores indicate greater severity.

Factors That Interfere with Sport Performance

The Sport Interference Checklist (SIC; Donohue, Silver et al., 2007) was used to measure factors that interfere with sport performance in training and competition (e.g., "How often does being too critical of yourself interfere with your performance in training; or in competition). Each scale (Training, Competition) includes 26 items (1 = never, 7 = always). Responses are summed to obtain total scores; higher scores indicate greater interference. Psychometric properties of the SIC are excellent (Donohue et al., 2007; Donohue et al., 2019).

Study Design

Intervention outcomes (SCL-90-R and SIC) were assessed at baseline, 4-months post-baseline, and 8-months post-baseline.

Outcome Improvement

Outcome difference scores for each measure were derived by subtracting the post-assessment score from its respective baseline score. Higher scores indicate greater symptom severity, thus positive difference scores indicate improvement.

Hypotheses

It was hypothesized that (a) session attendance of athletes, (b) session attendance of supportive others (partialling out variance due to the athletes' session attendance), and (c) number of supportive other types involved throughout intervention would be positively related to outcome improvements in SCL-90-R and SIC-Training and Competition scores.

Results

Descriptive Analyses

The average number of sessions attended by athletes was 10.33 ($SD = 3$) while supportive others attended 5.19 ($SD = 3.35$) of the athletes' sessions. The average number of supportive other types (e.g., parent, coach, teammate) involved in each of the athletes' sessions was 1.97 ($SD = 1.06$).

Table 1 shows how many athletes involved the various types of supportive others in sessions. Twenty-two athletes (61.11%) involved their parents in at least one intervention session, and all relationship types were involved in at least one intervention session. Of all sessions attended by the participants ($n = 372$), most ($n = 66$; 17.74%) were attended by a parent.

Table 1
Frequency and Percentage of Participants Who Involved Supportive Other Types in at Least One Session ($N = 36$) and Sessions Attended by at Least One Member of the Various Supportive Other Types in Sessions Throughout 4-Months of Intervention

Significant Other Types Involved Throughout 4-Months of Intervention	Participant ($N = 36$)		Participant Sessions (372 attended by participants)	
	λ	%	λ	%
Parent	22	61.11	66	17.74
Teammate	17	47.22	37	9.95
Intimate Partner	10	27.78	40	10.75
Coach	9	25.00	24	6.45
Non-Parent Family Member	8	22.22	34	9.14
Non-Teammate Friend	5	13.89	24	6.45

Table 2 shows how many athletes involved two or more supportive others in intervention. The results indicate 29 of the 36 athletes (80.56%) involved two or more supportive others in at least one intervention session, while only 3 (8.33%) failed to involve a supportive other in intervention. As seen in the bottom of Table 2, 50% of the sessions involved at least one supportive other.

Table 2
Supportive Other Involvement and Attendance Throughout the 4-months of Participants' Intervention

Supportive Other Involvement	Participant (<i>N</i> = 36)	
	λ	%
Two or more SOs involved in intervention	29	80.56
Only one SO involved in	4	11.11
No SOs involved in intervention	3	8.33
Supportive Other Attendance	Participant Sessions (372 attended by participants)	
	λ	%
# of sessions no SOs were present	186	50.00
# of sessions only one SO was present	140	37.63
# of sessions two or more SOs were present	46	12.37

Note. SO = Supportive Other.

Table 3 shows that of the 186 sessions attended by supportive others, they attended sessions in person most frequently ($n = 85$; 46%) followed by telephone ($n = 51$; 14%), and all methods of participation were used to some extent.

Table 3
Frequency and Percentage of Supportive Other Session Participation Method Throughout the 4-months of Participants' Intervention

Supportive Other Participation Type	Supportive Other Sessions (186 attended by SO)*	
	λ	%
SO engaged in person	85	45.70
SO engaged via telephone	51	27.42
SO engaged via video-conference	19	10.22
Multiple types of engagement in one session	31	16.66

Note. SO = Supportive Other. *Only includes 170 out of 186 sessions where supportive other was present for whom data was available.

Examination of Main Hypotheses

Hypothesis 1: As hypothesized, Table 4 shows the athletes' session attendance was correlated with decreased severity of factors interfering with their sport performance in training, $r(36) = .46, p = .002$, and competition, $r(36) = .36, p = .014$. However, the athletes' session attendance did not significantly correlate with improvements in their psychiatric symptomology ($p = .25$).

Hypothesis 2: Table 4 shows correlation coefficients examining the association between the supportive others' session attendance and the athletes' outcome improvements in psychiatric symptomology and sports interference in Training and Competition (partialling out participant session attendance). Contrary to hypotheses, these results were not significant ($ps. > .05$).

Table 4
Correlations between Participant Attendance and Outcome Improvements in Psychiatric Symptoms (SCL-90-R) and Factors that Interfere with Sport Performance (SIC) (N=36)

Variable	1	2	3	4	5	6
1. Participant Session Attendance	-					
2. SO Session Attendance	.66**	-				
3. # of SO Types Involved in Intervention	.58**	.67**	-			
4. SCL-90-R Baseline to Post Difference	.12	.05	.33*	-		
5. SIC Training Baseline to Post Difference	.46**	.31*	.44**	.69**	-	
6. SIC Competition Baseline to Post Difference	.36*	.28	.40*	.72**	.88**	-

Note. SO = Supportive Other, SCL-90-R = Symptom Checklist-90-Revised, SIC = Sport Interference Checklist. $N = 36$. * $p < .05$; ** $p < .01$ (1-tailed).

Hypothesis 3: As hypothesized, Table 5 shows that after controlling for the athletes' session attendance, the number of types of supportive others involved throughout intervention were associated with improvements in the athletes' psychiatric symptomology, $r(36) = .32, p = .03$. However, number of supportive other types involved in intervention was not associated with severity of factors interfering with the athletes' sport performance in Training ($p = .09$) or Competition ($p = .08$). Therefore, including a variety of supportive other types in TOPPS significantly contributes to improvements in psychiatric symptomology above and beyond the session attendance of athletes, but not improvements in factors that interfere with the sport performance of athletes.

Table 5

Correlations between Outcome Improvements and Supportive Other Session Attendance and Number of Supportive Others Involved in Intervention While Partialling out the Participants' Attendance (N=36)

Variable	Supportive Other Session Attendance	# of Supportive Other Types Involved in Intervention
1. SCL-90-R Baseline to Post Difference	-.04	.32*
2. SIC Training Baseline to Post Difference	.00	.24
3. SIC Competition Baseline to Post Difference	.05	.25

Note. SCL-90-R = Symptom Checklist-90-Revised, SIC = Sport Interference Checklist. $N = 36$.

* $p < .05$ (1-tailed).

Discussion

There is increasing evidence that support systems have a positive influence on the mental health of collegiate athletes, although the impact of these contributions has yet to be assessed within the context of athletes' mental health intervention. In the current study, the utility of one particular aspect of a sport-specific mental health intervention (the intentional engagement of student athletes' supportive others) was examined.

Given that no information is available regarding basic characteristics of supportive others in family based mental health intervention for athletes (or methods of including them in therapy sessions), the initial data analyses were focused on determining the extent to which supportive others of collegiate athletes can be successfully recruited to participate in family-based intervention. Along this vein, the vast majority (81%) of student-athletes in the examined sample engaged two or more supportive others throughout their 4 months of intervention. Only 3 (8%) of the athletes did not involve any supportive others throughout intervention. At least half of all intervention sessions were attended by one or more supportive others, most often by parents. This is encouraging because others have inferred that because collegiate athletes are likely to desire independence from their parents, it may be difficult to engage them in collegiate athletes' mental health intervention. While athletes most often engaged parents, intimate partners, non-parent family members, teammates, coaches, and non-teammate friends were substantially involved, usually in person although telephone and video-conferencing were used in 46% of the sessions. The results suggest athletes' mental health interventions are capable of engaging the supportive others of athletes, and that telephone- and video-conferencing technologies are very important methods of engagement for the supportive others of athletes who would likely be uninvolved in treatment. This finding has great implications for athletes' family-based treatment during COVID-19.

Session attendance of athletes was positively associated with improvements in factors that interfere with their sport performance in training and competition, but not improvements in

their psychiatric symptomology. The unique contribution of supportive other attendance was not associated with outcome improvements, whereas the number of supportive others involved in intervention was associated with improvements in psychiatric symptomology. Collectively these results suggest individually-based interventions may be sufficient to improve factors that interfere with athletes' sport performance whereas engagement of multiple supportive others may facilitate improvements in athletes' mental health. Moreover, although anecdotal, involving a variety of supportive others appeared to facilitate communication between these systems, and strategically improve the athletes' goals for mental health. Involving multiple supportive others also permitted strong relationships to grow across systems (e.g., between a coach and parent) so concerns could be effectively managed. Parents and intimate partners were frequent attendees and appeared to be most likely to discuss intimate issues specific to the athletes' mental health, while less often bringing in coaches or teammates complemented goals that were specific to sports; providing therapeutically natural combinations of support that were functionally related to outcomes. It is clear from the literature that supportive others, and strong social support in general, are essential in the wellbeing of athletes. The results of this study support a connection between the involvement of social support systems and improvements in mental health through family-based mental health intervention.

In conclusion, extant studies have been conducted by scientists to systematically examine mental health interventions in collegiate athletes, and to our knowledge no research has previously examined how intervention participation of athletes' teammates, coaches and family influence mental health outcomes of athletes. Therefore, the results of this study represent an advancement in sport-specific mental health intervention development, showing the incorporation of a variety of supportive others is associated with improved mental health outcomes of collegiate athletes, and providing a framework in which similar programs can be developed in controlled clinical trials.

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