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Referral Practices: Are Sport Psychology Consultants Out of Their League?

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ABSTRACT

The purpose of the study was to examine the referral practices of sport psychology consultants in Canada. Eighteen (male = 10, female = 8) sport consultants registered with the Canadian Mental Training Registry (CMTR) returned a completed Referral Questionnaire for Sport Consultants and consent form (response rate = 51.4%). Means and standard deviations were calculated for the questions asked on a 5-point Likert scale. On the average, respondents indicated that they rarely encounter athletes with clinical problems and clients are rarely referred to them. This finding, however, was not consistent across the sport psychology consultants surveyed with some always referring and others never referring to registered psychologists or mental health professionals. When referrals are made, they are directed primarily toward specialists and those with an interest in sport. The National Sport Centre is one body that sport psychologists can tap into for referral lists. In the initial consultation, approximately half of the sport psychology consultants broach the topic of referral with their clients. The referral process is explained more thoroughly during subsequent sessions. Strategies sport psychology consultants employ to facilitate the referral process include networking, updating referral lists and maintaining contact with the client once the referral process has been initiated.

Introduction

In North America, the qualifications of individuals practicing in the area of sport psychology are diverse with the majority of practitioners receiving graduate degrees from schools and departments of Kinesiology. For instance, Teetor, Waite and Pettit (1993) surveyed 34 doctoral students who had recently graduated from programs in sport psychology. The results of the survey indicated that about 75% of doctoral students had undergraduate and/or masters degrees in physical education, kinesiology, sport studies, sport science, or exercise science. The authors suggest that the choice of counseling/clinical psychology programs to offer doctoral degrees in sport psychology accounts for the small number of graduates from counseling/clinical psychology programs. Only one program director in clinical psychology or counseling [out of nine listed in the Association for the Advancement of Applied Sport Psychology (AAASP) directory of doctoral programs] acknowledged that a doctoral degree in sport psychology could be earned from his/her department.

Similar results were discovered by Petrie and Watkins (1994). These researchers surveyed 61 counseling psychology programs that were accredited by the Washington, DC: American Psychological Association (APA) and members of the Council of Counseling Psychology Training Programs (CCPTP) to determine the extent that training in sport psychology was integrated into counselling/clinical psychology programs. The findings revealed that 93.8% of psychology programs did not offer a sport psychology course at the undergraduate level and 92.2% did not provide a course in sport psychology at the graduate level. Furthermore, all of the program directors who responded to the survey indicated that they did not plan to offer a course in sport psychology at either level in the future.

Consequently, few practicing sport psychology consultants have graduated with doctoral degrees from counseling/clinical psychology programs in which skills such as counseling/psychotherapy, psychopathology and psychological assessment are developed (Heyman & Andersen, 1998; Williams & Scherzer, 2003). These results raise considerable concern in the field of sport psychology. Practicing sport psychology consultants may not have the training to deal with issues that are clinical in nature because they have received their degrees from kinesiology programs where training in counseling/psychotherapy, psychopathology, and psychological assessment may not be provided.

This concern is compounded by the fact that anyone can claim to be a sport psychology consultant. Although, associations like AAASP have developed certification programs in which sport psychology consultants must hold a graduate degree related to sport psychology and have specialized training in the area (including knowledge of psychopathology), licensing procedures are limited (Cox, 2002). Currently, a governing body similar to the College of Psychologists of Ontario that regulates the services and practices of sport psychologists does not exist. As a result, individuals with very little background training or knowledge in dealing with assessment techniques and intervention strategies can provide counseling services to athletes who may have issues that reach clinical levels and warrant attention (Simons & Andersen, 1995).

In Ontario, Canada, the Regulated Health Care Practitioners Act (1991) states that only members of the College of Psychologists of Ontario are legally permitted to identify a disease or

disorder as the cause of symptoms in an individual (College of Psychologists of Ontario, 1997). In this jurisdiction, sport psychology consultants should not communicate a diagnosis to their athletes in the process of referring the athlete to another professional. Not only will sport consultants face a fine and imprisonment if they do so, they may also jeopardize the well-being of the athlete by intimidating him/her from receiving the treatment he/she needs.

It may seem unusual to associate psychopathology with athletes. Some researchers have suggested that athletes typically exhibit good mental health (Morgan, 1985), demonstrating a smaller range and frequency of mental disorders than the general population because of a natural selection process (Van Raalte & Andersen, 2002). They argue that it would be too difficult for a person with a severe depressive disorder or borderline personality disorder to handle the demanding schedule and regimen to which an athlete must adhere. Alternatively, the number of individuals with severe pathology may be lower among the athletic population because they engage in regular physical activity, which is commonly used as a therapeutic treatment for many disorders including depression (Brewer & Petrie, 2002).

Nonetheless, it is important to remember that athletes are members of the larger population and as such, are not immune to psychopathology (Brewer & Petrie, 2002). A recent assessment of sport psychology services offered at the University of Washington noted that 42% of athletes who used such services sought the assistance of sport psychology consultants to deal with personal/mental health issues (Leffingwell, Wiechman, Smith, Smoll, & Christensen, 2001). Williams and Scherzer's (2003) survey of the applied experiences of graduate students supported these findings. Forty-four percent of doctoral students encountered issues that were not related to sport and spent 24% of their time on these issues.

Indeed, many issues that are initially categorized as performance-related become more clinical in nature over the course of consultation with an individual athlete (Leffingwell et al., 2001; Tebbe, Goodrich, & Etzel, 2005; Van Raalte & Andersen, 2002). Researchers have documented different types of psychopathology in athletes including eating disorders, alcohol/ substance abuse, stress/anxiety disorders, personality disorders, Tourettes' syndrome, depression, anger/aggression control problems, relationship issues and sexual dysfunction (Andersen, Denson, Brewer, & Van Raalte, 1994; Brewer & Petrie, 2002; Heyman & Andersen, 1998). In many instances, clinical problems can occur as a direct result of the sport environment. Anorexia nervosa and bulimia nervosa, for example, may occur as a result of pressure to look aesthetically pleasing in sports such as gymnastics, figure skating, and diving or by weekly public weigh-ins inherent to weight-class-based sports such as wrestling and judo (Heyman & Andersen; Swoap & Murphy, 1995).

Clearly, sport psychology consultants cannot disregard the possibility that clinical issues may arise during the course of consultation with an athlete. Unfortunately, the field has not progressed to the point where sport psychology consultants must be trained to make diagnoses and incorporate psychodynamic interventions into their treatment repertoire. Therefore when psychopathology is suspected, researchers suggest that sport psychology consultants realize the limitations to their abilities to contend with clinical issues. If the consultant does not have adequate knowledge and/or training to competently cope with issues that fall outside the realm of performance enhancement, the athlete should be referred to a psychologist who is qualified to

handle such issues (Brewer & Petrie, 2002; Heyman & Andersen, 1998; Simons & Andersen, 1995; Van Raalte & Andersen, 2002).

For this reason, it is important for sport consultants to develop a comprehensive referral network of individuals with expertise in a variety of areas so the best possible service for their athletes is provided (Andersen et al., 1994; Brewer & Petrie, 2002; Heyman & Andersen, 1998; Van Raalte & Andersen, 2002). A licensed psychologist who has experience dealing with personal or interpersonal issues may be considered for one referral but a psychologist better suited to work with athletes suffering with anxiety and depression should be approached for another referral (Heyman & Andersen, 1998). The referral list should be comprised of a number of local clinicians and psychologists who are able to deal with different aspects of psychopathology including individuals who have displayed an interest in working with an athletic population and are willing to find mutually agreeable times to meet clients. Furthermore, because many athletes live on a strict budget, the referral network should include professionals who will provide services for a modest fee (Andersen et al., 1994; Van Raalte & Andersen, 2002),

It is important to note, however, that some athletes may not be receptive to the referral process. The negative portrayal of psychologists' behavior in the media and the stigma associated with seeing a psychologist have made athletes reluctant to engage in psychotherapy (Andersen, Van Raalte & Brewer, 2000; Giges, 2000). Athletes may view counseling as a sign of "weakness" or a threat to their personal autonomy. Furthermore, athletes may fear that their involvement in psychotherapy may cause coaches and teammates to judge the athlete negatively, which may adversely affect their sport participation (Brewer & Petrie, 2002; Linder, Brewer, Van Raalte, & DeLange, 1991; Linder, Pillow, & Reno, 1989; Pierce, 1969; Pinkerton, Hinz, & Barrow, 1989). Maniar, Curry, Sommers-Flanagan, and Walsh (2001) found that when it comes to dealing with sport performance-related issues such as slumps, athletes prefer getting help from coaches over professionals, counsellors, and clinical psychologists. Who athletes prefer to turn to for help when faced with problems outside the realm of sport performance is uncertain.

Van Raalte and Andersen (2002) provide a number of suggestions to help sport psychology consultants effectively manage the referral process. First, they should prepare athletes for the possibility of referral by discussing the referral process in the first meeting with the athlete and providing a handout on the topic of referral that can be read by the athlete later. Second, when it is apparent that the athlete's problems fall outside of the scope of performance enhancement, the sport psychology consultant should explain to the athlete why the referral is being made, to whom the referral is being made, and what is usually involved in the therapy sessions with that particular professional. Van Raalte and Andersen also encourage sport psychology consultants to use terms that the athlete is familiar with from their work in performance enhancement instead of pathological terms. The use of language readily understood by athletes should help them to accept help from another source rather than fear what may be involved in working with a "shrink".

One alternative that may be considered is to refer "in" the professional. A team approach may help the athlete to feel more comfortable with the professional because the meeting will take place in an environment the athlete is familiar with. In addition, the trust and rapport already established with the sport psychology consultant may help the athlete to develop a new therapeutic alliance with the professional to whom he/she is being preferred (Andersen et al.,

1994; Heyman & Andersen, 1998; Van Raalte & Andersen, 2002). The athlete may also feel better in this situation because fears of abandonment by the sport psychology consultant are diminished (Van Raalte & Andersen, 2002). Whether the professional is referred in or not, it is very important that sport psychology consultants continue their work with their athletes while the referred professional deals with the athlete's clinical issues so their athletes do not feel abandoned (Heyman & Andersen). A team approach may provide the most complete service for the athlete. After all, the primary goal of the referred professional and sport psychology consultant is the general welfare of the athlete.

Information on the referral practices of sport psychology consultants, however, is very limited. It is not certain how many sport psychology consultants even refer out when athletes present issues beyond their competence. The concerns regarding the adequacy of training and credentialing in sport psychology, point to the need for further investigation. The purpose of this study, therefore, was to examine the referral practices of sport consultants in Canada.

Method

Participants

Thirty-five male and female sport psychology consultants who are registered with the Canadian Mental Training Registry (CMTR) were mailed questionnaires with a cover letter and consent form attached. Eighteen (male = 10, female = 8) returned a completed questionnaire and consent form for a response rate of 51.4%. This response rate was due, in part, to the fact that a follow-up mailing to non-respondents was not done because officials at the CMTR preferred to mail questionnaires out to its members directly from their office.

The ages of the participants ranged from 27 to 59 years (M = 37.8). The average number of years they had been a member of the CMTR was 3.5 years (range = 1-7) and had offered their services as a sport consultant for 8.9 years (range = 5-25). Only one respondent indicated that he/she was a registered psychologist. With regard to the highest university degree obtained, 8 had a Ph.D. and 10 had a masters degree (either a M.A. or M.Sc.). When asked what was the program of study while taking this degree, 15 respondents indicated sport psychology, 2, athletic counselling and 1, education.

The Canadian Mental Training Registry

Similar to the AAASP, the CMTR is an association that sport psychology consultants can register with. To become a member, an individual must have educational experience in mental training and performance enhancement, a background understanding of sport science, first-hand experience in sport, mental training consulting experience and favourable client evaluations (Canadian Mental Training Registry, 2003). The CMTR is clear with regard to what services their consultants do and do not provide.

Provide: Mental training consultants teach and facilitate the learning of mental skills that are essential to high level performance such as goal setting, concentration, dealing with adversity, mental imagery, mental preparation for practice and competition, and effective performance

evaluation. They counsel athletes, coaches, and parents on ways to improve positive communication, listen to their concerns and perspectives, and help them draw upon their strengths. Mental training consultants help athletes to increase their body awareness and control, and assist them in maintaining a positive perspective while competing and when recovering from injury or setbacks. They serve as a "sounding board" for athletes, coaches, and parents, especially when they are contemplating important decisions. Mental training consultants encourage athletes to believe in themselves, and discuss with them how to transfer the mental skills learned through sport to other endeavours outside of sport. Many consultants are also involved in teaching children various mind/body skills and try to help them to develop and maintain a positive and healthy perspective about themselves, others, sport, and life.

Do not provide: Mental training consultants do not conduct psychometric testing for the purpose of diagnosing or treating psychiatric disorders; nor do they provide psychotherapy, prescribe drugs, deal with deep-seated personality disorders or mental illness. The treatment of patients with mental disorders clearly falls outside the scope of ongoing mental training consulting work with athletes or others pursuing excellence. This is a distinctly different role from the mental strengthening role that mental training consultants engage in with athletes and coaches. www.coach.ca/e/mental_training/coach_info.htm

Presently, the CMTR is inactive and is in the process of reviewing the accreditation process. However, at the time of data collection it was an active accreditation body.

Measures

Background Information

Participants completed a background information questionnaire that measured background information including: gender, age, geographic location, level of education attained, level of training in counseling/clinical psychotherapy, amount of apprenticing experience, amount of experience consulting athletes, work setting, and number of patients treated per week.

Referral Questionnaire

The Referral Questionnaire for Sport Consultants (RQSC) was developed by the researchers to assess the referral practices of sport consultants. The questionnaire consisted of 14 questions on a 5-point Likert scale (1 = never, 2 = rarely, 3 = half of the time, 4 = almost always, 5 = always). In addition, respondents were asked if they were familiar with the provincial regulations for making diagnoses and whether they keep a referral list. Space was provided for additional comments regarding their referral practices. This open-ended question provided valuable information about the referral practices of sport psychology consultants that were not addressed in the closed-ended questions (Cozby, 1993; Gordon, Milos, & Grove, 1991).

Procedure

After ethical approval for the proposed study was granted by Lakehead University's Research Ethics Board, all the members of the CMTR at the time of data collection (N = 35) were

sent a survey package consisting of a cover letter, an informed consent form, an instruction sheet, and the RQSC. The instruction sheet reminded the participants to read the cover letter and sign informed consent form before completing the RQSC and returning it in the enclosed self-addressed stamped envelope. An executive summary of the findings were sent to all participants who indicated that they wished to receive one.

Results

Means and standard deviations were calculated for the Likert-type questions found on the RQSC (see Table 1). </TD<< TR>

Table 1. Means and Standard Deviations for the Referral Practices Questionnaire on a 5-Point Likert Scale

	M	*SD*
1) How often do you encounter athletes with clinical problems in your counselling sessions?	2.0	.64
2) How often do you review the possibility of referral with your clients in the initial consultation?	3.1	1.32
3) How often do you provide additional information on referral practices to your clients?	2.2	.55
4) Do you intentionally network to make contact with other mental health professionals whom your clients can refer to?	3.3	1.27
5) How often do you update your referral lists?	2.5	1.15
6) How often do you refer clients out to other mental health professionals?	1.9	.42
7) How often are clients referred to you by other mental health professionals?	1.9	.80
8) How often do you consider the special needs of your clients (limited funds and availability) when making a referral?	3.9	1.26
9) How often do you refer your clients to a mental health professional who is interested in sport and working with an athletic population?	2.9	1.6
10) How often do you refer your clients to a mental health professional whom they have previously worked with?	1.9	.83
11) How often do you refer your clients to a mental health professional who specializes in the problem that your client is experiencing?	3.3	1.6
12) How often do you explain to your clients why the referral is being made, to whom and what is usually involved in the sessions?	3.8	1.6
13) How often do you avoid psychological terminology and use language the client can understand when explaining the referral process?	4.6	.72
14) How often do you maintain contact with your client once the referral has been made?	3.5	1.2

When asked if the respondents were familiar with provincial regulations for making diagnoses, 13 said yes (72.2%) and 5 said no (27.8%). With regard to whether they keep a referral list, 11 said they did (61.1%) and 7 said they did not (38.9%). Respondents indicated that they rarely (M = 2) encounter athletes with clinical problems in their counselling sessions. Because of this, referrals to mental health professions (including ones that they have previously worked with)

occur rarely (1.9 in both instances). Similarly, clients are rarely referred to the respondents (*M* =1.9). It would seem that when referrals are made, they are directed toward those with an interest in sport (*M* = 2.9) and more often, those who are specialists (*M* = 3.3). However, the high standard deviations (1.6) found in Questions 9 and 11 indicate that this practice is inconsistent across the respondents.

In the initial consultation, on the average, approximately half of the participants indicated that they broach the topic of referral with their clients (*M* = 3.1). This finding was inconsistent across the respondents (never = 1, rarely = 7, half the time = 3, almost always = 3 and always = 4). During subsequent sessions, on the average, the referral process seems to be explained in more detail - i.e., why the referral is being made, to whom and what is involved (*M* = 3.8), but this finding also was found to be inconsistent across respondents with 4 reporting that they never explain and 6 reporting that they always explain (*SD* = 1.6). Psychological jargon is avoided when explaining these practices (*M* = 4.6).

The results from questions pertaining to the process of referral indicate that some respondents employ strategies to facilitate this process, e.g., networking (*M* = 3.3), updating referral lists (*M* = 2.5), and maintain contact with clients after the referral is made (*M* = 3.5), while others do not. Of some encouragement, respondents almost always (*M* = 3.9) consider the special needs of clients (such as limited funding and availability to attend sessions) when making a referral.

Discussion

The Frequency of Referral

Although the majority of sport psychology consultants surveyed kept referral lists and recognized that this practice is "…a fundamental part of being a good professional", (R15) they rarely refer athletes to other mental health professionals. For two of the respondents, referral occurs through the National Sport Centre. They acknowledged that: "the athlete service managers have an abundance of contacts in a variety of specializations." (R10)

Other sport psychology consultants may not refer athletes out because they are trained in clinical issues and therefore, feel competent in their ability to help athletes with psychodynamic problems. For instance:

I have a Ph.D. in clinical psychology and am registered both as a clinical counsellor and psychologist - so am qualified to deal with clinical issues - which I sometimes do. However, my focus is performance and I do not as a rule work with significant clinical problems or substance abuse issues. (R14)
I am trained as a clinical psychologist also, so I am often the person people refer athletes in the community to. I don't need to update my referral list as I am very active in that community and know the individuals that I can refer athletes to through these connections. (R2)

It is possible that the practice of referring clients to mental health professionals is not recognized as a pressing need for most sport psychology consultants. One participant indicated

that he/she has never had a client with a clinical problem but if and when this happens, then a referral list will be generated. Another sport psychology consultant explained that the issue of referral had yet to present itself in the course of his/her work with athletes. To quote:

In the 8 years that I have been working as a consultant, I have never had to refer an athlete to a clinical psychologist - but I would if I suspected severe mental problems, e.g., drug/alcohol abuse, eating disorders, severe depression. (R1)

Such claims are alarming given the results of recent research (i.e., Leffingwell et al., 2001; Williams & Scherzer, 2003). The incidence of psychopathology in athletic populations cannot be disregarded. Personal and mental health issues often become apparent over the course of consultation with athletes. The boundary between performance enhancement and clinical issues may not always be clearly delineated.

Unfortunately, as one respondent noted many "…sport psychology professionals in the past haven't had adequate counselling education and training [to deal with clinical issues]." R15 It may be difficult for consultants who do not possess a strong background in counseling/psychotherapy, psychopathology, and psychological assessment to recognize when a situation is beyond their competency and should be referred out (Tebbe et al., 2005). Mandatory training in these areas would equip sport psychology consultants with the knowledge and skills necessary to deal with clinical issues. The importance of such training is evident in the following quote:

During my Ph.D., I referred one athlete onward for clinical assistance. This assistance was of poor quality. This inspired me to return to school and undertake a Post-Doc in Clinical Psychology. Personally, the emphasis is rarely on referring onward. However, I do have a group of Clinical Psychologists who I can touch base with when encountering a challenge. These colleagues are highly regarded, well educated, and willing to assist. (R16)

Explaining Referral to Clients

Findings of the present study revealed that the task of explaining referral to clients varies among sport psychology consultants. Half of the respondents acknowledged that they do not discuss the potential of referral in their initial sessions with athletes and although some respondents indicated that they provide additional details on the topic in later sessions, this practice was also inconsistent.

It is encouraging, however, that all of the respondents indicated that if a referral is necessary they explain the process in a language their clients are able to understand, intentionally avoiding the use of psychological jargon which may confuse athletes and discourage them from receiving specialized treatment. One sport psychology consultant highlighted the importance of clearly communicating to athletes when English is not their primary language:

It is imperative that we speak to clients in a manner that they understand. I go to great lengths to communicate sport psychology terms in words that are understandable and meaningful to the athlete and coach. This is especially important when working with younger athletes and those

who speak English as a second language. (R3)

Sport psychology consultants should be cognizant of the way in which the referral process is communicated. The possibility of working with other mental health professionals should be discussed in the initial consultation session and then described in detail at a later point if referral is necessary. Athletes may be more receptive to the referral process if they understand what why the referral is being made, to whom, and what is involved in the therapy sessions (Van Raalte & Andersen, 2002).

The Process

Sport psychology consultants surveyed clearly understood the importance of considering the special needs of athletes when referring onwards. Respondents indicated that they almost always account for the limited budget and busy schedules of their clients when choosing another professional to refer to. Unfortunately, few sport psychology consultants indicated that they attempt to facilitate the referral process by networking, updating referral lists and maintaining contact with the client once the referral process has been initiated. Such practices are essential. Situations may arise which are not clinical in nature but still necessitate a referral. A sport psychology consultant explained:

I have been able to develop a good referral network which also considers the location of the athlete. If the athlete can't get to see you as often as they need to or time are inconvenient, this is also a stressor for young athletes trying to work, go to school, train and compete. You often have to refer even when you don't need to for clinical/ethical issues. (R13)

To provide the best possible service for the athlete, sport psychology consultants should also consider cultivating relationships with professionals in other fields such as nutrition, and sport medicine. The following quote illustrates the importance of networking with professionals in areas relevant to working with athletic populations:

I think that having a network of qualified professionals (not just mental health professionals but other health professionals like doctors who specialize in sport, sport nutritionists) is extremely important. I have a great list of contacts and will not hesitate to give their names to the athletes with whom I work if I feel that they could benefit from seeing these people. (R1)

Closing Remarks

Because the majority of sport psychology consultants do not have extensive training in clinical psychology and are not licensed by a regulatory body, they need to be well versed and practised in outside referral. Results from this study indicate that this does not seem to be the case. The practise of referral seems to be offered inconsistently and depends on the practitioner's knowledge and comfort in dealing with issues that are clinical in nature as well as his/her willingness to network with mental health professionals.

The authors recommend that certification bodies such as The Canadian Mental Training Registry and the American Association for Applied Sport Psychology ensure that its members are

fully informed of the importance of outside referral and that lists of prospective consultants with clinical expertise are maintained. In time, the requirements to become a practising sport psychologist should include training in clinical psychology; a process that may diminish the importance of outside referral.

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