One case, four approaches: The application of psychotherapeutic approaches in sport psychology.

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Abstract

Sport and exercise psychology practitioners tasked with service provision within any environment can decide which framework(s) they draw upon to inform their applied work. However, the similarities and differences between psychotherapeutic approaches are under represented in current literature. Therefore, this paper brings together practitioners from four dominant psychotherapeutic approaches to address one specific hypothetical case. Four different cognitive behavioral approaches are outlined, namely rational emotive behavior therapy (REBT), cognitive therapy (CT), schema therapy (ST), and acceptance and commitment therapy (ACT). Each practitioner outlines their approach and proceeds to address the case by covering assessment, intervention and evaluation strategies that are specific to their approach. Similarities and differences across the approaches are discussed and implications for practice are put forth. Finally, two further practitioners introduce motivational interviewing (MI) as an additional framework to foster the working alliance.

Keywords: CBT; applied sport psychology; soccer; counselling; philosophy of practice

One case, four approaches: The application of psychotherapeutic approaches in sport psychology

A practitioner tasked with the provision of sport psychology usually has an opportunity to decide which framework(s) they draw on to inform applied work. Applied sport psychology historically draws mostly from cognitive-behavioral approaches to psychotherapy. Known as 'the Canon' (Andersen, 2009), the most prevalently reported techniques are imagery, relaxation, goal setting, and self-talk. All four have obvious roots in cognitive behavioral therapies (CBTs) but rarely are the origins of these techniques recognized in sport psychology literature. Also, these techniques are often used in isolation as 'mental skills' and in absence of full psychotherapeutic procedures. Therefore, there is a dearth of information in published literature concerning the use of CBTs with athletes (McArdle & Moore, 2012).

One common misconception is that CBT represents one specific approach. In contrast, CBT is an umbrella term that captures a family of therapies predicated on the blending of cognitive- and behavior-based elements (Bennett & Oliver, 2019). This includes rational emotive behavior therapy (REBT; Ellis, 1957), cognitive therapy (CT; Beck, 1976), schema therapy (ST; Young, Klosko, & Weishaar, 2003), and acceptance and commitment therapy (ACT; Hayes, Stroshl, & Wilson, 2012), amongst other approaches. Research in sport has found support for many of these approaches (REBT: Turner, 2016a; CT: Didymus & Fletcher, 2017; ACT: Gardner & Moore, 2012). With so many approaches all under the CBT umbrella, practitioners are challenged to train in, and adopt, one or more (or none) of these approaches. This is challenging because differences between the CBTs are not always clear, and there is limited professional practice literature that deals with the explicit usage of different CBTs. The main aim of the current paper is to address a hypothetical case (Jordan) using four dominant psychotherapeutic approaches, to encourage some discussion about

therapeutic training in sport and exercise psychology.

With the above aim in mind, this paper brings together four practitioners with expertise in four dominant psychotherapeutic approaches, namely REBT, CT, ST, and ACT (CBTs), to address one case. The four approaches were selected because they represent both second wave (REBT, CT) and third wave (ACT, ST) CBTs, which share some characterisitcs, but also fundamentally differ. In addition, REBT, CT, and ACT are particularly popular in sport psychology professional practice and applied literature, whilst ST is a relatively novel approach to sport psychology. We wanted to present a paper that provided details across these CBTs, but also highlighted differences across the approaches. In additional to the four CBTs, two additional practitioners bring expertise in motivational interviewing (MI; Miller & Rollnick, 2013), a counselling approach presented as a valuable adjunct to CBT. The first author assembled the practitioner team by contacting prominent experts in each of the selected approaches. Once the team was assembled, collectively a case narrative was developed that reflected a typical case we might work with in sport. The collective experiences of the team were abstracted out into the case of Jordan, and each practitioner was tasked with addressing the case using the approach for which they held significant expertise. So in what follows, the REBT expert authors the REBT section, and CT expert authors the CT section, and so on. Each CBT practitioner outlines their approach and proceeds to address the case by covering assessment, intervention and evaluation strategies specific to their approach. In a final stage, each section was reviewed by a highly experienced (> 25 years) CBT practitioner (HCPC Registered, British Association of Behavioural and Cognitive Psychotherapies Accredited), trainer, and supervisor, to ensure the accuracy of each approach. The coverage of these four approaches marks a shift in effective sport psychology practice, whilst introducing the reader to different ways of approaching a case. It is hoped that this paper encourages discussion about therapeutic training in sport and exercise

psychology. The approaches are organized in chronological order from when they were originally conceived in the literature, but first, we introduce the hypothetical case that each approach will address.

The Case

Jordan is a 25-year-old professional soccer athlete competing in the top domestic league. Jordan has fully invested in soccer since the age of 17, deciding not to pursue further education, and focus solely on soccer. Jordan has been playing at the same club since the age of 9, coming up through the academy system to secure a starting place in the first team. After a period of underperforming in training and matches, the coach decided not to start Jordan in the next game, placing Jordan on the bench for the first time in two years. The team played well, and subsequently, Jordan has remained on the bench for three consecutive games. You [the practitioner] notice that Jordan has become distant, not displaying the usual vigor you have observed in the past, and is bickering with teammates more frequently. In a brief conversation with you yesterday, you open up some informal dialogue with Jordan about the situation, in which Jordan commented that “I’ve been dropped…it’s made me feel so angry, and really embarrassed.” Jordan also communicates to you that “the coach thinks I’m not good enough” and that “it will be downhill from here for sure.” Jordan asks to speak with you in more detail, and so you arrange a more formal and private one-to-one session.

Rational Emotive Behavior Therapy (REBT)

The practitioner holds an MSc in applied sport and exercise psychology, a PhD in sport psychology, is a Health Care Professions Council (HCPC) Registered and British Psychological Society (BPS) Chartered Sport and Exercise Psychologist, and is also Accredited with the British Association of Sport and Exercise Sciences (BASES). They have been working as a sport and exercise psychologist since 2008 and hold an Advanced Certificate in REBT. Developed by psychotherapist Dr. Albert Ellis in the 1950s (Ellis,

1957), REBT is considered to be the first CBT, and is different from other therapies most notably due to its emphasis on rational (flexible, non-extreme, & logical) and irrational (rigid, extreme, & illogical) beliefs as the key cognitive mediators between a situation (or inferences about a situation) and affective and behavioral reactivity (Ellis & Ellis, 2018). To reflect this cognitive mediation model, a GABCDE framework is used to help clients become aware of the role rational and irrational beliefs play in how they feel and behave. If clients present with irrational beliefs (iB) that, in response to situations or events (A), manifest to block or impede their goals (G) by triggering unhealthy emotions and maladaptive behaviors (C), clients are encouraged to rigorously dispute (D) and challenge these irrational beliefs. Rational beliefs (rB) are then encouraged and reinforced to help the client experience healthy emotions and adaptive behaviors (E).

There has been a recent upsurge in literature examining REBT within sport and exercise settings (e.g., Turner & Bennett, 2018), with irrational beliefs being associated with psychological distress (Turner, Carrington, & Miller, 2019) and increased burnout (Turner & Moore, 2016) in athletes. Also, REBT is an effective approach for reducing irrational beliefs and associated dysfunctional cognition, emotions, and behaviors (see Turner, 2016a). The extant literature provides general guidance on how REBT can be applied with athletes (e.g., Turner, 2019), yet details of how REBT can be applied to specific cases are scarce.

Initial Assessment

It is possible for an initial assessment to be brief. Ellis maintained that whilst historical factors can influence psychological wellbeing, we disturb ourselves in the present. Therefore, my main aim in an initial conversation with Jordan would be to garner as much contextual information as possible, with a focus on the present. During this initial conversation, it would be important for me to show genuine interest and curiosity to accurately understand Jordan's current thoughts and feelings. I would not challenge myself or

the client to explore the presence of rational or irrational beliefs (Bs). I would also avoid biasing my assessment of Jordan with preconceived notions of irrationality. I would also not assume that Jordan's responses (C) are disproportionate or inappropriate, and would not rule out the idea that her emotions could aid goal attainment at this stage.

Assessing C. In my formal face to face assessment, I would attempt to ascertain whether Jordan is experiencing Unhealthy Negative Emotions (UNE; dysfunctional, and maladaptive) or Healthy Negative Emotions (HNE; functional, and adaptive; Ellis, 1994) in relation to being side-lined by the coach. Through fully exploring Jordan's emotional and behavioral experiences in relation to A, I can understand whether her emotions are helping or hindering goal attainment - not all emotions are unhealthy and targets for change (Kashdan & Biswas-Deiner, 2014). We would talk about her behavioral reactions to A (as we currently understand it). If my assessment reveals that Jordan is experiencing UNEs, then I will target the specific UNEs for change. For the purposes of this paper, we could suggest that Jordan is displaying shame (UNE). In REBT, shame is typically predicated by thinking that one has acted in a way that falls very short of ones ideal, and that one is being looked down upon. Shame is evidenced by Jordan's behavior; withdrawal, saving face by attacking other(s), and defending threatened self-esteem in self-defeating ways (e.g., being excessively defensive and alienating others as a result; Dryden, 2016).

Assessing A. I would next help the client to more deeply explore the initial inference (A) so that we can better understand the specific irrational beliefs at the center of Jordan's shame. To do this, I would use inference chaining (Ellis, Gordon, Neenan, & Palmer, 1997; Turner & Bennett, 2018) to go beyond the initial A that Jordan has been "dropped" and find that it is really the perception that she has let people down, that is bringing forth Jordan's shame. This more critical A can help us to discover potential irrational beliefs (iB) held more deeply. An example of Jordan's irrational beliefs might be, "I don't want to, and therefore I

must not, let people down, I can't stand it when I do, and doing so makes me a failure." Jordan has demands about not letting people down ("I must not"), and frustration intolerance ("I can't stand it") and has self-depreciation beliefs ("I am a failure") about letting people down. These beliefs have been developed over time and may be triggered in situations where Jordan thinks that she has underachieved. By going beyond the initial inference (being dropped), Jordan can realize and verbalize the irrational beliefs held in relation to letting people down. Using inference chaining, I can help Jordan to see that it might not be the deselection (inferential A) that has directly caused the shame (C); it is the irrational beliefs (iB) Jordan has about letting people down (critical A) that has led to such shame. Following this assessment, I would administer the irrational Performance Beliefs Inventory-2 (iPBI-2; Turner & Allen, 2018) to psychometrically assess irrational beliefs. This acts as a formal baseline of irrational beliefs.

Intervention

GABC education. I consider the intervention work to really begin when I formally introduce the GABC framework to the client. The early stages of the work with Jordan would include psycho-education about the GABC framework of REBT (e.g., Turner et al., 2018). My priority is to help Jordan understand the connection between B and C. I would challenge Jordan's A-C language such as "being dropped has made me feel so angry, and really embarrassed," by asking, "what are you telling yourself about letting people down that is leading to this embarrassment?" I am positing that the real cause of UNEs at this point in time are beliefs about what has happened. It is not in the client's long-term interest for me to challenge the interpretation of events. How can either of us truly know the truth of the matter? For example, Jordan says "I'd be letting people down." We don't know whether Jordan would be letting people down or not, so why spend time making excuses and pretending that this cannot be the case? An important rule when dealing with A, is to assume

that A is true. I am sensitively placing Jordan at the center of her emotional turmoil, so that an elegant solution can be achieved (Wood, Barker, & Turner, 2017), where Jordan takes responsibility for emotional reactivity. It would be easy for me to say "of course you wouldn't be letting people down, why would you think that?" But that only allows me to help Jordan *feel* better about this situation; it does not address the cause of the UNEs (i.e., deep-rooted beliefs) that could cause future turmoil.

Disputation. Here I would help Jordan to challenge her irrational beliefs. Disputation is a collaborative and scientific process in which I see the client and practitioner as scientists in cahoots, testing the validity and utility of the client's beliefs. Disputation comprises a variety of arguments, but three main arguments are generally reported in sport literature (Bennett & Turner, 2018): an *Empirical* argument such as "Are your beliefs about letting people down consistent with reality?" "Let's be scientists, what does the data show?"; a *Logical* argument such as "Does it make sense that letting people down makes you a complete failure? Does it follow that because you don't want to let people down, that you 'must not'?"; and a *Pragmatic* argument such as "Are your beliefs helpful with future goal attainment? Is it useful to believe that you are a failure if you let people down?" I would usually supplement this disputation process with a variety of interactive activities such as the Big I little i technique (Lazarus, 1977), in which Jordan is encouraged to understand that she is capable of 'good' and 'bad' behaviours (little i) but rating her whole self is not possible because humans are too complex (Big I). I also use case examples from the real world to demonstrate the fallibility of global self-rating. For example, I reason that all athletes are capable of success *and* failure, but no athlete can be rated as a 'complete success' or 'complete failure'. I would aim to help Jordan accept the inherent fallibility of being human, and understand that self-worth is not conditional or contingent on success or failure.

Rational reinforcement. In this phase, we replace the irrational beliefs that have been

rendered false, illogical, and unhelpful, with rational beliefs. Initially, this is an intellectual process of understanding which beliefs the client could endorse instead of the irrational beliefs, but as the work develops and rational beliefs are reinforced, the client can gain emotional insight and start to experience genuine emotional change in line with their new rational beliefs. We can compare rational beliefs to the irrational beliefs by asking, "is it more true, logical, and helpful to believe that letting people down makes you a failure, or is it more true, logical, and helpful to believe that letting people down shows that you are a fallible human being?" Rational reinforcement can involve the client practicing their rational beliefs using self-statements such as the athlete rational resilience credo (ARRC; Turner, 2016b).

Homework. Homework assignments between sessions can maximize the work being done with the client, and can be cognitive, emotive, and or behavioral (e.g., Turner & Barker, 2014). The Smarter Thinking 2 App (Turner & Wood, 2018) is a cognitive activity that captures the GABCDE process digitally. The app helps the client to locate, dispute, and replace their irrational beliefs and offers a diary function allowing the practitioner to view the client's work. This is vital because homework needs to be reviewed as part of each session to assess client gains and areas for future development.

Evaluation

It is possible to take a client through assessment, education, disputation, and rational reinforcement in one session but this is reliant on the client connecting with the philosophy of REBT quickly and being open from the start. In my experience it is more typical for the assessment to take one telephone conversion and one face to face session, the GABC education to last one session, disputation to take one session (per irrational belief), and rational reinforcement to be completed in the following session. After the client and I are satisfied that the irrational beliefs have been addressed, we can then move onto imbedding the rational beliefs into everyday life, which could take one to two sessions, at the same time

constantly reviewing the GABCDE process to ensure comprehension and independent application. My final session is a wrap-up of what has been covered and an opportunity for the client to demonstrate REBT on me in a role play in which I will fictitiously adopt an irrational belief and the consequent UNE. Once I am confident that Jordan can apply REBT independently and that we have resolved her main issues, following research in the field (e.g., Turner & Davis, 2018), I would administer the iPBI to mark post-intervention changes.

Conclusion

In this section I have briefly introduced REBT and its main components, and have detailed some assessment and disputation techniques that could be used with Jordan. I have also indicated the process and flow of the work, which will depend on the client and the issue(s) at the heart of the work.

Cognitive Therapy (CT)

The practitioner has a PhD in sport and performance psychology, is a BASES accredited sport and exercise scientist (psychology support), a BASES supervisor and reviewer, a Science Council chartered scientist, and holds a primary certificate in cognitive behavioral therapy, training, and stress management. They have worked with athletes, coaches, support staff, and sports teams since 2008. CT (Beck, 1967) is a structured, short-term, present-orientated approach that focuses on changing cognition to bring about subsequent helpful changes in emotions and behaviors (Beck, Rush, Shaw, & Emery, 1979). To achieve such change, CT incorporates a variety of techniques that assume that negative thoughts are the result of underlying schemas and dysfunctional beliefs (see e.g., Beck, 2011). Originally developed as a treatment for depression (Rush, Beck, Kovacs, & Hollon, 1977) and stemming from a psychiatric standpoint, aspects of CT have been applied by sport psychology practitioners. For example, cognitive restructuring has been shown to have positive effects on athletes' sportsperson-like behavior (Mohr, 2001), emotions (e.g., Haney,

2004), and stress appraisals and performance (e.g., Didymus & Fletcher, 2017).

While many similarities between CT and other CBTs exist, CT has some distinguishing features. For example, CT is based on a more complex model than other CBTs and focusses on stressors, reactions, and beliefs. CT often discusses beliefs in terms of core beliefs (e.g., those that are deeply held), intermediate beliefs (e.g., relating to attitudes, expectations), and automatic thoughts. Rather than being a philosophical modality like REBT, CT is a more concrete approach that focuses on the therapeutic alliance to develop, amongst other things, unconditional other acceptance (i.e., the understanding that others can accept us unconditionally). CT also emphasizes collaboration between the practitioner and the client where active participation from both parties leads to co-discovered solutions and the client becoming his or her own practitioner. One other distinguishing feature of CT is that the main change agent is testing the validity of negative automatic thoughts, either via cognitive restructuring or behavioral experiments. An important part of CT is psycho-education that is adapted to the individual's level of neuropsychological functioning. During this education, the practitioner encourages the client to recognize, evaluate, and respond to dysfunctional thoughts (Beck, 2011), which empowers individuals to take an active role in managing their presenting issues.

Assessment

After introductory discourse and setting of expectations, one of the first questions that I would ask Jordan is "What brings you here today?" The aim of this first open question is to encourage Jordan to talk, to begin building rapport, and to instigate the process of cognitive conceptualization (Beck, 1995). The initial phase of conceptualization takes the form of a one-to-one assessment session that usually lasts between 90 and 120 minutes. During the assessment session, I would take notes to facilitate my conceptualization beyond the session and during future sessions and would ask a series of open questions that adopt a Socratic

style (i.e., open but guiding). I would also reflect a developing partnership between Jordan and I by taking an active role in questioning and listening. Some of the key questions that I aim to be able to answer by the end of the assessment session include "How did Jordan develop the presenting problem(s)?" "What are Jordan's most basic beliefs about self, the world, and others (e.g., teammates, coaches, family)?" "What are Jordan's assumptions, expectations, rules, and attitudes?" and "What automatic thoughts and emotions are helping to maintain the problem(s)?"

The process of cognitive conceptualization lasts for the duration of the intervention and evolves alongside the therapeutic alliance between me and Jordan. I may use tools such as a thought adjustment sheet (TAS, see Table 1), which can be used to record negative automatic thoughts, emotions, and believability, during the initial phase of conceptualization. The TAS could also form the basis of between-session homework tasks (Beck, 2011; Fehm & Mrose, 2008) to facilitate transfer of learning to real-life situations. Psychometric tools may also be appropriate in Jordan's case to assess target variables (e.g., affect, performance) pre- and post-intervention. For example, it may be helpful for me to use a measure of affect (e.g., the Positive and Negative Affect Schedule; PANAS; Watson, Clark, & Tellegen, 1988) at the start of the therapeutic relationship to ascertain Jordan's baseline positive and negative affect. A measure of subjective performance satisfaction (SPS; see e.g., Didymus & Fletcher, 2017) may also help Jordan to reflect on performance at baseline.

Intervention

The primary aim of a CT intervention for Jordan is to address thoughts and inferences about self and the coach (e.g., "the coach thinks I'm not good enough") and future expectancies (e.g., things being perceived as "downhill from here for sure") with the goal of subsequently addressing feelings of anger and embarrassment. This, in turn, would influence Jordan's behavior (e.g., bickering with teammates) and help with work towards soccer related

goals. The intervention with Jordan starts during the assessment session and would continue for approximately five sessions (see Beck, 1995, 2011) that would be regularly spaced (e.g., once per week) based on Jordan's needs and competitive schedule. Ideally, each session would last between 60 and 90 minutes (dependent on availability) and could be supplemented by less frequent booster sessions after the intervention has ended. Each session is structured with an introduction (e.g., setting of the agenda for the session, discussion of homework tasks that have been completed since the last session), middle (e.g., discussion of new information and presenting problems that feed into the cognitive conceptualization), and end (e.g., recap of discussions, agreement of next homework task). The intervention focuses throughout on educating Jordan to recognize, evaluate, and respond to dysfunctional thoughts and underlying beliefs (see Beck, 2011).

The mechanism of change during the intervention involves an ongoing focus on the automatic thoughts that Jordan experiences in response to various soccer-related situations, associated emotions, and the behaviors that are displayed as a result of the thoughts and emotions experienced. The physiological component of presenting problems is also explored to help Jordan understand the links between situations, thoughts, emotions, and the impact of these on physiological states. To facilitate change, I would ask questions such as "What is an alternative way of viewing this situation?" once our client has shared some of their automatic thoughts. I may also ask questions like "What is the worst that could happen and how would you cope if it did?" and "What influence does believing your automatic thoughts have?" These questions are designed to apply the main agent of change in CT, which is to test the validity of negative automatic thoughts. An important part of the intervention is Jordan's engagement with homework tasks, which would be agreed and reviewed during each session. Each homework task would be developed with, rather than for, Jordan so the exact nature of them varies client-to-client. However, some suggestions include working through a TAS

section by section to record thoughts and emotions between sessions or creating two lists of goals: one for the intervention and one for soccer.

Ending and Evaluating the Relationship

Jordan is ready to end the intervention when automatic thoughts are consistently more helpful, belief in the negative automatic thoughts is reduced, emotions are generally facilitative for soccer performance, and behavior toward teammates and others is more favorable. To smooth Jordan's transition out of the intervention, sessions would be tapered from once per week to, for example, once every other week and eventually to three- or four-week intervals. During this time, we would explore Jordan's automatic thoughts about ending the intervention to remain aware of potential concerns. The structure and content of the final session is similar to all previous sessions but includes more of a focus on what Jordan has learnt during the intervention and this will be implemented independently in the coming weeks and months. The intervention can be evaluated via verbal feedback from Jordan and via assessment of learning in view of original goals. Re-using the PANAS and SPS measures to gather immediate and delayed post-intervention data is also likely to be helpful.

Conclusion

To summarize the CT approach to Jordan's case, the emphasis is on the links between cognition, emotion, and behavior, which are primarily accessed and changed via a focus on challenging the evidence base of and believability in negative automatic thoughts. A sound therapeutic alliance is essential for a successful intervention, as is authenticity on both my and Jordan's parts alongside engagement with homework tasks.

Schema Therapy

The practitioner holds a Doctorate in Clinical Psychology and is a HCPC registered Practioner Psychologist, and is also Chartered with the BPS. The practitioner has an MSc in sport and exercise psychology, and have been working as a Clinical Psychologist since 2006.

They have been a certified Schema Therpist with the International Society for Schema Therapy (ISST) since 2015. The goal of Schema Therapy (ST) is to identify and modify maladaptive thinking, feeling, and behaving. However, ST has a larger emphasis on past experiences and emotions, and change happens through understanding the development of schemas. The goals of ST are to identify and reduce maladaptive coping behaviours (which perpetuate schemas and reduce the likelihood of schema change), whilst developing healthier, more adaptive alternatives, and healing unhelpful schemas (Masley, Gillanders, Simpson, & Taylor, 2012; Young et al., 2003). It is more accurate to say that ST reflects an integrated model of therapy that combines aspects of CBTs, Gestalt experiential therapy, and psychoanalytic thinking. The aim is for clients to become aware of the schema being triggered and insert thoughts between emotion and action to take control of their weakened schemas. In ST, schemas are considered to be extremely stable and enduring themes that develop during childhood, and are dysfunctional to a significant degree (Young, 1999). These schemas serve as templates for the processing of later experience, but result from a child's adaptive attempt to cope with a lack of fit between their needs and the environment they grew up in (Linehan, 1993). In adulthood, these schemas result in dysfunctional perceptions that govern the way a person sees themselves, others, and the world. Eighteen individual schemas have been identified (see Young, Klosko & Weishaar, 2003). Maladaptive schemas are defined as "extremely stable and enduring themes that develop during childhood, are elaborated throughout an individual's lifetime, and are dysfunctional to a significant degree. These schemas serve as templates for the processing of later experience" (Young, 1999, p. 9). Schemas influence thoughts, feelings, and behaviors, and maladaptive schemas are, for example, positively related to psychological distress (Calvete, Estévez, López de Arroyabe, & Ruiz, 2005). Calvete et al. (2005) showed that certain schemas relate to anger and anxiety, and Hawke and Provencher (2011) and Aspin (2018) found a significant reduction in anxiety

symptoms using ST.

The lack of literature on the use of ST in sport may be due to ST being a relatively new and comparatively under researched CBT, and does not necessarily reflect ST's poor fit into the sporting context. On the contrary, ST and the schemas it proposes are relevant to athletes (Turner, Aspin, & Gillman, 2019). Given the dearth of ST-related work in sport, this section represents an important step in introducing how ST could be applied with athletes.

Assessment

In the assessment, the aim is to explore schema-related thoughts and feelings, and their origins. My first question might be "you said to me yesterday that you feel the coach thinks you are not good enough, can you tell me more about that?" This open-ended question starts a conversation to identify whether, and which, schemas are present. I am listening to the way thoughts are described and what feelings are present to match these with my knowledge of the how the schemas are defined. For example, I have heard Jordan's comments about not being picked for the team again, and this negative thinking about performance (and the assumption that improvement is impossible) is indicative of a Failure to Achieve schema. Asking "does this experience remind you of any time in your past?" starts to explore the schema's origins and helps Jordan and me to understand where and why Jordan learned to think and feel this way. Jordan could be experiencing Failure to Achieve and Defectiveness schemas, which develop from childhood needs for praise and confidence building not being sufficiently met. This may have left feelings of disappointment or deflation as Jordan does not have sense of success or competence. It is usual to pick out a few schemas within how clients talk during the first meeting and I would also ask Jordan to complete the Young Schema Questionnaire (Young, 2005), often between the first and second sessions. When reviewing the questionnaire we would identify two or three schemas to address.

Next is an imagery exercise where Jordan describes a recent time when the schema

was triggered, such as being told to stay on the bench. Once strong emotions are present the client is asked to wipe that image from their mind, keeping the feelings, and picture a time, as young as possible, when they felt the same. Imagery is used to explore the origins of the schemas because placing oneself in our mind's eye into a past situation helps us to remember the details of the thoughts and, particularly, emotions. This is important to gather more information to understand the schema but particularly for the client to get an emotional sense of the origin of the schema. This helps the client to challenge the schema driven thoughts through the realization that the schema's origins are in a past, rather than the present moment.

Intervention

The intervention aims to weaken the influence of the schema. Imagery for change rescripts past experiences to have a healthier experience that meets the child's needs, allowing healthier attitudes such as confidence and competence. The client recounts the childhood event with closed eyes and the psychologist asks guiding questions, such as "where are you, what can you see, who is there, what are they saying, what is the expression on their face?" Re-scripting starts when events in the image do not meet the child's legitimate needs (that all children have a right to be met), where the client usually becomes upset (sometimes tearful) and or their body language changes markedly, and or when there is a logical sense in the room that this is not right for the child. The psychologist is directive in telling the client how to imagine the situation so that their needs are met. As clients get to know their needs, they can become more active in re-scripting. Imagery is not to pretend that difficult events did not happen, rather, changing other people's responses in line with what the child needed. This gives a different emotional understanding; that the schema is not the objective truth but a creation due to experiences of needs not being met. This helps to distance the client from their schemas.

Another technique to challenge schemas is to use an empty chair to represent

schemas. The client can discuss with each schema what "it" wants, what "it" thinks, why "it" is there and what "its" purpose is. This is an abstract concept that even young clients can grasp quickly. A chair is identified to represent the schema being worked on, and another chair to represent the healthy and functional part of the client. Clients move between chairs speaking from either the schema or healthy part of themselves and hold this conversation until the healthy part feels it has won the 'argument'. The dialogue could go as follows:

Jordan, being the Failure to Achieve schema: "you will never be a good enough soccer player, you will never be chosen again".

(Moves chairs) *Jordan, as the healthy part of the self*: "that's a horrible thing to say, why would you say that?"

(Moves back) *Failure to achieve chair*: "because if you think you are going to be successful you will be very disappointed, I am trying to protect you from that pain".

Healthy chair: "but you are stopping me from even having chance as your negativity stops me being able to put in the effort I need to get picked each week".

Failure to Achieve: "but that negativity is your realization that you'll never be any better and means you will be prepared for the inevitable".

Healthy part: "but you are holding me back [gets angry], you are stopping me, you are making me despondent, you are making me play worse, I'm not having it any more, I will not listen to you anymore!"

This feeling that Jordan gets of triumph and powerfulness at having won over the schema is the aim of chair work; the belief and self-confidence that the client can fight the schema and win. There is realism as the psychologist and client are not pretending that Jordan will be the best athlete, just that the client has given their all and is not held back by the schemas. The client is also encouraged to identify and question the schemas outside of the sessions by using a monitoring sheet to record the trigger, emotions, thoughts, behaviors, and

identify the schema. This helps them to understand how schemas operate and can be challenged in daily life, and can be backed up by keeping lists of evidence to the contrary of the schema in order to build confidence that they can overcome the schema-related thinking.

Evaluation

The work ends when the client feels they have some control over the schemas, although they may not be symptom free. This is evident when the client feels confident in their use of self-talk to challenge the schema and win, and in using some or all of the above techniques to continue progressing without the psychologist. The number of sessions is dependent on the difficulties the client brings but between 10 and 20 sessions is often sufficient to bring about lasting change. Finishing therapy is typically an anxiety provoking time and a follow-up session a few weeks later can be offered to trouble shoot issues before ending. If the therapy has been lengthy or an outcome measure is sought for auditing/research the YSQ can be re-administered but this is not standard practice.

Conclusion

ST is about helping clients to change deeply held beliefs by accessing and changing the emotions felt in childhood when the schemas formed. Imagery and chair work are used to develop more healthy views and emotions and to encourage doubt that the schemas are factual. For some, however, issues are related to other people, and ST is an individual-based therapy with limited scope for a formal understanding of how a person's schemas may impact those around them. However, ST is an effective way for empowering people to challenge their inner voices that hold them back and allowing them to fulfil their potential.

Acceptance and Commitment Therapy (ACT)

The practitioner has an MSc in sport and exercise psychology and PhD in sport and performance psychology. They gained Chartered Psychologist status with the BPS in 2010, and they have 10 years' experience working as a sport psychologist with athletes and coaches.

They have extensive ACT training including BPS approved ACT training with Mindfulness Training Ltd. Practitioners adopting CBTs such as REBT and CT seek to challenge 'negative' or unhelpful thoughts, emotions, and bodily sensations that athletes might feel hinder their performance. Athletes are helped to develop strategies to remove and/or replace these internal experiences with more 'positive' or useful ones. In contrast, ACT posits that applying problem-solving strategies to those internal experiences (e.g., striving to reduce anxiety) is actually a root cause of psychological suffering . Therefore, rather than trying to help athletes rid themselves of these unwanted experiences in pursuit of what might be considered an 'ideal' performance state (i.e., optimal anxiety, high in confidence, relaxed, in flow, etc.), ACT approaches seek to change the relationship an individual has with internal experiences.

ACT uses "acceptance and mindfulness processes and commitment and behavioral activation processes to produce psychological flexibility" (Hayes, Strosahl, & Wilson, 2012, p. 97). ACT contends that six core processes underpin psychological flexibility (i.e., the ability to stay in contact with present moment experineces and, depending on the situation, persist or change behavior in pursuit of values). These processes are: flexible attention to the present moment, values, committed action, self-as-context, cognitive defusion, and acceptance (see Hayes et al., 2012). Deficits in any of these core processes can result in psychological rigidity (i.e., an inability to adapt to changing life circumstances), the root cause of suffering. The key to psychological flexibility, therefore, is an open, centered, and engaged response style, where individuals can accept and make room for unpleasant mental activity, pay conscious attention to the present moment, and stay connected to chosen values through daily life actions. Growing research indicates that Mindfulness-Acceptance-Commitment (MAC; Gardner & Moore, 2004, 2006) approaches are related to improvements in mindfulness, flow, performance, and lower competitive anxiety (e.g., Noetel, Ciarrochi, Van Zanden, & Lonsdale, 2018). It should be noted, however, that while initial findings are

encouraging, further research with more clearly defined intervention protocols and more carefully selected control groups is needed to increase confidence in the efficacy of MAC-based interventions. Indeed, in a recent systematic review (Noetel et al., 2018) it was indicated that many studies found positive effects for acceptance interventions, but that there was limited internal validity across studies. Therefore, the extant research exploring ACT prohibits strong causal claims about the benefits of ACT in athletes, and clearly. researchers should undertake more research in this area, addressing the limits of past work.

Assessment

The first stage of assessing the client in ACT is understanding how *they* see their issue at this particular time, so we might start by asking Jordan, “can you tell me a little about what you're struggling with at the moment?” Jordan mentions anger and embarrassment at being cut, and indicates experiencing unhelpful thoughts about the future (“it will be downhill from here for sure”) and what the coach thinks (“coach thinks I’m not good enough”), so let us assume that the conversation is steered towards those unhelpful thoughts, sensations, and emotions.

To reformulate the issue in ACT terms, we focus on the six core ACT processes and try to establish the unique version of psychological inflexibility Jordan is experiencing (Luoma, Hayes, & Walser, 2017). There is no right or wrong place to start in ACT case formulation, but since Jordan began by discussing embarrassment and anger, we might start by establishing the thoughts and feelings that Jordan is avoiding or fused with (i.e., thoughts that Jordan believes are literally true and that guide behavior in an unhelpful way). Fusion with thoughts can present as clients' ongoing and fixed evaluations of themselves, so Jordan's current experience (anger/embarrassment) seems fused with the future-oriented “downhill” outcome (despite the potentially infinite number of other possible outcomes of the current reality, i.e., being on the bench for three games).

During case formulation in ACT, it is important to focus on the function of Jordan's presenting behaviors, emotions, and thoughts, rather than their form. For example, Jordan bickering with teammates might serve the function of displaying passion for the team (a valued action), but is perhaps more likely to be a way of avoiding unwanted feelings (experiential avoidance) of inferiority. As such, we might seek further information about the thoughts and behaviors Jordan seems to be avoiding ("what do you mean when you say you're embarrassed?", "do these issues show up in your bodily sensations at all?"), and their specific function ("where does that thought take you?" , "does bickering help you or harm you?").

We would then explore other core processes that might be contributing to inflexibility. For example, Jordan dwells on past performances and has mentioned worry about the future(inflexible attention). Jordan has come through the system to secure a starting role and seems very much attached to that 'version' of the self (attachment to conceptualized self). Given Jordan's history, pursuing soccer at the expense of education and being with this club for 16 years, it seems prudent to explore current values (potential lack of contact with values). Finally, Jordan seems to be displaying impulsive, self-defeating behavior (i.e., avoiding feelings of inferiority/criticism by not putting in effort), action that is moving Jordan further away from valued living (inaction, impulsivity, avoidant persistence). Hayes et al. (2012), provide a number of useful tools such as assessment anchors (a numerical method of tracking the six psychological flexability processes), the psy-flex planning tool (a visual and easy to interpret case formulation tool), and the ACT Advisor (a quick client assessment tool) to facilitate case formulation and intervention planning. Once the main issues are established in ACT terms, we might also consider factors that can limit motivation for change (e.g., lack of understanding about the cost of avoidance), and any strengths that could help build psychological flexibility (e.g., experiences of mindfulness, openness, acceptance, or

committed action that can serve as powerful metaphors to be used in consultancy).

Intervention

There are two main goals with initial ACT consultations. First, exploring Jordan's current and previous attempts to 'solve' the problem, with the aim of highlighting the ultimate ineffectiveness of trying to control, reduce, or eliminate unwanted thoughts, feelings, and sensations. We should discuss explicit coping strategies that Jordan has tried, but also less conscious behaviors ("what typically happens when you start to notice these feelings of embarrassment?") to demonstrate that these behaviors (bickering, lack of effort) have a purpose (i.e., reduction or control of unwanted experiences). In effect, we're already in the intervention stage here. Second, we should explore Jordan's *willingness* to try an approach other than control. We start this process by examining the workability of Jordan's attempts to manage the issue through two routes: 1) by establishing whether attempts to solve the problem worked out how Jordan thought they would ("has becoming distant actually reduced anger and embarrassment?"), and 2) by asking what attempts to manage the issue have cost in terms of living in pursuit of values (e.g., "what would you be doing with your time if you weren't busy trying to manage your anger/embarrassment/thoughts about what your coaches think about you?"). As an ACT practitioner, it is important to make sure that what is happening here is a genuine, non-judgmental examination of whether strategies have worked in a client's life. Jordan might well think that strategies have worked in the short-term (and they might have), but the fact that Jordan is here seeking help ("and yet here we are"), is an indication of the long-term unworkability of control. Any number of *creative hopelessness* (dysfunctional state of mind that one is unable to see a meaningful future for oneself) exercises might be used to highlight this such as the Chinese fingertrap metaphor (the harder you struggle to get out, the tighter it becomes around your fingers), and the Tug-of-War metaphor (let go of the rope instead of struggling (see Strosahl, Hayes, Wilson, & Gifford,

2004, for explanations of these and many other exercises). Only then can we explore willingness to try something different, such as unhooking (creating distance between thoughts and feelings, and actions), or the two scales metaphor (to encourage acceptance), and subsequently work on relevant core processes.

It has been suggested that traditional Psychological Skills Training (PST) interventions are incompatible with ACT (Gardner & Moore, 2006). However, I would argue that elements of goal setting are important in working towards committed action, and that forms of imagery are often used in mindfulness exercises. It is important, however, to note that any efforts to undermine 'faulty' or maladaptive cognitions, or to emphasize reducing unwanted thoughts or sensations, are at odds with ACT and can ultimately be confusing for clients (Luoma et al., 2017).

There is no "right" place to start applied work, but in this case, exploring values might be important given the disconnect between Jordan's apparent values (sporting achievement, teamwork) and behavior (withdrawing, lack of effort). Other relevant intervention goals might include exposure to experiences of self-as-context (i.e., taking a perspective from which challenging experiences can be observed) to unhook the client from a conceptualized view of themself (e.g., take your mind for a walk, leaves on a stream) and promoting contact with the present moment to help with acceptance of 'unpleasant' emotions (e.g., mindfulness, 'just noticing' exercises).

Evaluation

While some clients may immediately grasp the idea that their control strategies are ultimately unworkable, others may take a lot longer to reach the stage where we can begin working on developing psychological flexibility. As such, it is extremely difficult to indicate how long an ACT intervention might take. Typically though, somewhere between 6-10 sessions provides the opportunity to work on relevant ACT processes in way that might move

the client forwards. Evaluation in ACT is ongoing, and constant re-evaluation of treatment goals occurs throughout consultancy (Hayes, Strosahl, Luoma, Smith, & Wilson, 2004). Psychometric tools such as the Acceptance and Action Questionnaire-II (AAQ-II: Bond et al., 2011) could be used to evaluate experiential avoidance, and several of the case-formulation tools described above can also function as ongoing assessment tools. However, when the client is engaging in committed action based on chosen values and is demonstrating the open, centered, and engaged response style discussed at the start of this section, we can consider bringing the consultancy to a close.

Conclusion

The therapeutic relationship itself is at the heart of the ACT intervention. It is accepting and focused on values, with the therapist modelling and reinforcing the psychological flexibility being taught. While a detailed discussion about the therapeutic relationship in ACT is beyond the scope of this article, Hayes et al. (2012) provide a useful chapter that examines the powerful nature and challenges of this relationship in ACT.

General Conclusion

The preceding sections covering four prominent CBTs have offered a brief portrayal of each approach that allows the reader to compare and contrast (see Table 2, or consult Dryden, 2012, for a comprehensive comparison). Clearly, within the scope of a short paper such as the present one, it is not possible, nor was it our aim, to communicate the full complexity and nuances of each approach. The main aims of the paper were to address the case of Jordan using four dominant psychotherapeutic approaches, with a view to encouraging some discussion about therapeutic training in sport and exercise psychology. However, one must acknowledge that our selection of four CBTs causes some discriminative problems, because we omit many CBTs in favour of REBT, CT, ACT, and ST. Our intention in the current paper is not to provide a comprehensive discussion about all possible CBTs, as

more detailed and expansive information can be found elsewhere (e.g., Dryden, 2012). But we have biasedly leant towards CBT approaches that we as practitioners are very familiar with and have sufficient expertise within. With the case of Jordan, it is possible that none of the CBTs we cover in this paper is best for the resolution of the case. We do not intend to be prescriptive here and do not suggest that with a case like Jordan's one can only use one of the four CBTs we present. On the contrary, we hope to illustrate that a case can be approached in many ways and that practitioners could aim to develop a broad therapeutic skillset that includes a range of approaches. The reader will no doubt gravitate to one or more, or none, of the outlined approaches and it is hoped that if not already trained in the approach/es they will seek formal training in one of the CBTs presented here, or one of the many other CBTs. In sport psychology, there are many examples of interventions that take valuable and effective techniques from a variety of psychotherapeutic approaches (e.g., The Canon) that can help athletes to achieve their potential. However, with this paper we hope that practitioners will decide to supplement their knowledge by formally training in a CBT to strengthen the work they do and to add additional procedural reliability to their work. The CBTs covered in this paper offer a vast array of well-tested and validated procedures that can be applied with athletes to aid wellbeing and performance. Whilst we advocate training in psychotherapies, it is also important to be cognizant of ethical and professional boundaries within which sport and exercise psychologists must practice. Indeed, whilst a sport and exercise psychologist's knowledge and use of psychotherapies could have important implications for athlete mental health, "this is not to say that sport psychologists should 'treat' athletes for mental illness; this is ethically beyond many practitioners' professional competencies and occupational remit" (Turner, 2016a).

Clearly, practitioners' philosophies of practice have bearing on the approach they take to any case, the approaches they train in, which of course, can influence their philosophy of

practice. There are some fundamental differences in the philosophical underpinnings across some of the approaches included in the current paper, not least because we include a range of second and third wave CBTs. Whilst REBT and CT sit squarely within CBT, ST represents an integration of CBT, Gestalt experiential therapy, and psychoanalytic principles. ACT diverges from REBT, CT, and ST markedly because it directly challenges the cognitive restructuring problem-solving strategies that are at the core of REBT, CT, and ST. Rather than asking "can we think and feel differently" its asks "can we accept and make room for unpleasant psychological states?" REBT and CT are often conflated and confused with each other, in part because of the closeness of their conception in time and because they share some common assumptions about the role of cognitions in psychological wellbeing. However, REBT and CT are epistemologically different since REBT is a philosophically based therapy and CT is an empirically based therapy (Padesky & Beck, 2003). As such, CT boasts far more efficacy studies than REBT and has been more rigorously tested. In practice, REBT is concerned with the rationality of core beliefs, whilst CT is more concerned with the functionality of beliefs. Whilst CT encourages guided discovery in identifying and testing one's beliefs, REBT emphasizes the direct disputation of beliefs using a structured method. There are comprehensive resources that readers can access that offer a deeper analysis of the differences between CBTs (e.g., Dryden, 2012). Of course, there are also some similarities across the approaches included in the present paper. All emphasize collaboration between the practitioner and the client where active participation from both parties leads to the client becoming his or her own practitioner. There is also an emphasis on conducting client assessments in a collaborative and Socratic manner with a view to developing a strong therapeutic alliance.

The authors of the current paper are not dogmatic about any of the approaches covered in this paper. Practitioners may choose to adopt person-centered therapeutic (PCT)

and or psychodynamic therapeutic (PDT) approaches to their work. The prominence of CBTs has been driven in part by the greater corpus of available evidence, and by guidelines proposed by the National Institute for Clinical Excellence (NICE, 2005) concentrating on CBTs (Stiles, Barkham, Mellor-Clark, & Connell, 2008). There is relatively less research evidence for PCT and PDT approaches compared to CBTs but the efficacy and effectiveness of PCT has been systematically examined (e.g., Ward et al., 2000). Evidence suggests little difference in effectiveness across CBT, PCT, and PDT approaches on a range of presenting issues (Stiles et al., 2008), or across different CBTs (Stefan, Cristea, Szentagotai-Tatar, & David, 2019). However, the comparative efficacy and effectiveness of each approach on athlete outcomes remains under-researched and is a justified direction for future research. A useful overview of CBT, PCT, and PDT as applied to sport is offered by Watson, Hilliard, and Way (2017), who echo the call made by various experienced consultants (e.g., Poczwardowski & Sherman, 2011; Sharp, Hodge, & Danish, 2014) for practitioners to operate within a theoretical perspective.

Also, each of the CBTs in this paper chart distinct assessment, intervention, and evaluative processes to support Jordan's case. In addition, each approach points to the significance of collaboration (e.g., CT & REBT), therapeutic alliance (e.g., ACT) and intervention commitment (e.g., ST) for effective practice with Jordan. Previous research has noted instances of clients in clinical settings failing to engage with psychological therapies (e.g., Moloney & Kelly, 2004), and illustrates athletes who are introduced to cognitive behavioral strategies but fail to practice or apply them consistently (e.g., Brown, 2011; Mack, Breckon, O'Halloran, & Butt, 2018). One possible explanation for this is a lack of athlete readiness for the content of the intervention (Massey, Gnacinski, & Meyer, 2015). Irrespective of content, practice style or experience, the practitioner's ability to form a close and collaborative therapeutic relationship with the client will largely dictate whether or not

the psychological support is deemed to be effective (Cropley, Hanton, Miles, & Niven, 2010). The correlation between the strength of the therapeutic relationship and successful outcomes is one of the most robust findings within counselling psychology (Watson, Hilliard, & Way, 2018). The importance of this alliance has been understood in counselling psychology at least since the conception of person-centred counselling (e.g., Rogers, 1957), and the delineation of the features of a strong working alliance (agreement on goals; assignment of tasks; development of bonds; Bordin, 1979). Links can clearly be made to the sport psychologist-athlete relationship, and yet in sport psychology, there is scant guidance on how to actually cultivate these relational bonds (Mack, Breckon, Butt & Maynard, 2017). This is perhaps because of an emphasis placed on the Canon and other outcome-orientated therapeutic tools and techniques, over the relational, person-centred aspects of the alliance. Clinical and counselling psychology literature, on the other hand, may offer such information (Watson et al., 2018).

Across all CBT approaches covered in the current paper, there is a focus on strengthening the practitioner-client working alliance and readying the client for the work. One approach which practitioners could consider integrating with their use of CBTs in sport is MI (Miller & Rollnick, 2013), to actively increase athlete readiness for action-orientated therapy, and enhance the practitioner-athlete relationship. For the present paper, two additional practitioners with expertise in MI were consulted to provide a brief of MI. One practitioner has an MSc in sport & exercise psychology and is completing a PhD in sport psychology, and has been practising MI in sport and exercise settings since 2012, and became an MI trainer affiliated to the Motivational Interviewing Network of Trainers (MINT) in 2015. The other practitioner has an MSc in sport & exercise psychology, a PhD in sport psychology, and has completed the Stage Two Qualification in Sport and Exercise Psychology with the BPS. They have been working as a sport psychology consultant since

2013 and hold a Primary Practicum Certification in REBT.

MI

Originally conceived as an adjunct treatement of addiction, MI is a client-centred and evidence based psychotherapy that strengthens the client's intrinsic motivation for change, through the exploration and resolution of ambivalence (Miller & Rollnick, 2002). Central to MI is the development of a therapeutic alliance, that is, the relationship between the client and therapist (Copeland, McNamara, Kelson, & Simpson, 2015). Whilst garnering an autonomy-supportive relationship with the client (Miller & Rollnick, 2013), MI practitioners adopt a collaborative and empathetic communication style to maximize the working-alliance. The four core principles on which MI is founded include: 1) a relational component (spirit) that seeks to develop a collaborative partnership between the practitioner and client. MI advocates that the practitioner attempts to demonstrate accurate empathy (accurate understanding of athletes' thoughts and feelings) and compassion (desire to alleviate athlete distress), and views the athlete as knowledgeable and resourceful, and an active agent in their progress. 2) This spirit is brought to life via the use of specific communication skills known as OARS (Open-ended questions, Affirmations, Reflections, and Summaries). 3) The four + processes (engage, evoke, focus, plan, maintain) offers a structure to a single session, or for ongoing support. 4) MI is sensitive to the language clients use regarding behaviour change, and aims to selectively elicit and reinforce 'change talk' while reducing 'sustain talk' and resistance to change. MI is distinct in that practitioners aim to help their clients to become a more committed advocate and intrinsically motivated for their own change, rather than assuming the role of the advocate for change themselves (Kertes, Westra, Angus, & Marcus, 2011). This intrinsic shift towards the intervention process is significant considering much one-to-one support requires honest introspection, inter-session tasks, and diligence from the client (Norcross, Karpiak, & Lister, 2005). In sum, the counselling approach of MI offers an

integrative framework to actively increase athlete readiness for action-orientated therapy, enhance the practitioner-athlete relationship, and complement the previously presented psychological approaches. For further details on these core components and the development of a working alliance using MI in sport psychology see Mack et al. (2017).

Conclusion

The current paper applies four difference psychotherapeutic approaches to the hypothetical case of Jordan to briefly portray the main characteristics of REBT, CT, ST, and ACT, when applied to the same presenting issues. We hope this paper encourages practitioners and researchers to examine each approach more rigorously in sport and exercise settings. It is also hoped that practitioners will report their utilization of psychotherapeutic approaches within sport and exercise settings to deepen and widen the knowledge base.

References

Andersen, M. B. (2009). The "canon" of psychological skills training for enhancing performance. In K. F. Hays (Ed.), *Performance psychology in action: A casebook for working with athletes, performing artists, business leaders, and professionals in high-risk occupations* (pp. 11-34). Washington, DC: American Psychological Association.

Aspin, G., (2018). Clinical outcomes of a transdiagnostic individual schema focused therapy group in NHS primary care in the UK, poster presentation at International Society for Schema Therapy Conference, Amsterdam, Netherlands.

Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects*. New York City, NY: Harper & Row.

Beck, A. T. (1976) *Cognitive therapy and the emotional disorders*. New York City, NY: International Universities Press.

Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. New York City, NY: Guilford Press.

Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond* (2nd ed.). New York City, NY: Guilford Press.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York City, NY: Guildford Press.

Bennett, R., & Oliver, J. E. (2019). *Acceptance and commitment Therapy: 100 key points and techniques*. Abingdon, United Kingdom: Routledge.

Bennett, R., & Turner, M. J. (2017). The theory and practice of rational emotive behaviour therapy (REBT). In M. J. Turner. & R. Bennett (Eds.), *Rational Emotive Behaviour Therapy in Sport and Exercise* (pp. 4-19). Abingdon, United Kingdom: Routledge.

Bond, F. W., Hayes, S. C., Baer, R. A., Carpenter, K. M., Guenole, N., Orcutt, H. K., Waltz, T., & Zettle, R. D. (2011). Preliminary psychometric properties of the Acceptance and Action Questionniare-II: A revised measure of psychological flexibility and experiential avoidance. *Behavior Therapy, 42*, 676-688. doi: https://doi.org/10.1016/j.beth.2011.03.007

Brown, J. L. (2011). Cognitive behavioral dtrategies. In J. K. Luiselli & D. D. Reed (Eds.), *Behavioral Sport Psychology* (pp. 113–126). New York, NY: Springer. http://doi.org/10.1007/978-1-4614-0070-7_7

Calvete, E., Estévez, A., López de Arroyobe, E., & Ruiz, P. (2005). The schema questionnaire-short form: Structure and relationship with automatic thoughts and symptoms of affective disorders. *European Journal of Psychological Assessment*, *21*, 90-99. doi:10.1027/1015-5759.21.2.90

Copeland, L., McNamara, R., Kelson, M., & Simpson, S. (2015). Mechanisms of change within motivational interviewing in relation to health behaviors outcomes: a systematic review. *Patient Education and Counseling*, *98*(4), 401-411. doi:10.1016/j.pec.2014.11.022

Cropley, B., Hanton, S., Miles, A., & Niven, A. (2010). Exploring the relationship between effective and reflective practice in applied sport psychology. *The Sport Psychologist*. *24*, 521-541. doi:10.1123/tsp.24.4.521

Didymus, F. F., & Fletcher, D. (2017). Effects of a cognitive-behavioral intervention on field hockey players' appraisals of organizational stressors. *Psychology of Sport and Exercise*, *30*, 173-185. doi:10.1016/j.psychsport.2017.03.005

Dryden, W. (2007). Resilience and rationality. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, *25*, 213-226. doi:10.1007/s10942-006-0050-1

Dryden, W. (2012). *Cognitive behaviour therapies*. London, United Kingdom: Sage Publications.

Dryden, W. (2016). *Attitudes in rational emotive behaviour therapy (REBT): Components, characteristics and adversity-related consequences*. London, United Kingdom: Rationality Publications.

Ellis, A. (1957). Rational psychotherapy and individual psychology. *Journal of Individual Psychology, 13*, 38-44. Retrieved from https://utpress.utexas.edu/journals/journal-of-individual-psychology

Ellis, A. (1994). *Reason and emotion in psychotherapy* (rev. ed.). Secaucus, NJ: Birscj Lane.

Ellis, A., & Ellis, D. J. (2018). *Rational Emotive Behavior Therapy*. Washington, DC: American Psychological Association.

Ellis, A., Gordon, J., Neenan, M., & Palmer, S. (1997). *Stress counselling: A rational emotive behavior approach*. London, United Kingdom: Cassell

Fehm, L., & Mrose, J. (2008). Patients' perspective on homework assignments in cognitive-behavioral therapy. *Clinical Psychology and Psychotherapy, 15*, 320-328. doi:10.1002/cpp.592

Gardner, F. L., & Moore, Z. E. (2004). A mindfulness-acceptance-commitment-based

approach to athletic performance enhancement: Theoretical considerations. *Behavior Therapy, 35*, 707-723. doi:10.1016/S0005-7894(04)80016-9

Gardner, F. L., & Moore, Z. E. (2006). *Clinical sport psychology*. Champaign, IL: Human Kinetics.

Gardner, F. L., & Moore, Z. E. (2012). Mindfulness and acceptance models in sport psychology: A decade of basic and applied scientific advancements. *Canadian Psychology/Psychologie Canadienne, 53*, 309-318. doi:10.1037/a0030220

Haney, C. J. (2004). Stress-management interventions for female athletes: Relaxation and cognitive restructuring. *International Journal of Sport Psychology, 35*, 109-118. Retrieved from http://www.ijsp-online.com

Hawke, L., & Provencher, M. (2011). Schema theory and schema therapy in mood and anxiety disorders: A review. *Journal of Cognitive Psychotherapy: An International Quarterly*, *25*, 257-276. doi:10.1891/0889-8391.25.4.257

Hayes, S. C., Strosahl, K. D., Luoma, J., Smith, A. A., & Wilson, K. G. (2004). ACT case formulation. In S. C. Hayes & K. D. Strosahl (Eds.), *A practical guide to Acceptance and Commitment Therapy* (pp. 59-73). New York City, NY: Springer

Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012). Acceptance and commitment therapy: The process and practice of mindful change (2nd ed). New York City, NY: Guilford Press.

Kashdan, T., & Biswas-Diener, R. (2014). *The power of negative emotion: How anger, guilt, and self doubt are essential to success and fulfillment*. London, United Kingdom: Oneworld Publications.

Kertes, A., Westra, H. A., Angus, L., & Marcus, M. (2011). The impact of motivational interviewing on client experiences of cognitive behavioral therapy for generalized

anxiety disorder. *Cognitive and Behavioral Practice*, *18*, 55-69. doi:10.1016/j.cbpra.2009.06.005

Lazarus, A. A. (1977) Towards an egoless state of being. In A. Ellis 7 R. Grieger (Eds.), *Handbook of Rational-Emotive Therapy*. New York City, NY: Springer.

Linehan, M. (1993). *Cognitive behaviour treatment of borderline personality disorder*. New York City, NY: Guilford Press.

Luoma, J. B., Hayes, S. C., & Walser, R. D. (2017). *Learning ACT: An Acceptance and Commitment Therapy skills-training manual for therapists* (2nd ed.). Oakland, CA: New Harbinger Publications.

Mack, R., Breckon, J., Butt, J., & Maynard, I. (2017). Exploring the understanding and application of motivational interviewing in applied sport psychology. *The Sport Psychologist*, *31*, 396-409. doi:10.1123/tsp.2016-0125

Mack, R. J., Breckon, J. D., O'Halloran, P. D., & Butt, J. (2018). Enhancing athlete engagement in sport psychology interventions using motivational interviewing: A case study. *The Sport Psychologist, 33*, 159-168. doi:10.1123/tsp.2018-0053

Masley, S.A., Gillanders, D.T., Simpson, S., & Taylor, M.A. (2012). A systematic review of the evidence base for Schema Therapy. *Cognitive behaviour therapy, 41*(3), 185-202. doi: 10.1080/16506073.2011.614274

Massey, W. V., Gnacinski, S. L., & Meyer, B. B. (2015). Psychological skills training in NCAA division I athletics: Are athletes ready for change? *Journal of Clinical Sport Psychology*, *9*, 317-334. doi:10.1123/jcsp.2014-0042

Matweychuk, W., DiGiuseppe, R., & Gulyayeva, O. (2019) A Comparison of REBT with Other Cognitive Behavior Therapies. In: Bernard M., Dryden W. (eds) *Advances in REBT*. Springer: Champaign, IL.

McArdle, S., & Moore, P. (2012). Applying evidence-based principles from CBT to sport

psychology. *The Sport Psychologist*, *26*, 299-310. doi:10.1123/tsp.26.2.299

Miller, W. R., & Rollnick, S. (2002). Motivational interviewing: Preparing people for change. New York: Guilford Press.

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change*. London, United Kingdom: Guilford Press.

Mohr, C. (2001). Learning how to be a good sport: An intervention aimed at increasing sportsperson-like behavior. *Behavior Change, 18*, 236-240. doi:10.1375/bech.18.4.236P

Moloney, P., & Kelly, P. (2004). Beck never lived in Birmingham: Why CBT may be a less useful treatment for psychological distress than is often supposed. *Clinical Psychology*, *34*, 4-9.

Noetel, M., Ciarrochi, J., Van Zanden, B., & Lonsdale, C. (2017). Mindfulness and acceptance approaches to sporting performance enhancement: A systematic review. *International Review of Sport and Exercise Psychology, 12*, 39-175. doi:10.1080/1750984X.2017.1387803

Norcross, J. C., Karpiak, C. P., & Lister, K. M. (2005). What's an integrationist? A study of self-identified integrative and (occasionally) eclectic psychologists. *Journal of Clinical Psychology*, *61*, 1587-1594. doi: 10.1002/jclp.20203

Noyce, R., & Simpson, J. (2018). The experience of forming a therapeutic relationship from the client's perspective: A metasynthesis. *Psychotherapy Research*, *28*, 281-296. doi:10.1080/10503307.2016.1208373

Padesky, C. A. & Beck, A. T. (2003). Science and philosophy: Comparison of cognitive therapy and rational emotive behavior therapy. *Journal of Cognitive Psychotherapy*, *17*, 211-224. doi:10.1891/jcop.17.3.211.52536

Poczwardowski, A., & Sherman, C. P. (2011). Revisions to the sport psychology service delivery (SPSD) heuristic: Explorations with experienced consultants. *The Sport*

Psychologist, *25*, 511-531. doi:10.1123/tsp.25.4.511

Rush, A. J., Beck, A. T., Kovacs, M., & Hollon, S. (1977). Comparative efficacy of cognitive therapy and pharmacotherapy in the treatment of depressed outpatients. *Cognitive Therapy and Research, 1*, 17-37. doi:10.1007/BF01173502

Sharp, L., Hodge, K., & Danish, S. (2014). Sport psychology consulting at elite sport competitions. *Sport, Exercise, and Performance Psychology*, *3*, 75-88. doi:10.1037/spy0000011

Stefan, S., Cristea, I., Szentagotai-Tatar, A., & David D. (2019). Cognitive-behavioral therapy (CBT) for generalized anxiety disorder: Contrasting various CBT approaches in a randomized clinical trial. *Journal of Clinical Psychology, 75*, 1188-1202. doi:10.1002/jclp.22779.

Stiles, W. B., Barkham, M., Mellor-Clark, J., & Connell, J. (2008). Effectiveness of cognitive-behavioral, person-centred, and psychodynamic therapies in UK primary-care routine practice: replication in a larger sample. *Psychological Medicine*, *38*, 677-688. doi:10.1017/S0033291707001511

Strosahl, K. D., Hayes, S. C., Wilson, K. G., & Gifford, E. V. (2004). An ACT Primer: Core therapy processes, intervention strategies, and therapist competencies. In S. C. Hayes & K. D. Strosahl (Eds.), *A practical guide to Acceptance and Commitment Therapy* (pp. 31-58). New York City, NY: Springer

Turner, M. J. (2016a). Rational Emotive Behavior Therapy (REBT), irrational and rational beliefs, and the mental health of athletes. *Frontiers: Movement Science and Sport Psychology*. doi:10.3389/fpsyg.2016.01423.

Turner, M. J. (2016b). Proposing a rational resilience credo for athletes. *Journal of Sport Psychology in Action*, *7*, 170-181. doi:10.1080/21520704.2016.1236051

Turner, M. J. (2019). REBT in Sport. In M. E. Bernard & W. Dryden (Eds.), *Advancing*

REBT Theory, Research and Practice. New York City, NY: Springer.

Turner, M. J., & Allen, M. (2018). Confirmatory factor analysis of the irrational Performance Beliefs Inventory (iPBI) in a sample of amateur and semi-professional athletes. *Psychology of Sport and Exercise, 35*, 126-130. doi:10.1016/j.psychsport.2017.11.017.

Turner, M. J., Aspin, G., & Gillman, J. (2019). Maladaptive schema as a potential mechanism through which irrational beliefs relate to psychological distress in athletes. *Psychology of Sport & Exercise, 44*, 9-16. doi:10.1016/j.psychsport.2019.04.015

Turner, M. J., & Barker. J. B. (2014). Using rational emotive behavior therapy with athletes. *The Sport Psychologist*, *28*, 75-90. doi:10.1123/tsp.2013-0012

Turner, M. J., & Bennett, R. (2018). *Rational Emotive Behaviour Therapy in Sport and Exercise*. Abingdon, United Kingdom: Routledge.

Turner, M. J., Carrington, S., & Miller, A. (2019). Psychological distress across sport participation groups: The mediating effects of secondary irrational beliefs on the relationship between primary irrational beliefs and symptoms of anxiety, anger, and depression. *Journal of Clinical Sport Psychology*, *13*, 17-30. doi:10.1123/jcsp.2017-0014

Turner, M. J., & Davis, H. (2018). Exploring the effects of rational emotive behaviour therapy (REBT) on the irrational beliefs and self-determined motivation of triathletes. *Journal of Applied Sport Psychology, 31*, 253-272. doi:10.1080/10413200.2018.1446472

Turner, M. J., & Moore, M. (2016). Irrational beliefs predict increased emotional and physical exhaustion in Gaelic football athletes. *International Journal of Sport Psychology, 47*, 187-199. Retrieved from http://www.ijsp-online.com

Turner, M. J., & Wood, A. G. (2018). *Smarter Thinking 2* (1.0) [Mobile application software]. Digital Kiln. Retrieved from https://itunes.apple.com/gb/store

Ward, E., King, M., Lloyd, M., Bower, P., Sibbald, B., Farrelly. S., Gabbay, M., Tarrier, N., & Addington-Hall, J. (2000). Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy, and usual general practitioner care for patients with depression. I : Clinical effectiveness. *British Medical Journal, 321*, 1383-1388. doi:10.1136/bmj.321.7273.1383

Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology, 54*, 1063-1070. doi:10.1037/0022-3514.54.6.1063

Watson, J., Hilliard, R., & Way, W. (2017, July 27). Counseling and Communication Skills in Sport and Performance Psychology. *Oxford Research Encyclopedia of Psychology.* Retrieved 8 Aug. 2019, from https://oxfordre.com/psychology/view/10.1093/acrefore/9780190236557.001.0001/acrefore-9780190236557-e-140.

Wood, A., Barker, J. B., & Turner, M. J. (2017). Developing performance using rational emotive behavior therapy (REBT): A case study with an elite archer. *The Sport Psychologist*, *31*, 78-87. doi:10.1123/tsp.2015-0083

Young, J. (1999). *Cognitive therapy for personality disorder* (3rd ed.). Sarasota, FL: Professional Resource Press.

Young, J. (2005). *Young schema questionnaire - short form 3*. New York City, NY: Schema Therapy Institute.

Young, J., Klosko, J., & Weishaar, M. (2003). *Schema therapy: A practitioner's guide*. New York City, NY: Guildford Press.

Table 1. Exemplar TAS based on Jordan's case (adapted with permission from Didymus & Fletcher, 2017).

1. Situation	**2. Automatic Thoughts**	**3. Emotions**	**4. Alternative Thoughts**	**5. Alternative Emotions**
Describe the situation clearly and concisely.	**What thoughts do you have about the situation? Rate the believability of these thoughts from 0% to 100%**	**What are you feeling? Rate the intensity of these emotions from 0% to 100%**	**What more functional thoughts could you have about this situation? Rate the believability of these thoughts 0% to 100%**	**How might you feel after having the alternative thought? Rate the intensity of these emotions from 0% to 100%**
Underperformance in training and competition, which presents as missed passes, lack of accuracy when shooting, and unhelpful muscle tension.	"I'm useless at football these days" (80%) "What's the point in trying any more" (50%) "I'll never make the starting line up if I continue to play like this" (70%)	Irritated (80%) Annoyed (80%) Upset (80%)	"This is just a phase and my effort will pay off in the end" (80%) "I will keep trying" (100%)	Determined (90%) Apprehensive (80%) Irritated (30%)
Being dropped from the starting line-up for three consecutive games.	"The coach thinks I'm not good enough" (100%) "It will be downhill from here for sure" (100%) "I will not play well even if I do make the starting team" (80%) "I bet they're laughing behind my back" (60%) "I have nothing to fall back on if football doesn't work out" (90%)	Angry (80%) Embarrassed (90%) Anxious (60%)	"It's worth trying" (100%) "I can play well" (80%) "I can have an impact on the game even if I start from the bench" (80%)	Excited (80%) Nervous (60%) Angry (30%)

Table 2. Comparison of CBTs for the case of Jordan (concept adapted from Matweychuk, DiGiuseppe, & Gulyayeva, 2019). This table is not a practice guide, but rather, it portrays the core elements of the hypothetical work done with Jordan.

Characteristics	**REBT**	**CT**	**ACT**	**ST**
Chief aims	Address core beliefs about the self to address the UNE of shame.	Address thoughts and inferences about self and the coach, and future expectancies, to address anger and embarrassment.	Change client's relationship with internal experiences to reduce experiential avoidance and produce psychological flexibility.	Identify and reduce deeply held maladaptive schemas of 'failure to achieve' and 'defectiveness' and develop more adaptive alternatives.
Cognitive mediation	Irrational and rational core beliefs determine emotional and behavioral reactivity.	Core and intermediate beliefs, and automatic thoughts, determine emotional and behavioral reactivity.	Psychological rigidity is the root of suffering, and psychological flexibility is the root of wellbeing.	Maladaptive schemas underpin view of self and world, leading to psychological distress.
Assessment	GABCDE conceptualization, development of working alliance, inference chaining, psychometrics.	Cognitive conceptualization, development of working alliance, the TAS, and psychometrics.	Case formulation, focus on the six core ACT processes, establish existence of psychological inflexibility, focus on function rather than form, psychometrics.	Explore existence and origins of schema-related thoughts and feelings, psychometrics, imagery.
Cognitive restructuring	Disputation of core beliefs is a core strategy, including empirical, logical, and pragmatic challenges.	Disputation of thoughts is a core strategy, primarily relying on empirical challenges.	Sceptical of disputation and avoids it. Efforts to undermine maladaptive cognitions are at odds with ACT.	Schemas empirically challenged, fought, controlled, and distanced. Veracity of schema is weakened.
Prominent treatment techniques	Psycho-education, strengthening the B-C connection, interactive activities, ARRC, homework tasks (Smarter Thinking App), role play.	Ongoing focus on functionality and veracity of automatic thoughts, psycho-education, homework tasks.	Acceptance and mindfulness processes, commitment and behavioral activation processes, diffusion, creative hopelessness exercises, self-as-context.	Imagery rescription, empty chair, homework tasks.