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Development and Validation of the Psychological Readiness Scale after Serious Injury (PRS-SI): A Study on Young Football Players

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A B S T R A C T

This study aimed to develop and validate a culturally adapted instrument—the Psychological Readiness Scale after Serious Injury (PRS-SI)—for assessing the psychological readiness of young football players to return to sport following a serious injury. A total of 265 male football players aged 17–25 from Mashhad, Iran, who had sustained at least one serious sports injury requiring a minimum of three months of recovery, participated in this psychometric study. The PRS-SI was constructed by integrating key elements from two established tools: the Psychological Readiness of Injured Athlete to Return to Sport (PRIA-RS), tailored to football contexts, and the Anterior Cruciate Ligament Return to Sport After Injury (ACL-RSI), which focuses on emotional, cognitive, and behavioral dimensions. Using Partial Least Squares Structural Equation Modeling (PLS-SEM), the measurement model demonstrated strong internal consistency, convergent and discriminant validity, and an excellent model fit. The final 21-item scale included four components: post-traumatic readiness, emotions, risk assessment, and confidence in performance. Structural analysis revealed that all four dimensions significantly and positively contribute to psychological readiness ($R^2 = 0.99$), with self-confidence in performance being the strongest predictor. The results underscore the importance of addressing emotional, cognitive, and confidence-related factors in rehabilitation, beyond physical recovery alone. The PRS-SI offers a reliable, valid, and contextually appropriate tool for evaluating athletes' psychological states post-injury and can assist clinical decisions, psychological interventions, and return-to-sport protocols. Its application may enhance individualized rehabilitation strategies and promote safer, more effective returns to competition among young athletes.

Keywords: *Psychological Readiness, Sports Injury, Return to Play, Football, Young Athletes, Rehabilitation.*

1. Introduction

Football, as one of the most popular and widely followed sports in the world, is inherently associated with significant physical and psychological demands. Football players face a high risk of musculoskeletal injuries, which can profoundly affect their athletic careers. Although sports injuries in football encompass a broad range, those classified as serious typically include anterior cruciate ligament (ACL) tears, meniscus tears, severe fractures, and major muscle strains or ruptures—injuries that generally require extended periods of rehabilitation and recovery (1, 2).

Such injuries not only impair athletes' physical performance but also have substantial psychological consequences. Injured athletes, particularly younger ones, often lack fully developed psychological coping mechanisms, and their professional identity is deeply intertwined with their athletic role. Consequently, a serious injury can trigger emotional reactions such as anxiety, depression, denial, anger, fear of returning, and reduced self-confidence (3-7). These psychological effects, beyond impacting mental health, can delay or even prevent a full return to prior performance levels (8).

In recent years, sport psychologists have increasingly emphasized that the rehabilitation process following injury must address not only physical aspects but also psychological factors-chief among them being the athlete's psychological readiness to return to sport (8). Psychological readiness is a multidimensional construct encompassing motivation, self-confidence, emotional regulation, focus, injury acceptance, and perceived physical competence. These factors can play a critical role in facilitating a successful return to sport (9). This is particularly crucial for young athletes who may lack the experience to manage psychological stressors effectively; a high level of readiness can enhance the likelihood of a successful return, reduce the risk of re-injury, and improve performance quality (10). Research evidence further supports that higher psychological readiness is significantly associated with faster, safer, and more sustainable returns to sport (9, 10).

Despite its importance, return-to-play decisions in practice are often based solely on medical and physiological indicators, with psychological factors frequently overlooked. This gap is especially pronounced in countries such as Iran, where there is a lack of culturally adapted, psychometrically validated tools for assessing psychological readiness. Although instruments like the ACL-RSI questionnaire have been developed to measure readiness (11), they are primarily limited to specific populations and injury types, such as ACL reconstruction, and have not been widely validated among football players or youth athletes.

Domestic research has made important strides in identifying the psychological consequences of sports injuries. For example, Zia et al. (12) showed that progressive muscle relaxation exercises significantly reduced fear of re-injury among athletes post-ACL reconstruction. Similarly, Kaviani et al. (13) found that injured athletes experienced elevated levels of pain-related anxiety. Mozaffarizadeh et al. (14) reported that mindfulness training reduced injury-related anxiety and improved football performance. Furthermore, psychometric studies by Kashani et al. (15) and Mehrsafar et al. (16) have confirmed the factorial validity of instruments assessing fear of re-injury.

In the realm of cognitive-emotional factors, Barzegari Soltanahmadi et al. (17) found that self-efficacy, pain catastrophizing, and kinesiophobia significantly influenced psychological adjustment in individuals with chronic pain. Khorvond and Latifi (18) investigated the relationship between components of psychological readiness, such as imagery, self-talk, and emotional control-and team cohesion among university football teams, finding significant associations.

At the international level, numerous studies have explored the role of psychological readiness in returning to sport. Ardern et al. (9) reported that only 40% of athletes who underwent ACL reconstruction returned to their previous level of competition, with lack of confidence in the knee and fear of re-injury cited as primary reasons. McPherson et al. (19) found that those who suffered a second ACL injury exhibited lower psychological readiness at the time of return. Rodríguez et al. (20) demonstrated that interventions such as imagery could reduce fear of re-injury and enhance self-confidence.

In this context, Kalatakis-Dos-Santos et al. (21) developed a new scale to assess fear of returning to sport and reported acceptable psychometric properties. Gómez-Espejo et al. (22) also emphasized the importance of psychological characteristics in achieving a safe and successful return to sport. More recently, a study by Amiri et al. (23) focusing on

Health Nexus
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young football players found that psychological readiness significantly predicted both fear of return to sport and fear of re-injury, highlighting the critical role of this construct in psychological rehabilitation.

Despite the growing body of literature, there remains no standardized, culturally appropriate tool in Iran for evaluating psychological readiness after serious sports injuries, particularly among young footballers. Thus, the development and validation of an indigenous instrument could contribute meaningfully to the advancement of sport psychology services in the country.

In response to this need, the present study aimed to design a novel tool for assessing psychological readiness among young football players by integrating two well-established international questionnaires: the Psychological Readiness of Injured Athlete to Return to Sport (PRIA-RS) scale developed by Gómez-Piqueras et al. (24), which is specifically tailored for football players and offers a comprehensive conceptual structure, and the Anterior Cruciate Ligament Return to Sport After Injury (ACL-RSI) questionnaire developed by Webster et al. (11), which assesses cognitive, emotional, and behavioral dimensions of return to sport after ACL reconstruction. The conceptual and content integration of these instruments allowed for the development of a more comprehensive and cohesive scale capable of evaluating various facets of psychological readiness following sports injuries. This new tool, adapted to the cultural and psychological context of Iranian youth athletes - especially football players - was designed to be applicable in screening, counseling, and psychological interventions following injury.

2. Methods and Materials

2.1. Study Design and Participants

The participants in this study were all young male football players aged 17 to 25 in Mashhad, Iran, who had experienced at least one serious sports injury, such as ACL rupture, meniscus tear, major fracture, or severe muscle strain, that resulted in a minimum of three months away from training and competition. Due to the lack of access to accurate data regarding the total population, the sample size was determined using the rule of five participants per questionnaire item (53 items), resulting in a sample of 265 young football players.

Inclusion criteria were as follows: (1) being male; (2) age between 17 and 25; (3) providing informed consent to participate; (4) having experienced at least one serious injury within the past 12 months; and (5) being absent from training and competition for at least three months due to the injury.

Exclusion criteria included: (1) being under 17 or over 25 years of age; (2) lack of a history of serious injury and absence from training; and (3) lack of consent to participate in the study.

This study was applied in its objective and descriptive-survey nature, with a psychometric approach. Its main aim was to design and validate a culturally adapted instrument for assessing the psychological readiness of injured athletes to return to sport. Participants were fully informed about the study objectives and the confidentiality and anonymity of their data. Written informed consent was obtained from all participants.

Subsequently, participants underwent comprehensive assessments to evaluate their psychological readiness. The study was conducted in accordance with the Declaration of Helsinki and its later amendments. Also, this research has been approved by the Ethics Committee of the Iranian Research Institute of Sport Sciences under the approval code (IR/ssri.rec.2023.16007.2551).

Before the distribution of questionnaires, necessary coordination was made, and participants received explanations regarding the study objectives and instructions for completing the questionnaire. Data collection was conducted in person.

2.2. Measure

To assess psychological readiness after a serious sports injury, a questionnaire adapted from the studies of Gómez-Piqueras et al. (24) and Webster et al. (11) was used (see Appendix). The final instrument included 21 items across four components: (1) post-traumatic readiness (items 1-7), (2) emotions (items 8-13), (3) risk assessment (items 14-16), and (4) confidence in performance (items 17-21). Responses were scored using a 5-point Likert scale: Very Good = 5, Good = 4, Neutral = 3, Poor = 2, Very Poor = 1.

Health Nexus
E-ISSN: 2981-2569

2.3. *Data Analysis*

Both descriptive and inferential statistics were used for data analysis. Descriptive statistics were applied to categorize raw scores and calculate frequencies, means, and standard deviations. For inferential analysis, the Kolmogorov-Smirnov test was used to assess data normality. To validate the factor structure of the questionnaire, Partial Least Squares Structural Equation Modeling (PLS-SEM) was employed. This method is particularly suitable for psychometric research due to advantages such as not requiring data normality, efficiency with moderate sample sizes, and the ability to analyze complex models with multidimensional indicators (25).

Convergent validity was assessed using Average Variance Extracted (AVE) and factor loadings. Discriminant validity was examined using the Heterotrait-Monotrait Ratio (HTMT). Instrument reliability was evaluated using Cronbach's alpha and Composite Reliability (CR). The overall model fit was assessed using the Standardized Root Mean Square Residual (SRMR). The significance level was set at $\alpha \leq 0.05$. All statistical analyses were conducted using SPSS version 24.0 (IBM Corp., Armonk, NY, USA) for Apple Mac OS, and SMART PLS version 3.2.9.

3. Findings and Results

This section begins by presenting the demographic characteristics of the participants (Table 1).

Table 1

Demographic characteristics of the participants

Variable	Range/type	Frequency	Percentage
Age (Years)	17 to 20	133	50.2
	21 to 23	51	19.2
	24 to 25	81	30.6
		265	100
Longest time away from training and competition due to injury	At least 3 months	31	11.7
	4 to 6 months	79	29.8
	7 to 12 months	36	13.6
	More than a year	119	44.9
		265	100
The level of competition	Intra-city	45	17
	Provincial	79	29.8
	National	131	49.4
	International	10	3.8
		265	100
Type of injury	Fractures	40	15.1
	Ruptures	127	47.9
	Dislocations	43	16.2
	Other injuries	55	20.8
		265	100
Duration of recovery	At least 3 months	25	9.4
	4 to 6 months	82	30.9
	7 to 12 months	41	15.5
	More than a year	117	44.2
		265	100

The highest and lowest frequency based on age were in the "17–20 years" group (50.2%) and the "21–23 years" group (19.2%), respectively. In terms of the longest duration of absence from training and competition due to injury, the highest frequency belonged to the "more than one year" category (44.9%) and the lowest to "at least 3 months" (11.7%). Regarding the level of competition, most participants competed at the "national" level (49.4%), while the fewest competed at the "international" level (3.8%). The most common injury type was "ruptures" (47.9%), whereas "fractures" were the least frequent (15.1%). Finally, for recovery time, the highest proportion reported "more than one year" (44.2%), and the lowest reported "at least 3 months" (9.4%).

Health Nexus
E-ISSN: 2981-2569

Next, the normality of data distribution was examined using the Kolmogorov–Smirnov test. As the significance level was less than 0.05, it was concluded that the variables were not normally distributed. Therefore, Partial Least Squares (PLS) was deemed appropriate for hypothesis testing.

In the analysis of the measurement model, results showed that all factor loadings, Cronbach's alpha (α), Composite Reliability (CR), and Average Variance Extracted (AVE) exceeded their respective threshold values-0.40 to 0.70 for factor loadings, 0.70 for α and CR, and 0.50 for AVE (see Figure 1 and Table 2). While the preferred minimum for factor loadings is 0.70, loadings between 0.40 and 0.70 are acceptable if AVE and CR are sufficiently high (26). These results indicate satisfactory internal consistency reliability.

Figure 1

Initial measurement model in factor loading mode

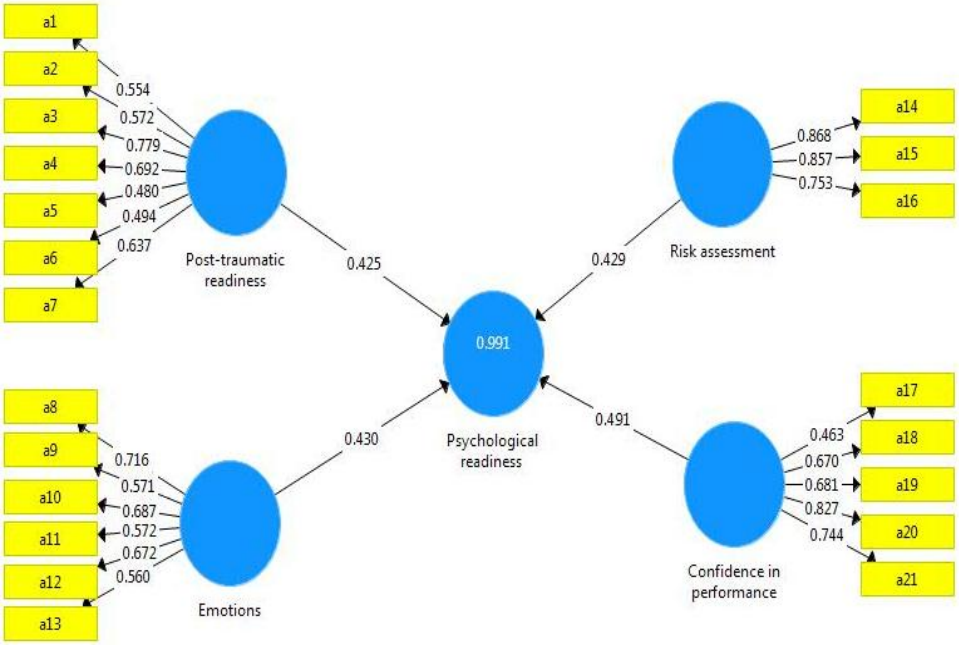


Table 2

Measurement model and descriptive results

Variable	Component	Indicators	Loadings	Mean	SD	α	CR	AVE
Psychological readiness	Post-traumatic readiness	a1	0.554	3.61	0.53	0.787	0.740	0.611
		a2	0.572					
		a3	0.779					
		a4	0.692					
		a5	0.480					
		a6	0.494					
		a7	0.637					
	Emotions	a8	0.716	3.18	0.81	0.798	0.799	0.600
		a9	0.571					
		a10	0.687					
		a11	0.572					
		a12	0.672					
		a13	0.560					
	Risk assessment	a14	0.868	3.26	1.02	0.769	0.866	0.685

Health Nexus
E-ISSN: 2981-2569

	a15	0.857					
	a16	0.753					
Confidence in performance	a17	0.463	3.48	0.79	0.732	0.771	0.636
	a18	0.670					
	a19	0.681					
	a20	0.827					
	a21	0.744					

SD=Standard Deviation; α= Cronbach's alpha; CR= Composite Reliability; AVE= Average Variance Extracted

As shown in Table 3, all Heterotrait-Monotrait Ratios (HTMT) remained below the 0.90 threshold, suggesting no issues with discriminant validity and confirming convergent validity of the variables.

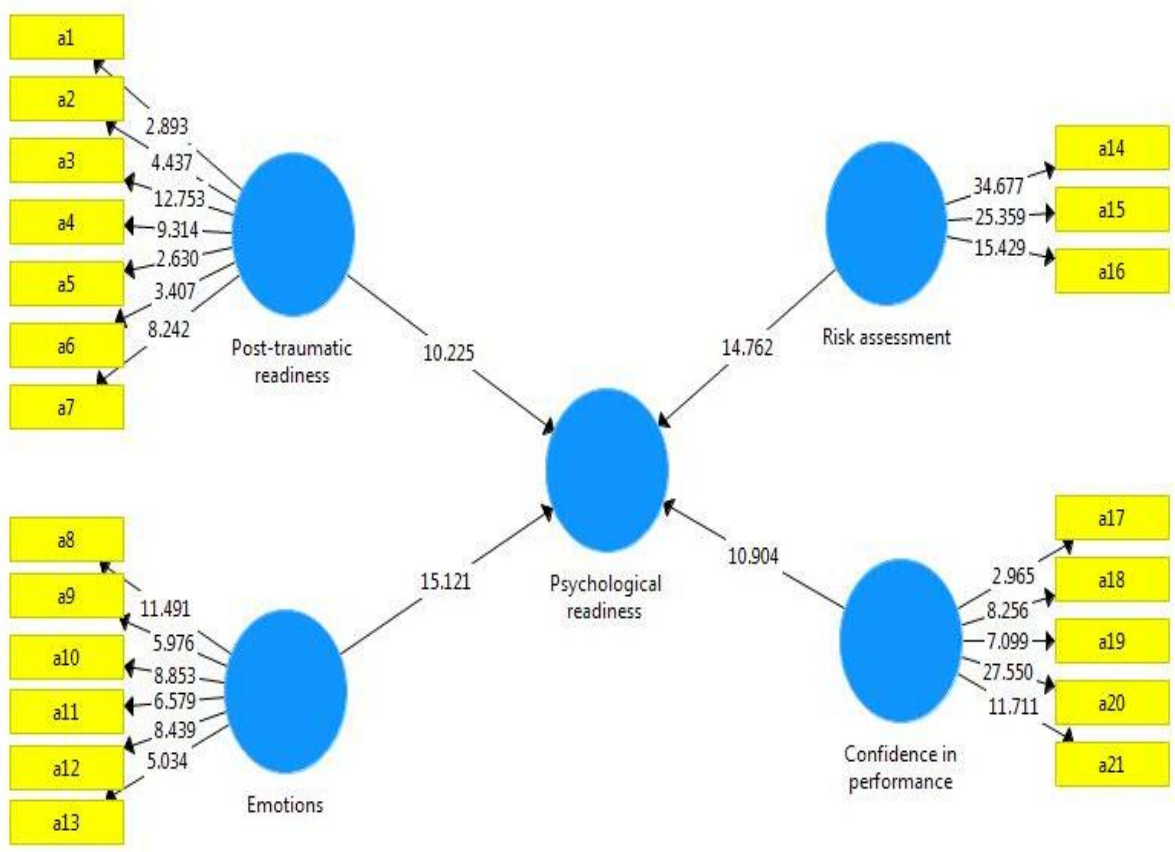
Table 3

HTMT Results

Variable	Post-traumatic readiness	Emotions	Risk assessment	Confidence in performance
Post-traumatic readiness	0.660	-	-	-
Emotions	0.436	0.633	-	-
Risk assessment	0.521	0.500	0.558	-
Confidence in performance	0.668	0.856	0.717	0.827

Figure 2

Structural model in t-value mode



Health Nexus
E-ISSN: 2981-2569

Table 4

Results of the research structural model

Variable	Component	Indicators	t-value	R^2	F^2	Q^2	VIF	SRMR
Psychological readiness	Post-traumatic readiness	a1	2.893	0.990	3.347	0.957	1.279	0.072
		a2	4.437				1.295	
		a3	12.753				1.642	
		a4	9.314				1.308	
		a5	2.630				1.087	
		a6	3.407				1.088	
		a7	8.242				1.276	
	Emotions	a8	11.491		5.341		1.853	
		a9	5.976				1.397	
		a10	8.853				1.934	
		a11	6.579				1.320	
		a12	8.439				2.296	
		a13	5.034				1.778	
	Risk assessment	a14	34.677		10.517		1.750	
		a15	25.359				1.749	
		a16	15.429				1.395	
	Confidence in performance	a17	2.965		6.093		1.033	
		a18	8.256				1.371	
		a19	7.099				1.470	
		a20	27.550				1.722	
		a21	11.711				1.490	

R^2= Coefficient of determination; F^2= Effect size; Q^2= Model's predictive relevance; VIF= Variance Inflation Factor; SRMR= Standardized Root Mean Square Residual

Table 4 shows that all path coefficients exceeded the critical value of 1.96 and were statistically significant at the 0.05 level. The R^2 value was calculated at 0.99, which is well above the 0.26 threshold and indicates a strong level of explained variance. The F^2 values were greater than 0.35, suggesting large effect sizes. The Q^2 value was 0.95, indicating good predictive relevance of the model (as $Q^2 > 0$). Additionally, the VIF values were below 3, confirming no multicollinearity among constructs. The SRMR (Standardized Root Mean Square Residual) was found to be below 0.08, indicating a good model fit.

Finally, as illustrated in Figures 2 and 3 and presented in Table 4, the structural model analysis revealed that all four components had significant and positive effects on psychological readiness after serious injury: post-traumatic readiness ($\beta = 0.425$, $t = 10.225$, $p < 0.05$), emotions ($\beta = 0.430$, $t = 15.121$, $p < 0.05$), risk assessment ($\beta = 0.429$, $t = 14.762$, $p < 0.05$), and confidence in performance ($\beta = 0.491$, $t = 10.904$, $p < 0.05$). Together, these components explained 99% of the variance in psychological readiness after serious injury ($R^2 = 0.990$).

4. Discussion and Conclusion

The present study aimed to develop and validate a culturally adapted scale to assess the psychological readiness of young football players after a serious sports injury. The results of the measurement model analysis using Partial Least Squares Structural Equation Modeling (PLS-SEM) indicated that all psychometric indicators-including factor loadings, internal consistency (as measured by Cronbach's alpha and Composite Reliability), Average Variance Extracted (AVE), and HTMT ratios-fell within acceptable ranges. These findings demonstrate that the scale possesses adequate precision, coherence, and construct validity, supporting its use as an effective tool in the psychological rehabilitation process of injured athletes.

The findings of the structural model analysis provide compelling support for the robustness and explanatory

Health Nexus
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power of the proposed model of psychological readiness after a serious injury. All path coefficients exceeded the critical threshold of 1.96 and were statistically significant at the 0.05 level, confirming the hypothesized relationships among the model constructs. The exceptionally high R^2 value of 0.99 indicates that the four identified components collectively explain 99% of the variance in psychological readiness after serious injury a level of explained variance that is rarely observed in psychological models and suggests excellent model performance. Moreover, the F^2 values, all above 0.35, demonstrate that each construct exerts a strong and meaningful influence within the model. The Q^2 value of 0.95 further supports the model's predictive relevance, while the absence of multicollinearity among variables (VIF < 3) ensures the stability and reliability of the results. The SRMR value below 0.08 also affirms that the model exhibits a good overall fit.

Critically, each of the four components-post-traumatic readiness ($\beta = 0.425$), emotions ($\beta = 0.430$), risk assessment ($\beta = 0.429$), and confidence in performance ($\beta = 0.491$)-demonstrated significant and positive effects on psychological readiness. Among these, confidence in performance emerged as the strongest predictor, highlighting the central role of perceived ability in facilitating return-to-sport readiness. Together, these findings underscore the multifaceted nature of psychological recovery and reinforce the importance of addressing emotional, cognitive, and confidence-related factors in rehabilitation programs.

From a theoretical standpoint, the findings align with the model proposed by Gómez-Piqueras et al. (24), which views psychological readiness after injury as a multidimensional construct encompassing mental readiness, emotional responses, risk appraisal, and performance confidence. Similarly, Webster et al. (11) have emphasized the critical role of psychological factors in a successful return to professional competition. The four-factor structure identified in the present study supports these theoretical frameworks and confirms that such constructs are valid and measurable within the Iranian athletic context.

Demographic findings also revealed key insights. Notably, more than 44% of participants had been absent from training and competition for over one year highlighting the severity and chronic nature of injuries in the target population. Such extended absences may lead to significant psychological consequences, including decreased motivation, reduced self-confidence, identity disruption, and fear of re-injury all of which are captured within the scale's components.

Discriminant validity, assessed via HTMT, confirmed that the scale's components are conceptually distinct. This indicates that negative emotions (e.g., anxiety, fear), perceived mental readiness, individual risk assessment, and confidence in physical performance are interrelated yet independent psychological constructs-each requiring specific attention in rehabilitation programs.

Comparison with previous research also adds credibility to the present findings. For example, Aghababa & Bagiyan Kolemarzi (2021) emphasized the importance of emotional regulation in facilitating return to sport. Similarly (27), Jalili Shishavan (2023) highlighted the roles of social support and emotional coping strategies to reduce the psychological damage to the athletes (28). Although the current study did not directly measure social support, its psychological effects may be indirectly reflected in the emotions and risk assessment dimensions, suggesting future avenues for expanding the tool.

A notable strength of this research is its specific focus on a well-defined population of male footballers aged 17–25 with at least one serious injury in the past 12 months. Unlike many prior studies based on student or general populations, this study targets a specialized and sport-experienced group, enhancing the scale's accuracy and practical relevance.

The findings confirm that the developed scale is both valid and reliable for assessing psychological readiness to return to sport after injury. It effectively captures critical components such as psychological readiness, negative emotional states, risk assessment, and confidence in performance. As such, it can assist professionals in accurately evaluating an injured athlete's psychological state and tailoring effective interventions. Moreover, this tool may serve as part of the clinical or educational decision-making process regarding athletes' return to competition.

Based on the study's results and the validated factor structure, several practical recommendations can be made for different stakeholder groups to support young athletes' psychological return to sport following serious injury:

Health Nexus
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Sports psychologists can incorporate the scale into periodic assessments to evaluate readiness among injured athletes. The results may help identify individuals who, despite physical recovery, are not yet psychologically prepared to return. These insights can guide targeted interventions aimed at improving performance confidence, regulating negative emotions, and reducing perceived re-injury risk.

Coaches, particularly at youth and semi-professional levels, can use this tool to gain deeper insight into their players' psychological status post-injury. Such understanding can enhance return-to-play decisions, reducing the risk of re-injury or performance decline. Coaches can also help rebuild athletes' self-confidence by creating a supportive environment.

Parents play a key role in their children's psychological recovery. The study suggests that psychological factors like fear of re-injury and performance anxiety significantly affect return-to-play. Parents should avoid pressuring their children into returning prematurely and should foster an emotionally safe environment while maintaining communication with coaches and psychologists.

Clubs and sports federations can integrate this tool into their return-to-play protocols to adopt a more holistic approach to readiness assessment. It is also recommended that sports psychologists become permanent members of team support staff, especially in youth categories. Workshops for coaches and medical staff on the importance of psychological readiness and how to interpret the scale can further enhance the practical utility of the tool.

This study is not without limitations. First, the sample was limited to male football players aged 17-25 in Mashhad, Iran, which restricts the generalizability of findings to other age groups, genders, and geographical regions. The results may differ for female athletes, those over 25, or athletes from other cities or provinces. Second, due to the lack of comprehensive demographic data on injured athletes, a convenience sampling method was used. This may increase selection bias and limit the randomness of the sample. Third, the study focused exclusively on football. Although football has one of the highest injury rates, the scale's applicability to athletes in other sports (e.g., volleyball, wrestling, gymnastics, or martial arts) remains uncertain. Fourth, the study assessed only psychological readiness, without integrating physiological or medical readiness indicators. Since return-to-sport is influenced by a multidimensional interaction of psychological, physical, medical, and social factors, omitting these aspects may limit the interpretation of results. Fifth, the use of a self-report instrument introduces potential response bias, such as social desirability or individual misinterpretation of items.

In light of these limitations, several suggestions are made for future studies: 1) Expand the target population to include female athletes, those over 25 years of age, or adolescents under 17, to enhance the scale's generalizability. Conducting research across various regions in Iran or in other countries would also allow for cross-cultural comparisons and localization assessments. 2) Validate the scale in other team sports (e.g., volleyball, basketball, futsal) and individual sports (e.g., wrestling, athletics, taekwondo), which would support the creation of sport-specific adaptations. 3) Use probability-based sampling methods (e.g., random, stratified, or cluster sampling based on injury type, competition level, or age) to improve sample representativeness and reduce selection bias. 4) Combine psychological assessments with physiological and medical indicators to offer a comprehensive, interdisciplinary model of return-to-sport evaluation. 5) Employ qualitative methods-such as interviews, thematic analysis, or focus groups-alongside questionnaires to gain deeper insights into athletes' subjective experiences, attitudes, and emotional challenges during recovery. 6) Design intervention studies to evaluate the effectiveness of psychological programs (e.g., mental imagery, cognitive restructuring, emotion regulation training) based on the outcomes of this readiness scale.

Authors' Contributions

All authors equally contributed to this study.

Declaration

In order to correct and improve the academic writing of our paper, we have used the language model ChatGPT.

Transparency Statement

Data are available for research purposes upon reasonable request to the corresponding author.

Health Nexus
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Declaration of Interest

The authors report no conflict of interest.

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Ethics Considerations

The study placed a high emphasis on ethical considerations. Informed consent obtained from all participants, ensuring they are fully aware of the nature of the study and their role in it. Confidentiality strictly maintained, with data anonymized to protect individual privacy. The study adhered to the ethical guidelines for research with human subjects as outlined in the Declaration of Helsinki.

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Health Nexus
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Appendix

(Psychological Readiness Scale after Serious Injury (PRS-SI)

Items No.	Items	Very good/much	Good/much	Neutral	Poor/low	Very poor/low
1	How would you evaluate your progress during the recovery period through rehabilitation/functional exercises since your injury?					
2	Overall, how would you describe your mood after completing your rehabilitation program?					
3	How would you assess your physical condition for a potential return to sport after completing rehabilitation?					
4	How would you evaluate the functional status of your injured body part after completing the rehabilitation program?					
5	After completing rehabilitation, do you experience any discomfort or limitations that prevent you from performing normal exercises?					
6	After rehabilitation, to what extent do you feel pressure from those around you to return to training with your team?					
7	After rehabilitation, how would you rate your overall readiness to potentially return to full training?					
8	After rehabilitation, do you feel stressed about returning to regular training with your team?					
9	After rehabilitation, how secure do you feel about the injured area of your body when performing physical movements?					
10	After rehabilitation, do you feel nervous about engaging in sport or physical activity?					
11	After rehabilitation, do you feel calm and relaxed when thinking about participating in sport or physical activity?					
12	After rehabilitation, are you terrified that your injured body part might get hurt again during sport?					
13	After rehabilitation, are you afraid that your injured body part might accidentally get reinjured during sport?					
14	After rehabilitation, to what extent do you expect to get injured again immediately upon returning to training?					
15	After rehabilitation, to what extent do you believe that participating in sport might lead to reinjury of the previously injured body part?					
16	After rehabilitation, to what extent does the thought of undergoing another surgery and rehabilitation program discourage you from playing sport?					
17	After rehabilitation, how confident are you that your injured body part will not bother you during sport?					
18	After rehabilitation, how confident are you in your ability to play sport without focusing on your injured body part?					
19	After rehabilitation, are you confident that your injured body part can withstand the demands of sport?					
20	After rehabilitation, how confident are you in your ability to perform at your pre-injury level?					
21	After rehabilitation, how confident are you in your ability to perform well in your sport?					

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