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## **Mental Illness in Intercollegiate Athletics: Educating and Planning for Emergencies**

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Mental Illness in Intercollegiate Athletics

MENTAL ILLNESS IN INTERCOLLEGIATE ATHLETICS: EDUCATING AND PLANNING FOR EMERGENCIES

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### Abstract

The mental health of athletes is a growing frontier that presents with its own specific risk factors and manifestations of different psychiatric disorders. The purpose of this project was to obtain information about specific psychological illnesses that can then be communicated to athletes, coaches, administrators, athletic trainers, and other stake holders in the overall health of athletes as well as create an emergency action plan (EAP) for Bowling Green State University in the case of an emergent situation involving an athlete suffering from a mental illness. This project focuses on signs and symptoms of specific mental illnesses including major depressive disorder (MDD), anxiety disorders, and eating disorders as well as their specific impact on athletes and provides recommendations from current research on the subjects of education and planning for an emergency where the athlete may be a danger to themselves or others. The EAP developed from this information includes specific instructions in case of an emergency, individuals to contact for notification if an emergent event takes place, important addresses, and maps if medical transport is necessary. The educational presentation created from the research in this project includes signs and symptoms of specific disorders, applicable statistics, and general instructions on how to deal with a student-athlete suffering from a psychological disorder. All of this information works to provide a comprehensive program for the Bowling Green State University sports medicine department designed to care for athletes with psychological illnesses in the safest manner possible.

### Mental Illness in Intercollegiate Athletics: Educating and Planning for Emergencies

According to the National Institute of Mental Health's National Survey on Drug Use and Health (2014), 43.6 million American adults have experienced some type of mental illness. This same survey also showed that 20.1% of those adults who were ages 18-25 were diagnosed with a mental illness. Beginning in the mid-1990s, collegiate counseling centers started reporting that the psychological needs of college students have become focused on severe psychological ailments. The psychological conditions most often treated by campus counseling centers are anxiety and depression, but the prevalence of eating disorders is often overlooked as another extremely common diagnosis among the college student population (American Psychological Association, 2011). Therefore, this review of literature will focus on anxiety disorders, depressive disorders, and the disordered eating spectrum because of their prevalence among collegiate athletes. Because of the incidence of these mental health issues, this review of literature will delve into the logistics of creating an educational component as well as an emergency action plan for the Bowling Green State University athletics department in order to properly educate its stakeholders and care for an athlete in an emergent situation in the safest, and quickest manner possible.

According to Kessler et al. (2012), 16.6% of Americans over the age of thirteen report that they have experienced a major depressive episode (MDE) and 14.4% report that they have been diagnosed with major depressive disorder (MDD). The general collegiate population is no different and experiences mental health disorders with an emphasis on depression-type episodes. A survey by the American College Health Association (ACHA) reported that 32.6% of

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respondents have felt so depressed that it was “difficult to function” (2014). The ACHA survey (2014) indicates that the student-athlete population has a lower prevalence of depression, 21% of male student-athletes vs. 27% of male non-athletes and 28% of female student-athletes vs. 33% of female non-athletes. While it appears that there is a lower number of depressed non-athletes, this still remains a significant problem within collegiate athletics.

Depression, or major depressive disorder, is characterized by several symptoms according to the Diagnostic and Statistical Manual of Mental Disorders, 5<sup>th</sup> Edition (2013). In order to be diagnosed with MDD, a patient must have five of the nine symptoms which include: “depressed mood” or irritability, decreased interest or enjoyment in most activities, “significant” weight change or change in appetite, change in sleep patterns, “psychomotor agitation or retardation,” “fatigue or loss of energy,” guilt/worthlessness, inability to focus, and suicidality (APA, 2013, p. 161). The symptoms the patient experiences will also cause “significant distress” that impairs the individual “in social, occupational, or other important areas of functioning” (APA, 2013, p. 161). The DSM-V also categorizes “disruptive mood dysregulation disorder,” “persistent depressive disorder,” “premenstrual dysphoric disorder,” “substance/medication-induced depressive disorder,” “depressive disorder due to another medical condition,” “other specified depressive disorders,” and “unspecified depressive disorder” as “depressive disorders” that are characterized by a saddened mood that interferes with the patient’s ability to function in daily life (APA, 2013, p. 155).

While there is no universally accepted cause of MDD in individuals, there is some general consensus on the origin of the disease. Kendler, Karkowski, and Prescott (1999) found that genetic predispositions to personality, such as being “difficult” or “neurotic” may increase the risk of an individual having a major depressive episode. The study also showed evidence that

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“stressful life events,” such as assault, rape, divorce, or serious injury or illness, could be associated with major depressive episodes as well as the potential that someone with a certain genetic make-up could choose to be in more stressful situations, also increasing their risk for a depression diagnosis (Kendler, Karkowski, & Prescott, 1999). Bader (2014) also indicates that the sport environment may offer its own individual risk factors for the development of MDD. He lists “psychological response to injury,” “psychological response to end of athletics career,” and “overtraining” as risk factors, but adds the disclaimer that “most” incidents of depression are likely because of outside influences (e.g., biological make-up of the individual, their mindset and mental state, and stressors in their social environment) (Bader, 2014, p. 33).

While depression has a high prevalence among the collegiate population, anxiety has become the most prevalent mental health disorder among adolescents and young adults (Rapee, Schniering, & Hudson, 2009). A 2008 study by Rosenthal and Wilson determined that 83% of college student respondents had “moderate” or “clinically significant” levels of distress (p. 64). The Anxiety and Depression Association of America (2014) determined that about 40 million Americans over the age of 18 have anxiety and three-fourths of them have had a depressive episode before the age of twenty-two. Not only does anxiety affect the general population of young adults, but is seen in the student-athlete population as well. When asked whether or not they believe anxiety is “an issue” among college athletes, 85% of surveyed collegiate athletic trainers answered “yes” (Neal et al., 2013).

Anxiety disorders can have one of several classifications. These specific disorders include generalized anxiety disorder (GAD), separation anxiety disorder, selective mutism, specific phobias, social anxiety disorder, panic disorder, agoraphobia, substance/medication-induced anxiety disorder, and other specified/unspecified anxiety disorders (APA, 2013). An

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individual with GAD, the most common of these disorders (ADAA, 2014), usually experiences “severe” and “unrealistic” worry about every day events and happenings (ADAA, 2015). People who experience anxiety disorders often expect the worst when there is no reason for concern. They are unsure how to put a stop to the “worry cycle” and feel that they are not in control of their anxiety (ADAA, 2015).

While it is difficult to say what the root cause of anxiety is, there are several factors that researchers believe contribute to the development and persistence of anxiety throughout a patient’s life. Some research from the late ‘90s and early 2000s showed that anxiety disorders may be preceded by an “inhibited temperament” in children (Hayward et al., 1998). An inhibited temperament is characterized by “shyness, inhibition, and withdrawal” (Rapee, Schniering, & Hudson, 2009, p. 316). Hayward et al. (1998) found evidence that children who were diagnosed with anxiety disorders were described as inhibited or withdrawn. Prior et al. (2000) produced results that indicated that those children who exhibited shy behaviors early in their lives were at a higher risk of presenting with symptoms of anxiety disorders later in life. Other research suggests that anxiety could develop because of the parenting style their parents use (Rapee, 1997) or because of learning experiences they had when going through the developmental stages (Mineka & Zinbarg, 2006).

One of the most established theoretical models that attempts to explain anxiety disorders is Mowrer’s two-stage theory of fear (Goldman, 2014). This theory eventually influenced the “Avoidance Model of Worry and GAD” (Behar et al., 2009). In these models, the patient associates a signal or action with a negative or “noxious” outcome and may infer that every time they perform the action there will be a negative outcome. The models also indicate that avoidance is a “trial-and-error” process that is the individual’s response to the noxious event.



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The person will continue to avoid the situation and feel calm and relieved when they successfully do so. This works in a cyclical pattern because the constant avoidance continues to provide the patient with relief (Goldman, 2014).

Another prevalent group of mental health disorders among athletes are eating disorders and disordered eating. Disordered eating is a spectrum of beliefs and behaviors about food and nutrition (Torstveit, Rosenvinge, & Sundgot-Borgen, 2008). These include “preoccupation with body weight and shape, food restriction, and dieting as well as bingeing, vomiting, and the abuse of diuretics, laxatives, and diet pills” (Torstveit et al., 2008, p. 108). These actions are done with the intention of decreasing body weight and compensating for their internal dissatisfaction with their body and/or appearance (Torstveit et al., 2008). These behaviors can lead to serious health effects such as electrolyte imbalances, irregular heartbeats, osteoporosis, peptic ulcers, pancreatitis, gastric rupture, and can even be fatal to the athlete (Thompson, 2014). These behaviors however differ from eating disorders because they “do not manifest the full range of psychological traits usually associated with clinical cases of an eating disorder—i.e. interpersonal distrust or perfectionism” (Hesse-Biber, Leavy, Quinn & Zoino, 2006, p. 211).

While the DSM-V (APA, 2013) describes a multitude of eating disorders, the disordered eating continuum includes symptoms that could eventually progress to three different disorders: anorexia nervosa, bulimia nervosa, and binge-eating disorder (Bonci et al., 2008; Thompson, 2014). Anorexia nervosa is characterized by the patient’s inability to maintain body weight above or at the normal weight for the person’s developmental stage because of caloric restriction, a serious fear of gaining weight or becoming “fat” and skewed self-evaluation of appearance or denial about the severity of their weight (APA, 2013). Anorexia nervosa also is categorized into two types: restrictive and binge-eating/purging (APA, 2013). In restrictive anorexia nervosa, the

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individual does not participate in bingeing/purging activities but merely restrict their food intake. In binge-eating/purging anorexia nervosa the individual regularly engages in bingeing episodes or purging behaviors such as self-induced vomiting or the misuse of laxatives, diuretics, or enemas (APA, 2013). Patients with anorexia nervosa also may have beliefs about food that are incorrect or extreme (Fletcher, Cole, & Meyer, 2008). The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* previously included the symptom of amenorrhea as a requirement for the anorexia nervosa diagnosis (APA, 2013). This requirement has since been removed in the newest edition so that the disorder encompasses male patients and females who take contraceptives (APA, 2013).

Bulimia nervosa also has its own individual criteria as set forth by the DSM-V (APA, 2013). In order for an individual to be diagnosed with bulimia nervosa he or she must have five characteristics (APA, 2013). First, there must be recurrent episodes of binge eating. These episodes are described as the individual eating a portion of food that is larger than a normal meal in a short period of time as well a lack of control over the act of eating during this time. Second, the individual participates in repeated compensatory behaviors such as vomiting, excessive exercise, fasting, or abuse of laxatives, diuretics, or enemas. Third, the binge eating and compensatory behaviors happen at least once a week for three months. Fourth, the person's view of him or herself is heavily influenced by weight and physical appearance. Fifth, these episodes do not only occur during times of anorexia nervosa (APA, 2013). Bulimia nervosa also has four categories describing its severity: mild, moderate, severe, and extreme (APA, 2013). A case is classified as "mild" if there are 1-3 episodes of bingeing per week, "moderate" if there are 4-7 episodes of bingeing per week, "severe" if there are 8-13 bingeing episodes per week, and "extreme" if there are fourteen or more bingeing episodes per week (APA, 2013, p. 345). Many

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individuals with bulimia nervosa will act secretively and experience guilt after an episode of binge eating. Another distinctive characteristic of bulimia nervosa is the fact that those who suffer from it are typically in the normal weight range for their developmental stage as opposed to those with anorexia nervosa who are under the normal weight range (Fletcher, Cole, & Meyer, 2008).

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* now includes binge-eating disorder which was previously housed under “eating disorder not otherwise specified” (APA, 2013). Binge-eating disorder is characterized by repeated episodes of bingeing that are not followed by compensatory behaviors such as vomiting, fasting, excessive exercise or misuse of diuretics or enemas. Individuals who suffer from binge-eating disorder may eat quickly and even if they do not feel hungry, may feel guilty or embarrassed after an episode, and are generally distressed over their eating habits. In order to be diagnosed with this disorder, the episodes must occur once a week for three months (APA, 2013).

There are several factors that could potentially lead to the development of an eating disorder in an athlete. The first of these is a genetic influence. For many years, it was believed that eating disorders were only influenced by the environment and the sociocultural norms the patient is subjected to (Bulik et al., 2007). However, research has found that genetics, in combination with environmental factors, do have an effect on the development of the disorder (Mazzeo & Bulik, 2009). It is likely that there are a number of genes that create a code for proteins that in turn influence these traits (Mazzeo & Bulik, 2009).

Another suggestion is that certain personality traits influence the development of an eating disorder. According to Keel and Forney (2013) personality traits create a person's

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perception of their environment and cause that person to relate to and interact with that environment in a certain manner. “Negative emotionality,” or a broad categorization of personality that includes “tendency to experience dysphoria, negative self-evaluation, and low self-esteem,” has been believed to impact the possibility of a patient developing disordered eating habits or an eating disorder (Keel & Forney, 2013, p. 436). Widiger (2011) also adds that those who are “high in conscientiousness have high levels of self-discipline, competence, and achievement-striving” which he confirms are characteristics required for an individual to successfully lose weight (p. 103).

The concept of “perfectionism” has long been stated as an important risk factor to the development of an eating disorder, specifically anorexia nervosa (Bastiani et al., 1995; Shafran, Cooper, & Fairburn, 2003; Tyrka, Waldron, & Gruber, 2002). As early as 1995, Bastiani et al., compared groups of controls, anorexic patients, and anorexic patients who had regained the weight they had lost due to the disease and found that those classified in the anorexic group exhibited a perfectionist personality and that this trait was not a side effect of the anorexia nervosa. Those who had gone through weight restoration still exhibited the perfectionist behaviors and their responses to the research questions indicated that the majority of their perfectionist tendencies are “self-imposed” and not because of external expectations.

### **Mental Health in Athletes**

While athletes face many of the same stressors as non-athlete college students, the athletic environment also adds another dimension of risk factors that could contribute to the development of a mental health disorder (Kroshus, 2014). Often “general clinicians,” or those who do not generally interact with the athletic population and environment, are the mental health

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professionals that diagnose and treat athletes with psychiatric disorders (Reardon & Factor, 2010). The fact that the clinician may be unfamiliar with the athletics environment complicates the understanding the disorders of many athletes because it is difficult for these “outsiders” if they do not have a thorough knowledge of the athletic environment and its unique issues (Reardon & Factor, 2010). There is also a tendency to “idealize” those who are athletes and overlook the significance of certain psychiatric symptoms (Reardon & Factor, 2010). Athletes themselves also have a propensity for concealing “weaknesses” or exhibiting behaviors that in the general population would indicate a psychiatric disorder is present. For example, paying attention to their diet or being overly physically active are behaviors that are common in athletes but may be symptoms of a psychiatric disorder (Reardon & Factor, 2010).

Bader (2014) states that athletes probably experience depression symptoms because of factors that are unrelated to sport, but symptoms of MDD may develop because of a “psychological response to the end of [their] athletics career” (p. 33). This could be because their identity is centered on their athletic participation and when that identity is threatened it could further enhance his or her depression (Bader, 2014). However, Weigand, Cohen, and Merenstein (2013) produced results in a study of 163 former collegiate athletes and 117 current collegiate athletes that showed that levels of depression were actually lower in those that were two years or less removed from athletic participation in comparison to those who were still participating at the time of the study. Their findings imply that the loss of athletic identity may not have that large of an effect on all individuals and the stressors of sport may put more strain on the psyche of athletes than their loss of identity.

The sporting environment also presents specific risk factors to developing disordered eating. Torstveit et al. (2008) state that while disordered eating and eating disorders are prevalent

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among both adolescent and adult athletes, they are especially prevalent in athletes who participate in sports that are sensitive to the athletes' weight. Schaal et al. (2011) also found that the highest rates of eating disorders in females were found in those who participated in endurance sports, such as distance running, and aesthetic sports, such as gymnastics. While athletes may face some of the same risk factors as non-athletes, it is believed that some sport environments make them more likely to participate in disordered eating in comparison to non-athletes (Currie, 2010).

An athlete may also be motivated to continue disordered eating behaviors after they have had preliminary success. Initially in sports that emphasize being lean, a reduction in body weight or body fat is presumed to increase performance (Currie, 2010). This could cause the athlete to associate positive results with this loss of weight and continue the behaviors, allowing him or her to inadvertently develop an eating disorder (Rodriguez, Di Marco, & Langley, 2009). Because of this, athletes who have a history of dieting, who have trouble making weight requirements for their sport, or who restrict caloric intake are believed to be at risk for the development of an eating disorder (Drinkwater, Loucks, Sherman, Sundgot-Borgen, & Thompson, 2005).

Kroshus (2014) states that a commonly referenced stressor in the life of collegiate athletes is that of "time demands" (p.73). Athletes spend an exceptional amount of time participating in their sport, especially during their sport's season. This schedule could cause them to become anxious because of the fear that he or she will be unable to "achieve academically or meet performance expectations in his or her sport" (Goldman, 2014, p. 30).

Abrahamsen, Roberts, and Pensgaard (2008) also found that the type of motivational climate in which the athlete participates in could have an effect on the level of anxiety an athlete

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experiences. The results of the 2008 study showed that those elite athletes who perceived their motivational climate, or the psychological and social atmosphere around the athlete, (Ames, 1992) as one with a “performance” focus, or a motivational climate that revolves around comparison of athletes and the outcome of the competition (Abrahamsen et al., 2008), tended to have more anxiety or worry. This study also showed that females experience more anxiety or worry than males and also encounter more concentration disruption than their male counterparts (Abrahamsen et al., 2008). The authors do say, however, that “whether the perceived motivational climate should be considered to moderate or mediate the gender effect on anxiety is an unresolved issues, and the present study gives no conclusive answers” (Abrahamsen et al., 2008, p. 459). But de Bruin, Bakker, and Oudejans (2009) also found in a study of a sample of female athletes that the presence of ego-oriented achievement, or a focus on winning and outcomes rather than the process, and performance climate was related to more “pathogenic weight control measures” (p. 76) such as “exercising in order to burn calories, fasting/strict diets, self-induced vomiting, use of diuretics/ diet pills, and use of laxatives/suppositories” (p. 75).

### **Athletic Trainers and Mental Health**

Athletic trainers (ATs) play a distinctive role in the care of an athlete. They often act as a friend and even confidant for the student-athletes (Neal, 2014). Yang et al. (2010) found that athletic trainers play a critical role in the mental support of an athlete post-injury and suggest that they may be the most “effective sources of high-quality support” for athletes (p. 378). Bonci et al. (2008) says that in the case of athletes with disordered eating specifically, “all certified athletic trainers should be prepared to assume the role of informed patient advocates in the management of athletes with DE” (p. 88). This means that the athletic trainer should use the knowledge that he or she gained from their education to clearly communicate with the athlete

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about his or her care and ensure that decisions are made in the best interest of the athlete. This can be generalized to athletes experiencing any type of mental illness. ATs have the education to identify athletes at risk, “confront” these athletes, and provide assistance as needed to facilitate proper care, but should always allow for physicians and those who specialize in the field of mental health determine diagnosis and treatment (Bonci et al., 2008).

Because of the important role athletic trainers play in the identification and initial response to a psychological disorder, they should be well trained and prepared in case a mental health emergency should occur. Clement, Granquist, and Arvinen-Barrow (2013) found in a survey of certified athletic trainers that they reported having limited access to sport psychology services and that there was no written protocol on how to refer athletes should those resources be needed. Considering that one of the tasks for the “organizational and professional health and well-being” domain in the athletic training role delineation study is “develop a support/referral process for interventions to address unhealthy lifestyle behaviors” (Board of Certification, 2010, p. 75) it seems that athletic trainers should have a more structured approach to the referral of student-athletes who are experiencing mental health ailments.

### **Recommendations**

In a 2006 study by Sharp, Hargrove, Johnson, and Deal 105 college students were randomly assigned into two groups. One group was given classroom instruction on mental illness in an attempt to de-stigmatize the act of seeking professional help when suffering from a mental illness. Both groups were then given surveys to analyze their beliefs about psychiatric disorders and their willingness to seek professional help. This study showed that those who underwent a mental illness training session had altered opinions about psychiatric disorders and said that they



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were more willing to seek professional help if they experienced psychological symptoms (Sharp, Hargrove, Johnson, and Deal, 2006). This supports the belief that if student-athletes, coaches, administrators, and other athletics department personnel were educated on the signs and symptoms of mental illness, they may be more willing to seek professional help or to assist someone they know in getting treatment for a psychological problem.

Buckley and Malouff (2005) also studied the effect of an educational session on the beliefs and actions of those who participate. Eighty college students were split into two groups. One group was shown a video highlighting the positive experience of several patients with psychotherapy. The control group viewed a video discussing a person's sense of "self." The results showed that those who watched the video about psychotherapy had more positive attitudes towards seeking professional mental health. These individuals also showed an increased tolerance towards the stigma associated with having a mental illness, an increased willingness to share private information with a counselor, and more confidence in mental healthcare professionals (Buckley & Malouff, 2005). This is another example of groups becoming more accepting of mental illness and seeking help from qualified professionals should the occasion arise. This is further confirmation that introducing a mental health educational program to the athletes of Bowling Green State University, may encourage them to seek help if they are experiencing depression, anxiety, eating disorders, or any other mental health issue.

Klenck (2014) provides several key components to creating a mental health care system that works to optimally care for the athletes that it intends to serve. The first component is "identifying members of the mental health services team" (Klenck, 2014, p. 101). Klenck (2014) points out that all universities should have an athletic trainer or team physician that serve as the "point person" to refer affected student athletes to mental health care professionals who can

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properly care for them (p. 101). He also suggests that care teams consist of clinical psychologists, psychiatrists, a licensed social worker, student-athlete services representatives, dietitians, drug/alcohol counselors, sport psychologists, sport administrators, and coaches. While it is understandable that not all institutions have all of these individuals available, the athletics department should at least coordinate with the university counseling services or an off-campus organization such as a hospital with a mental health care center or an in-patient care center (Klenck, 2014). The National Athletic Trainers' Association Position Statement includes that the care for an athlete with a mental disorder should be coordinated by the team physician (Bonci et al., 2008).

The second "best practice" that Klenck (2014) suggests is "raising awareness of the mental health services available" (p. 101). Klenck (2014) gives five suggestions on how to accomplish this part of the health care team's mission:

1. "presentations at team meetings;"
2. "presentations at coaches or staff meetings;"
3. "printed handouts or pamphlets with program information and contact numbers;"
4. "information posted on athletics department websites; and"
5. "use of social media (such as Facebook)." (Klenck, 2014, p. 101)

Klenck (2014) also instructs health care team members and administrators to utilize the opportunity that pre-participation physicals present to screen, recognize, and refer those who have a history of mental illness as well as those with a history of psychotropic drug prescriptions or recreational drug use. This action helps to anticipate incidents and also provides the opportunity to further educate and prepare the individuals who interact with the patient

frequently. Klenck (2014) suggests that those who are creating policy make plans for “communication among members of the mental health services team,” “medication management,” “crisis management,” “risk management,” and “transition of care” (p. 102).

Because of the stigma associated with mental health and seeking treatment, it may be difficult for the athlete to inquire about care themselves (Neal, 2014). Neal (2014) acknowledges that it may be “uncomfortable” to approach athletes about their mental well-being and instructs that “you have the facts correct, with context, relative to the behavior of concern before arranging for a private meeting with the student-athlete” (p. 105). It is important to ensure that you have properly identified warning signs of mental health disorders such as changes in eating habits, change in sleep patterns, “unexplained” weight change, mood swings, or withdrawing from social contact (Neal, 2014, p. 104). In order to create the most positive experience for the health care professional and the athlete, Neal (2014) suggests that athletic trainers:

- “Practice empathetic listening.
- Focus on the individual as a person and not as an athlete.
- De-stigmatize care seeking for mental health concerns.
- If you think the student-athlete might be a threat to him/herself or others, enlist emergency mental health services.” (p. 105).

Neal (2014) also states that when institutions are creating protocols or policies there should be a written plan for recognizing mental illness and referring the student-athlete to proper health care professionals. He also suggests that a “primary point of contact” or “point person” be established for each case. For example, an athletic trainer could be the individual to coordinate care and communicate between all of the stakeholders in the situation.

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Goldman (2014b) provided several “check lists” that could be used to create a written plan for dealing with athletes that experience mental health disorders. He suggests that the plan be included in the policies and procedures of the sports medicine staff and that the plan be flexible, address how to refer the athlete, how to educate the sports medicine staff, and what to do if the incident occurs after normal business hours (Goldman, 2014b). According to the National Collegiate Athletic Association Sport Science Institute (2016), the mental health emergency action plan should address suicidal or homicidal ideation, caring for sexual assault victims, caring for those who are threatening to those around them or experiencing psychosis, managing an athlete in a confused state, and caring for an athlete who has overdosed on drugs or alcohol or is intoxicated. This document also includes specific pieces of information that should be considered for the written emergency action plan. These elements include: when the individual responding to the emergency needs to contact emergency services, when the individual should contact an on-call counselor, state the expectations of each “stake holder” (e.g., coach, athletic trainer, other athletes) in the situation, identify specific steps the responding individual should follow, and have a procedure for reviewing the procedure post-emergency (NCAA, 2016).

In the case of an “emergency” mental health issue the responding individual should first “identify the risk” by asking specific questions such as “Am I concerned the student-athlete may harm himself/herself?” or “Am I concerned the student athlete may harm others?” (Goldman, 2014b, p. 110). This helps to establish the severity of the situation and determine if he or she should solicit help from other colleagues or emergency medical services. The responding individual should then manage any risks to the safety of the athlete or others they feel necessary while always remembering to keep himself or herself safe (Goldman, 2014b, p. 110). The

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emergency plan should also include what situations are appropriate for using this plan, when emergency medical services should be contacted, the local “involuntary retention” protocol, and when an on-call counselor should be contacted (NCAA, 2016).

In the case of a “nonemergency” mental health issue, Goldman (2014b) instructs the individual responding to the athlete to gather the appropriate information by asking questions that directly address suicide. If a nonemergency referral is necessary because the athlete is not contemplating suicide, the student-athlete should be provided with treatment options and allowed to “think it over” if necessary (Goldman, 2014b, p. 109). The written plan for this situation should include specific situations where the nonemergency approach is appropriate, who the athlete will be referred to, and who bears the responsibility of making the referral (NCAA, 2016).

In order to make the referral process more efficient at Bowling Green State University, a basic mental health referral decision chart has been created in the event that an emergent situation arises (see Appendix A). An in-depth emergency action plan outlining what situations are appropriate for its enactment, identifying the risk to the student-athlete or others, specific contact numbers and addresses of all sports medicine facilities, and how to direct follow-up care was also written to provide specific instruction for the care of an athlete in the case of a mental health emergency (see Appendix B). Because athletic trainers are only one part of the mental health care team, an educational presentation was also created in order to educate coaches, athletes, administrators, and other stakeholders on the signs and symptoms of common psychiatric illnesses, the risks associated with athletic involvement, how to care for an athlete with a mental health concern, and who to contact for follow-up care (See Appendix C).

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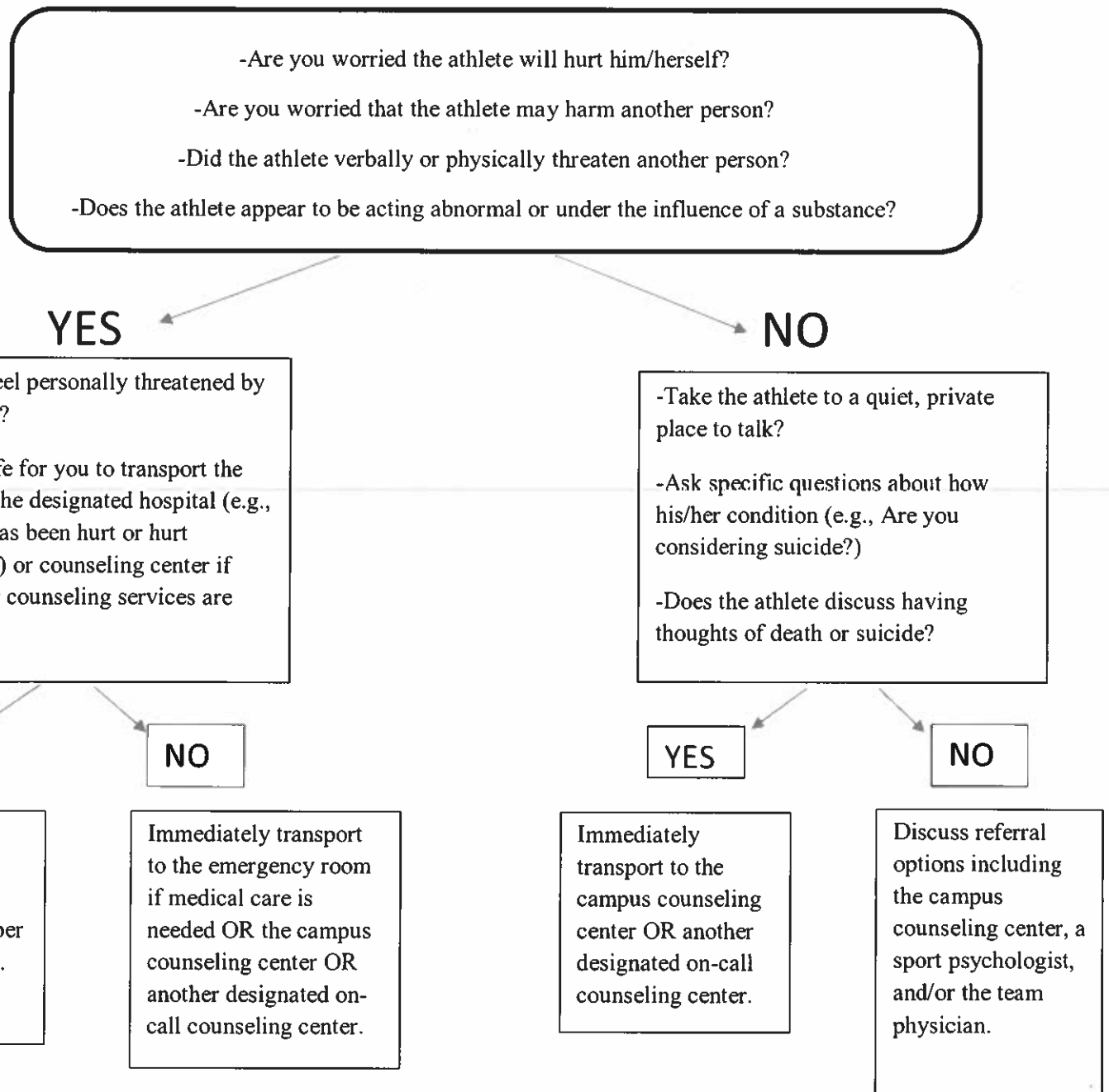
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Appendix A

**Student-Athlete Mental Health Referral Decision Chart**

An athlete has presented with a mental health issue (e.g., suicidal or homicidal ideation, was a victim of sexual assault, is experiencing psychosis, is confused, has overdosed, or is under the influence of drugs or alcohol):



(Goldman, 2014b; NCAA, 2016)

## Appendix B

# Bowling Green State University

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## Sports Medicine

### Mental Health Emergency Action Plan

- I. This framework is appropriate for an athletic trainer to utilize if an athlete:**
  - a. Has suicidal or homicidal ideation.
  - b. Has been a victim of sexual assault.
  - c. Is exhibiting threatening actions or behavior associated with psychosis.
  - d. Is in a confused or delirious state.
  - e. Is inebriated or has overdosed.
- II. Identify the risk**
  - a. Is there concern that the athlete may harm him/herself?
  - b. Is there concern that the athlete may harm another individual?
  - c. Was there any verbalized or physical threat made?
  - d. Do you feel threatened?
  - e. Is the athlete showing signs of unusual behavior that may or may not be influenced by substance use?
  - f. Is there a danger of harm in the future?
- III. If there is immediate risk**
  - a. Keep yourself out of harm's way.
  - b. Keep others out of harm's way.
  - c. If athlete is actively attempting to harm himself/herself call campus police (419-372-2346) immediately or if it is safe transport him/her to the nearest emergency room.
    - i. NOTE, use one of the following addresses below to inform dispatch of your specific location:
      1. Sebo/Doyt Perry Stadium Address: 1610 Stadium Dr. Bowling Green, OH 43403
      2. Stroh Address: 1535 Wooster St. Bowling Green, OH 43403
      3. Anderson Arena: Memorial Hall (Anderson Arena, BGSU campus)
      4. BGSU Ice Arena: 417 N. Mercer Rd. Bowling Green, OH 43403
    - ii. NOTE:
      1. Supervising Athletic Training Staff member should accompany the student-athlete to the hospital.

2. Notify other athletic training staff and administration immediately.
    - a. Alfred Castillo, Head Athletic Trainer
    - b. Dr. Jeffrey Nofztz, Head Team Physician
    - c. Lauren Ashman, Senior Associate Athletics Director/Senior Women's Administrator
    - d. Kit Hughes, Senior Associate Athletics Director
    - e. Student-Athlete's head coach
  3. Notify the athlete's parents immediately.
  4. Obtain and communicate insurance information and medical history.
  5. Appropriate documentation should be completed (e.g., SOAP notes, physician's visit notes, etc.)
- iii. If there is no immediate threat to the athlete or others (e.g., athlete verbally expresses suicidal ideation with no active attempt) and it is unsafe to transport him/her, contact the available psychological resources:
1. "THE LINK" Emergency Hotline (Behavioral Connections)
    - a. Phone: 419-352-1545
- iv. If there is no immediate threat to the athlete or others (e.g., athlete verbally expresses suicidal ideation with no active attempt) and it is safe to do so, transport to BGSU counseling center (during business hours) or "THE LINK" office at Behavioral Connections of Wood County, Inc. (24 hours a day).
1. BGSU Counseling Center
    - a. Phone: 419-372-2081
    - b. Address: 104 College Park Office Building
    - c. Walk in Hours: 1:30pm-4:00pm
  2. "THE LINK" office
    - a. Address: 1022 N. Prospect Street Bowling Green, OH 43402
- d. Get help from colleagues if needed.
- i. Alfred Castillo, Head Athletic Trainer
    1. Cell phone: 573-587-3402
    2. Office phone: 419-372-7088
  - ii. Dan Fischer, Associate Athletic Trainer
    1. Cell phone: 314-221-0765
    2. Office phone: 419-372-7238
  - iii. Chelsea Lowe, Assistant Athletic Trainer
    1. Cell phone: 303-241-9967
    2. Office phone: 419-372-7089

**Mental Illness in Intercollegiate Athletics**

- iv. **Rob Whitehurst, Assistant Athletic Trainer**
  - 1. Cell phone: 419-677-6641
  - 2. Office Phone: 419-372-2219
- e. If athlete is openly expressing threatening behavior, do not leave the athlete alone but do not interfere if he/she tries to leave.
- f. Do NOT leave him/her alone if possible.
- g. If this event occurs afterhours or when an athlete is not in your presence (e.g., he/she contacts you via phone):
  - i. Ask the athlete his/her location.
  - ii. Immediately contact emergency services via campus police.
    - 1. Phone: 419-372-2346
  - iii. Keep the athlete on the line if possible.

**IV. Direct Follow-Up Care**

- a. Contact necessary psychological professionals to facilitate follow up care (as directed by physician)
  - i. **Dr. Dryw Dworsky**
    - 1. Office Phone: 419-372-2540
  - ii. **Behavioral Connections of Wood County, Inc.**
    - 1. Phone: 419-352-5387
  - iii. **BGSU Counseling Center**
    - 1. Phone: 419-372-2081
    - 2. Address: 104 College Park Office Building

(Goldman, 2014b; NCAA, 2016)

Appendix C

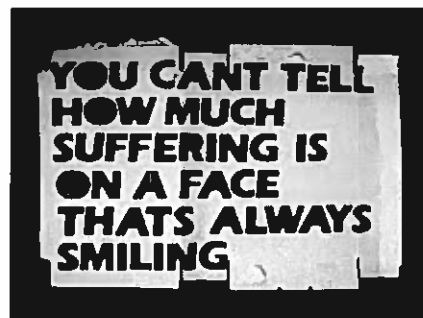
## Mental Health Issues in Athletics

Bowling Green State University  
Sports Medicine  
Danielle “Dani” Coppes, AT

## Mental Health by the Numbers

43.6 million American adults have dealt with some type of mental illness.

- 20.1% of those adults were between ages 18-25.
  - (National Institute of Mental Health, 2014).
- This is our demographic!!



## Depression Statistics

16.6% of Americans over 13 report a depressive episode  
14.4% of Americans over 13 have been diagnosed with major depressive disorder (MDD).

• (Kessler et al., 2012)

Generally athletes have been found to have lower rates of depression (ACHA, 2014) but still remains an issue within athletics.

## Depression (Major Depressive Disorder)

### Potential Warning Signs/Symptoms

- “depressed mood or irritability”
- Decreased interest or pleasure in most activities
- Significant weight change or change in appetite
- Change in sleep
- Change in activity
- Fatigue or loss of energy
- Guilt/worthlessness
- Diminished ability to think/concentrate
- Suicidality

(American Psychological Association, 2013)



AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION



## Depression (Major Depressive Disorder)

### Potential Causes/Risk Factors

- Personality
- “stressful life events”
  - An assault
  - A divorce
- Injury/illness
  - (Kendler, Karkowski, & Prescott, 1999)
- Sporting environment
  - Injury
  - End of career
  - Overtraining
    - (Bader, 2014)



## Anxiety Statistics

83% of college students were “moderately”- “severely” distressed

- (Rosenthal and Wilson, 2008)

40 million American adults have anxiety.

- 75% of those have an episode before the age of 22

(Anxiety and Depression Association of America, retrieved February 20, 2016)

85% of collegiate athletics trainers surveyed said anxiety is an issues among athletes.

- (Neal et al., 2013)

## Anxiety Disorders (General Anxiety Disorder)

“severe” and “unrealistic” worry about every day events and happenings (APA, 2013)

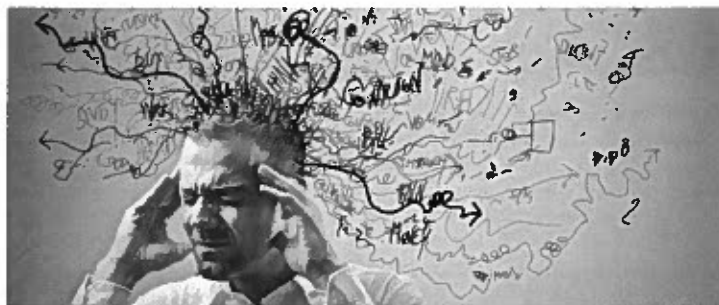
expect the worst when there is no reason for concern and feel that they are not in control of their anxiety

- (ADAA, 2015)

## Anxiety Disorders (General Anxiety Disorder)

### Potential Causes/Risk Factors

- Withdrawn/shy personality (Hayward et al., 1998)
- Parenting style/influence (Rapee, 1997)
- Negative experience in developmental stage (Mineka & Zinbarg, 2006)



## Eating Disorders

“preoccupation with body weight and shape, food restriction, and dieting as well as bingeing, vomiting, and the abuse of diuretics, laxatives, and diet pills”

Actions done in order to decrease body weight to compensate for dissatisfaction with appearance or weight

- (Torstveit, Rosenvinge, & Sundgot-Borgen, 2008)

3 major classifications: Anorexia nervosa (AN), Bulimia Nervosa (BN), Binge eating disorder (BED)

## Anorexia Nervosa

Inability to maintain normative body weight

Serious fear of gaining weight or becoming “fat”

- Skewed self-evaluation of appearance
- Restrictive vs. bingeing/purging
  - Restrictive- does not binge eat and then purge the intake
  - Bingeing/purging-regularly binge eats and then purges (self-induced vomiting, laxatives, diuretics, enemas)
- (APA, 2013)
- May also have incorrect/extreme food beliefs (Fletcher, Cole, & Meyer, 2008)

## Bulimia Nervosa

Five symptoms

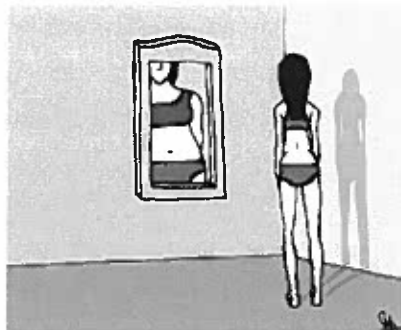
- Recurrent episodes of binge eating
- Repeated compensatory behaviors (self-induced vomiting, excessive exercise, fasting, abuse of laxatives, diuretics, enemas)
- Bingeing/purging happens at least once a week for three months
- Individual's view of themselves is heavily influenced by weight/appearance
- Episodes do not occur during periods of "anorexia"  
(APA, 2013)

## Bulimia Nervosa

Usually normal weight

May feel guilty after bingeing episode

- (Fletcher, Cole, & Meyer, 2008)



## Bulimia Nervosa

### Purging vs. non-purging

- purging-when individual regularly uses vomiting, laxatives, diuretics, enemas
- Non-purging-when individual uses fasting or excessive exercise to compensate

(APA, 2013)

## Binge Eating Disorder (BED)

Formerly “Eating Disorder Not Otherwise Specified” (EDNOS)

Repeated bingeing episodes not followed by purging

May eat quickly, even if not hungry

May feel guilty/embarrassed after episode

May be generally distressed over eating habits

Episodes must occur once a week for three months

- (APA, 2013)

## Eating Disorders

### Potential Causes/Risk Factors

- Genetic influence (Bulik et al., 2007)
- Environmental factors (combined with genetics) (Mazzeo & Bulik, 2009)
- Personality traits
  - Negative emotionality (low-self esteem, negative self-evaluation)
    - (Keel & Forney, 2013)
  - Self-discipline
  - Achievement-striving
  - Competence
    - (Widiger, 2011)
  - Perfectionism or “Type A” (Shafran, Cooper, & Fairburn, 2003)

## Mental Illness in Athletes

- Difficult to identify in athletes because sometimes people have a tendency to “idealize” those who participate in sport.
- Also, some actions that are normal in sport are symptoms of mental illness
  - i.e monitoring one’s diet  
(Reardon & Factor, 2010)



## Mental Illness in Athletes

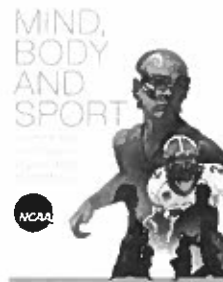
### Athletic Risk Factors

- Eating disorders in endurance (distance running) or aesthetic sports (gymnastics) (Schaal et al., 2011)
  - Decreasing weight can initially increase performance (Currie, 2010)
- Time demands (Kroshus, 2014)
- Motivational Climate/coaching style (Abrahamsen et al., 2008)



## How to Deal with an Affected Athlete (Neal, 2014)

- Practice empathetic listening
- Focus on the individual as a person, not an athlete
- De-stigmatize care seeking for mental health reasons
- If you think the athlete is a threat to him/herself, enlist the help of emergency medical services (p. 105)



## How to Deal with an Affected Athlete

Team physician or athletic trainer serves as “point person” for care (Klenck, 2014)

- Care team also consists of:
  - Psychiatrist
  - Clinical psychologists
  - Social workers
  - SAS representatives/academics
  - Dieticians
  - Drug/alcohol counselors
  - Sport psychologists
  - Administrators
  - Coaches
- (Klenck, 2014)

## How to Deal with an Affected Athlete

- Raising awareness of mental health resources (Klenck, 2014)
  - In case of emergency dial campus police (419-372-2346) or 911
  - Dr. Dryw Dworsky, Director of Psychological Services  
419-372-2540
  - Dr. Vikki Krane, Sport Psychologist  
419-372-7233
  - Behavioral Connections, counseling center  
419-352-5387
  - “The Link” Emergency Hotline  
419-352-1545
  - BGSU Counseling Center  
419-372-2081



## How to Deal with an Affected Athlete

Have a plan of action (Emergency Action Plan) to deal with a crisis (Bader, 2014)

- **Identify whether there is an immediate risk to safety**

- Is there concern that the athlete may harm him/herself?

- Is there concern that the athlete may harm another individual?

- Was there any verbalized or physical threat made?

- Do you feel threatened?

- Is the athlete showing signs of unusual behavior that may or may not be influenced by substance use?

- Is there a danger of harm in the future?

- (Goldman, 2014, p. 110)

## How to Deal with an Affected Athlete

- **Manage immediate risks**

- Is there concern that the athlete may harm him/herself?

- Is there concern that the athlete may harm another individual?

- Was there any verbalized or physical threat made?

- Do you feel threatened?

- Is the athlete showing signs of unusual behavior that may or may not be influenced by substance use?

- Is there a danger of harm in the future?

- (Goldman, 2014, p.110)

## How to Deal with an Affected Athlete

### For Emergency Action Plan:

- Know important phone numbers
  - Local police/emergency number
  - Head athletic trainer/director of sports medicine
  - Athlete's parents
  - Athlete's coach
  - Athletic administration
  - Team physician
- Know addresses of potential locations

For example, BGSU's plan includes addresses for the Stroh Center, Doyt Perry Stadium, Anderson Arena, and the BGSU Ice Arena, campus counseling center, and Wood County Behavioral Connections.