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Addressing Mental Health in Sport: An Applied Workshop for College Athletic Departments

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ADDRESSING MENTAL HEALTH IN SPORT: AN APPLIED WORKSHOP FOR COLLEGE
ATHLETIC DEPARTMENTS

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Master's Project

Kinesiology and Clinical Mental Health Counseling

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Addressing Mental Health in Sport: An Applied Workshop F\for College Athletic Departments

Preparing for the Workshop

It is important that participants recognize that the information being provided within this workshop may be new to some and old to others. Mental health is a sensitive topic and often is hard for individuals to discuss. This program is tailored to provide psychoeducation that is sport-specific and relevant to student-athletes, athletic department staff members, and mental health. The topics and material provided are not specific to each institution, rather I provide basic knowledge and information about why mental health should be discussed within athletic departments, common mental health issues student-athletes face, and what athletic staff members can do to help.

The goal of this workshop is to provide training to athletic staff members about why mental health should be addressed within collegiate sports and how they can help. In order to know how to help a student-athlete in distress, one must first understand what to look for. The first half of this workshop breaks down mental health terminology, addresses stigma, and discusses how athletic staff members can support overall well-being of student-athletes. The second half introduces interventions and four steps that athletic staff members can take when working with student-athletes. The sessions are as follows:

- Session 1: Mental health literacy
- Session 2: Perceived stigma about mental health and sport
- Session 3: Intentional communication
- Session 4: Recognizing signs/symptoms of common mental health issues
- Session 5: Reaching out

- Session 6: Referring student-athletes
- Session 7: Remaining supportive

Throughout the workshop, *athletic staff members* will be used to refer to those participating in the workshop. While student-athletes will benefit from the implementation of the skills learned, the target audience is athletic staff members. *Facilitators* refers to the individuals teaching the workshop. These individuals have gone through extensive training (i.e., master/doctoral programs) and are licensed professional counselors. Facilitators will come to workshops prepared and well versed on the material in order to train participants. Facilitators recognize that some institutions may request additional information or for sessions to emphasize a specific area/topic. If this is the case, facilitators should be contacted prior to the workshop to discuss the specific requests of each institution.

It is important for participants to keep in mind that discussing mental health may be uncomfortable for some people. Participants may hold differing views regarding mental health and how to treat it. Therefore, the following guidelines should be explained by facilitators and implemented by all participants throughout the duration of the workshop:

- Recognize different opinions/perceptions of others
- Treat everyone with respect
- Withhold from judgments about yourself and others
- Be willing to learn new information
- Maintain confidentiality (if necessary)

Prior to the workshop, athletic departments should share these guidelines with those who are planning to attend the workshop. Have a discussion about why the department has decided to complete the workshop and what can be expected. Allow time for questions and clarification

about the workshop and encourage those who plan to participate to share additional suggestions/ideas about how to create a safe learning environment.

Length of Sessions

This program was designed to be completed over the course of seven weeks, with one 60-minute session per week. However, this is simply a suggestion and may be extended or shortened based on the wants/needs of participants. It is expected that some topics may take longer than others and vice versa. There is allotted time at the end of each session for participants to ask questions and engage in meaningful dialogue, related to the content that was discussed. Due to the structure of this program, it is essential for participants to follow the suggested format of the program. This ensures that participants are educated and knowledgeable about mental health within college sports before attempting to intervene with student-athletes. Applied skills will be taught and practiced throughout the program, to ensure participants have learned the necessary skills and resources to assist student-athletes.

As previously mentioned, session lengths may be adjusted as necessary. While the program is structured to be completed within eight weeks, participants may request additional sessions following the eight-week program, based on their needs. This is encouraged as needed, to ensure all participants understand and feel comfortable with the materials.

Session Structure

Each session will open with an agenda, along with an overview of the purpose and objective of the session. Facilitators will come prepared with their own materials and supplies to run the sessions (e.g., role play scenarios, interventions, and activities). Should any extra equipment be needed, arrangements will be made prior to beginning to program. For easy follow, a layout of each session is provided.

Final Thoughts

At the end of each session, the facilitator will provide a brief summary of what was covered. This allotted time allows participants to ask any additional follow-up questions, time for self-reflection, or time to ask for clarification regarding the information presented. This space for discussion is built into each session to ensure that the content was received properly. Facilitators will stay after each session is complete, to ensure that all questions are answered. Additionally, each session will end with at “Most valuable lesson,” which is a brief statement relating to one key aspect of the session.

Session Agendas

Session	Objective	Intervention
1. Mental Health Literacy	Increase knowledge about signs and symptoms of mental illness and understand what a mental disorder is.	Present mental wellness on a continuum with thriving and resilience on one end and severe functional impairment on the other.
2. Perceived stigma about mental health and sport	Reduce stigmatizing beliefs about sport-related consequences and barriers to seeking mental health care.	Differentiate between mental toughness and mental wellness. Demonstrate characteristics of mental toughness allows student-athletes to perform at a high level, grow, and improve while trying to practice and compete through mental illness can have a negative effect on performance and overall wellbeing.
3. Intentional communication	Increase intentions to openly communicate about mental health with student-athletes.	Brainstorm in small groups about how athletic staff members can make it an expectation in their programs to communicate about mental health to student-athletes. Lead by example by making it clear to student-athletes that their approach to mental health is no different than supporting a student-athlete who is suffering a physical injury.
4. Recognizing signs/symptoms of common mental health issues faced by student-athletes	Be knowledgeable about the signs/symptoms of depression, anxiety, substance abuse, and eating disorders.	Small group discussions about signs/symptoms.
5. Reaching out	Understand why reaching out is important, know how to reach out, and knowing what questions to ask.	Practice exercise: active listening and open-ended vs close-ended questions.

6. Referring Student-athletes	Learn a step-by-step guide on how to refer and identify local available resources.	Role play: Sport specific case scenario about referring student-athletes and how athletic staff members can help student-athletes get the mental health services they need.
7. Remaining supportive	Learn how to remain supportive of student-athletes after learning they have sought mental health treatment.	Practice exercise: Attentive silence, body language, voice tone, physical distance, facial expressions, and reflection skills.

Session 1: Mental Health Literacy

The facilitator will begin session one of the program by introducing mental health, mental health literacy, and general signs and symptoms of mental health disorders. The goal of this session is to help participants learn what are mental disorders, how to recognize them, and how to appropriately discuss them. It is crucial that athletic staff members understand the rationale behind implementing this program and understand the benefits of supporting student-athletes' mental health. To do so, mental health will be presented on a continuum, with thriving and resilience on one end and severe functional impairment on the other end. The session will conclude with final thoughts.

What is a mental health disorder?

The Diagnostic and Statistical Manual of Mental Health Disorders (DSM-5) defines a mental health disorder by taking into consideration the following factors:

- A behavioral or psychological pattern that occurs in an individual
- Reflects an underlying psychobiological dysfunction
- Cause significant clinical distress in daily functioning and other important areas of life (e.g., work, school, etc.)
- Cannot be an expected response to common stressors or losses (e.g., loss of a loved one) or a culturally sanctioned response to an event (e.g., religious rituals)
- A result of social deviance or conflicts with society

Mental health literacy

Mental health literacy is knowledge and beliefs about mental disorders which aid in their recognition, management, or prevention (Jorm et al., 1997). It is important to note that mental health literacy refers to more than just possessing knowledge. Rather, it refers to and expands on

how one uses that knowledge to support the mental health of oneself or others. This includes knowledge about how to prevent mental disorders, recognize when a mental disorder is developing or occurring, help-seeking behaviors and available treatment options, self-help skills to aid with mild issues, and how to intervene during a mental health crisis (Jorm et al., 1997).

Signs/symptoms of mental health disorders

Given the amount of time spent with student-athletes, athletic staff members (e.g., coaches, athletic trainers, team doctors, etc.) are in an ideal position to recognize when student-athletes are having trouble. It is crucial that these individuals be able to recognize signs and symptoms of common mental health disorders, so they can begin to help student-athletes. The following table provides a general overview of common signs and symptoms that are present across the board in most, if not all, mental health disorders (Thompson & Sherman, 2007).

Behavioral Symptoms	Cognitive Symptoms	Psychological Symptoms	Physical Symptoms
<ul style="list-style-type: none"> • Disruption in daily activities • Social withdrawal • Irresponsibility or lying • Legal issues or issues with authority • Decrement in sport or academic performance • Substance use 	<ul style="list-style-type: none"> • Suicidal thoughts • Poor concentration • Confusion/difficulty making decisions • Obsessive thoughts • All or nothing thinking • Negative self-talk 	<ul style="list-style-type: none"> • Feeling out of control • Mood swings • Excessive worry/fear • Irritability • Low self-esteem • Lack of motivation 	<ul style="list-style-type: none"> • Sleep difficulty • Change in appetite/weight • Shaking/trembling • Fatigue/tiredness • Headaches • Overuse injuries

The above figure provides a lot of information for participants to absorb. It is important that participants understand what they are hearing/reading. The following activity will help participants digest and remember the information.

Name That Symptom Activity

Directions: Facilitators will read different scenarios out loud. Participants must decide which category of symptoms (e.g., behavioral, cognitive, psychological, physical) the scenario fits in. Facilitators will pass out white boards and dry erase markers to everyone. After hearing the scenario, participants will write down their answer on the white board and hold it in the air when facilitators instruct them to.

Materials: White boards and dry erase markers

Time: 10 minutes

Scenario 1: Your starting quarterback has not been attending practice. None of his friends or teammates have seen him and he has been in trouble with the law recently. When you ask him where he has been, he states he was at home visiting family. You spoke the local police department and know that is a lie.

Answer: Behavioral Symptoms

Scenario 2: Anna is a women's basketball player. You notice that she is very sluggish and appears very tired during practice. When you ask her what is wrong, she states she has not slept well the past week and has been experiencing headaches.

Answer: Physical Symptoms

Scenario 3: Dan tells his teammates that he does not see the purpose in living life anymore and he often thinks about what it would be like if he were not here.

Answer: Cognitive Symptoms

Scenario 4: Lisa has been on edge all week. She yells at her teammates over minor mistakes and then the next minute she is happy. She states over and over that she is worried something bad is going to happen to her.

Answer: Psychological Symptoms**Debrief Questions:**

1. Was it difficult to differentiate between types of symptoms? Why or why not?
2. What is one thing you learned from this activity?

Knowledge test

Many individuals do not know basic facts about mental health. There are many misconceptions in society about what mental health is, who experiences it, and how it develops. Participants will benefit from learning about these topics and use that information to help student-athletes. The purpose of the following activity is to get an idea about what participants know about mental health.

Fact or Fiction? Activity (modified from Centre of Addition and Mental Health et al., 2001)

Directions: This activity is designed to test participants' knowledge about mental health.

Facilitators will read each statement, one by one, asking participants to answer true or false.

Facilitators will provide the correct answer and a rationale after each question.

Time: 15 minutes

1. A person who has one or two parents with mental illness is more likely to develop mental illness.

True. Mental illness can be hereditary.

2. Mental illness is contagious.

False. Mental illness is not contagious. Heredity can, and often does, play a factor in the development of the disease.

3. Mental illness tends to begin during adolescence.

True. The first episode of a mental illness often occurs between the ages of 15 and 30 years.

4. Drug use causes mental illness.

True and False. Alcohol and other drugs sometimes play a role in the development of some symptoms and disorders, but do not usually cause the illness. However, long-term drug and alcohol use can lead to the development of drug-induced psychosis, which has many of the same symptoms of organic mental illness. Alcohol and drugs are often used as a means to cope with the illness, although using alcohol and drugs can make the symptoms of mental illness worse.

5. Mental illness can be cured with willpower.

False. Mental illness is associated with chemical imbalances in the brain and requires a comprehensive treatment plan.

6. People with mental illness never get better

False. With the right kind of help, many people with a mental illness do recover and go on to lead healthy, productive and satisfying lives.

7. People with mental illness tend to be violent.

False. People who experience a mental illness acutely sometimes behave very differently from people who do not. While some of their behaviors may seem bizarre, people with mental illness are not more violent than the rest of the population.

8. People who are poor are more likely to have mental illness than people who are not.

False. Income is not a factor in overall rates of mental health problems

9. Developmental disabilities are a form of mental illness.

False. Mental illness is often confused with developmental disabilities, even though the two conditions are quite different

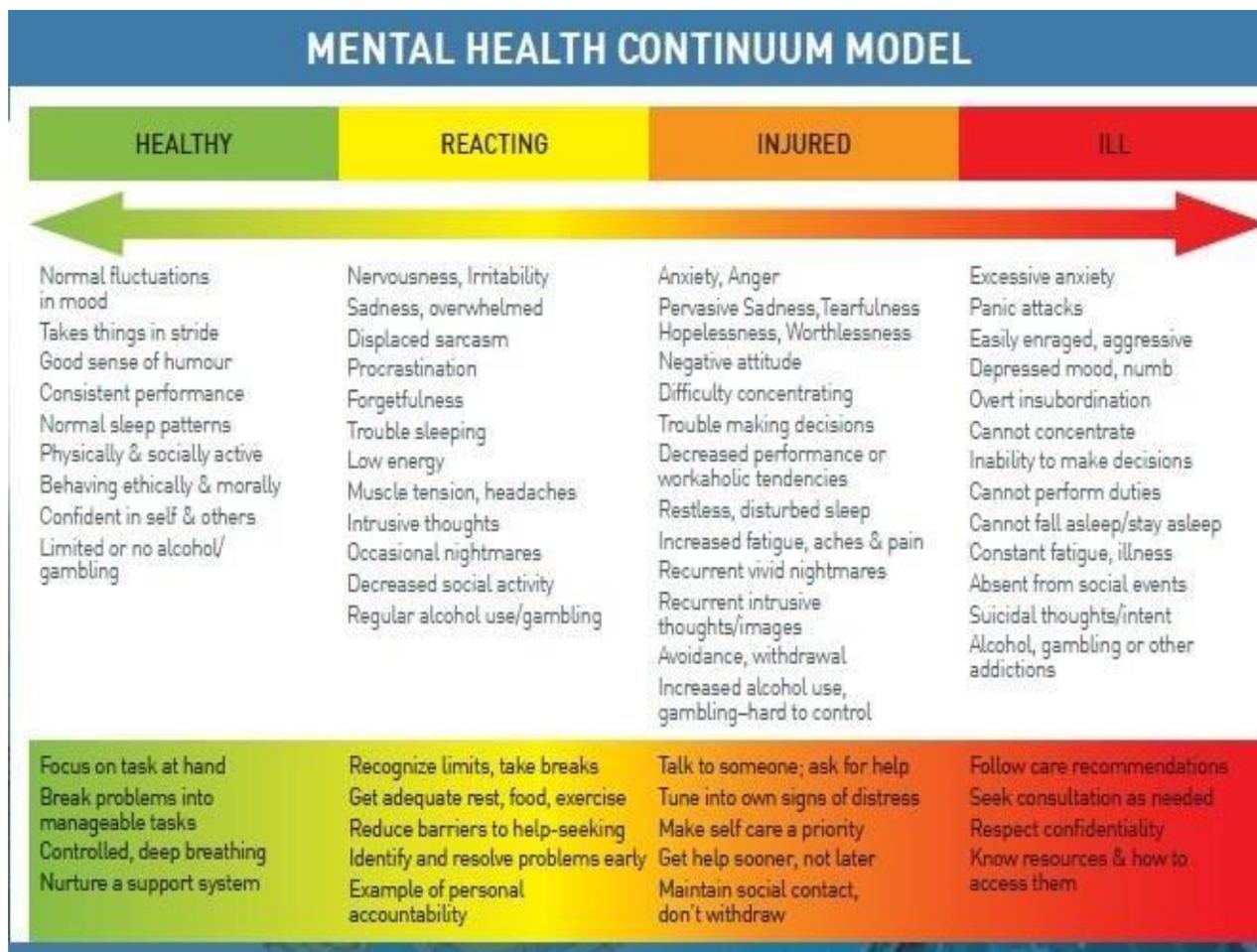
10. Poor parenting causes schizophrenia.

False. Childhood abuse or neglect does not cause mental illnesses such as schizophrenia. However, stressful or abusive environments may seriously impair a person's ability to cope with and later manage the illness.

Mental health on a continuum

Keyes (2002) suggests that good mental health is more than the absence of mental health disorders. Rather, good mental health includes overall wellbeing, how one feels about themselves, and one's ability to manage feelings and overcome difficulties (Keyes, 2002). To conceptualize this, think about mental health existing on a continuum. On one end is thriving and resilience and on the other end is severe functional impairment. When an individual is thriving, they can complete everyday tasks with little to no difficulty. They take things in stride, demonstrate consistent performance, and are socially active (NCAA, 2016). When an individual is experiencing severe functional impairment, they may report excessive stress or anxiety, be unable to concentrate, have an inability to sleep or eat, and cannot perform everyday duties. It is not uncommon for people to fluctuate between each side, with periodic distress and functional impairment in the middle (NCAA, 2016). It is normal for people to experience periodic distress occasionally, reporting temporary stress and worry. These feelings can be managed and eliminated with proper self-care and social support. However, if feelings of worry and stress begin to persist over long periods of time, it can lead to functional impairment (NCAA, 2016). Student-athletes who identify with the right side of the continuum for long periods of time should seek professional consultation. To support student-athletes' mental health and overall wellbeing, it is important for athletic staff members to know about this continuum. Once athletic staff members can understand a mental health disorder and recognize the signs and symptoms associated with them, then they can begin to help student-athletes. The figure below, adapted

from Keyes (2002), provides a visual for participants and shows common behaviors associated with each section of the continuum.



Mental Health Continuum Activity (modified from ReachOut Australia, 2020)

Directions: Ask participants to refer back to the Mental Health Continuum and ask them to think about where they fit at this minute. Rather than asking them to share aloud, ask participants to jot down their thoughts. Now ask them to think about where they would have fit last week and then last year. Discuss whether their position changed. It is important to ensure participants understand that our mental health and wellbeing fluctuates constantly.

- Ask them to think now about the influence the following situations may have on their mental wellness:
- What if...
 - They lost a close friend
 - Their pet died
 - They got a great exam result
 - A family member had financial concerns
 - They were worried about a friend feeling depressed
- Ask them to think about what some of the factors are that may cause a person to move up or down the continuum.
- Discuss the sorts of strategies that student-athletes may use to cope with one of these situations.
- Ask participants to think of who student-athletes may be able to turn to if one of these situations happened to them - Do they have a support network? Do they know where they can go for help?

Final thoughts

The first session can be overwhelming for anyone attending. Participants are presented with a lot of information and being challenged to remain open-minded about a sensitive topic. As previously mentioned, this may be the first time some participants are hearing/learning about this information. Facilitators will remind everyone not to judge anyone's feeling or thoughts, including their own and encourage open dialogue with participants.

The conclusion is great time to do a final check for understanding. A quick review about why this information is relevant and beneficial for athletic departments, student-athletes, and

staff members will be provided. During this time, participants are encouraged to ask questions and clarify any uncertainty about the information provided. The session will conclude with a brief statement about the next week's session.

Most valuable lesson: Openness, commitment, and practice are vital for the most success in this program.

Session 2: Perceived Stigma about Mental Health and Sport

This session builds off the information discussed in session one by providing psychoeducation about the stigma surrounding mental health and sport. The goal of this session is to help participants recognize stigmatized beliefs about sport-related consequences of seeking mental health care. This can include embarrassment, privacy, and confidentiality concerns student-athletes hold about seeking treatment, along with the many stereotypes about mental health that exist. Student-athletes may fear that being diagnosed may mean they will never recover, or that they will be treated unfairly by others (e.g., coaches, teammates, peers, parents, etc.). Additionally, mental toughness and mental wellness will be defined and explained to help participants understand the difference and recognize when a student-athlete might be struggling.

Perceived stigma about mental health and help-seeking behaviors in sport

It is no secret that stigma surrounds mental health. Stigma is the disgrace associated with a circumstance, quality, or person (). Think for a moment, how student-athletes are treated when they suffer a physical injury. There is a team of medical doctors and athletic trainers standing by to ensure a safe and quick recovery. Now, think about a student-athlete who is experiencing a mental health issue and imagine what treatment for that looks like. Treatment doesn't look the same does it? Did stereotypes or labels come to mind, along with concerns about embarrassment, privacy, or confidentiality? It has been documented throughout the literature that stigma is a major barrier to help-seeking in student-athletes (Gulliver, Griffiths, & Christensen, 2010). Not only do student-athletes have their own concerns and beliefs about mental health, those around them also have a large impact on their perception of mental health and whether they seek treatment. For example, a student-athlete may be experiencing mental health issues but fears that others (e.g., teammates, coaches, athletic staff members) may see their help-seeking behavior in

a manner that threatens or weakens their position on their team or tarnishes their relationship with that individual. As a result, treatment is not sought, and the student-athlete continues to struggle and their performance declines. Before continuing, let us take a few minutes to complete an activity, to get participants thinking about other reasons student-athletes may not seek treatment.

Brainstorm activity

The purpose of this activity is for participants identify why student-athletes may be reluctant to seek treatment for mental health issues. Participants will break into small groups and be given ten minutes to brainstorm as many reasons they can think of. When time is up, each group will be asked to share their ideas and engage a group discussion led by the facilitator. The facilitator will use the list below to add to the discussion.

List of reasons why student-athletes may not seek treatment

- Fear of losing status on the team
- Being perceived as weak
- Feeling unsure about where to seek help from
- Negative attitude towards seeking help
- Cultural factors
- Embarrassment, privacy, or confidentiality concerns
- Lack of accessibility (transportation, money, time, etc.)
- Not wanting to accept they are experiencing a mental health issue
- Wanting a “quick fix” or the notion they can fix it themselves

If coaches criticize student-athletes who share they are experiencing mental health issues, student-athletes can feel ashamed that they cannot deal with life events on their own. It is not

uncommon for people to assume that student-athletes are “healthy” at all times, given their status as an elite athlete. However, that is not always the case. Below is a list of common assumptions and misconceptions regarding the health and well-being of student-athletes.

Misconceptions about student-athletes

- They are always healthy because they are athletes
- They do not get burnt out
- They have a built-in support system because they are part of a team
- They can talk to their coach or teammates about life
- They rarely experience mental health issues

What does stigma feel like? Activity (modified from Time to Change, 2020)

Stigma can be a major barrier, preventing those experiencing a mental health issues from seeking help. The following activity is designed to help participants learn what it feels like to experience stigma.

Directions: Ask all participants to stand up. Read out loud, the different scenarios below and ask participants to consider how open they would feel talking about a mental health issue.

Scenario 1: A family wedding

The speeches have just finished, and you are chatting with extended family members (aunts, uncles, cousins, grandparents) that you have not seen for a while. The conversation moves to your current health and one of your family members asks how you have been?

- Remain standing if you if you are able to open up about your mental health issue and talk to them about some recent difficulties you have experienced.
- Sit down if you decide to brush it off and say I’m fine.

Scenario 2: A new job

It is your dream job and you just learned that you have been shortlisted for an interview. You are very excited. During the interview, the discussion moves to the gap in your CV where you had to take time off, due to mental health issues.

- Remain standing if you feel you are able to open up and discuss your mental health with the interviewers and explain the gap in your employment.
- Sit down if you decide to make up another reason.

Scenario 3: A first date

The night is going well, you just finished the appetizers and you are waiting for the entrees to be served. You have decided that you really enjoy your date's company and that you would like to see them again. The conversation moves to mental health and you bring up a television program regarding mental health that you have been watching.

- Remain standing if you are able to open up and discuss your connection to the show and how your experience with mental health relates.
- Sit down if you say nothing at all.

How many participants are left standing?

Discussion questions:

- What did each scenario make you think about?
- Why are some things harder to discuss/disclose than others?
- What do you think would happen if you talk about your mental health?

Brain teaser

Facilitators will give participants five minutes to write down on a sheet of paper, what the definition of mental toughness and mental wellness are. When time is up, facilitators will ask for volunteers to share their answers. This dialogue will lead into the following sections.

Mental toughness vs mental wellness

It is important for athletic staff members to understand the difference between mental toughness and mental wellness. Mental toughness refers to one's ability to manage and overcome difficult situations that may prevent one from succeeding (Thompson & Sherman, 2007).

Individuals who possess mental toughness can overcome doubts and worries on their own. These individuals remain focused, productive, and flexible, during good times and bad. Their resilience makes them less fearful of new experiences or uncertainty. While these characteristics can help student-athletes problem-solve on their own, they can also inhibit student-athletes from seeking help (Carr & Davidson, 2014). The notion that student-athletes must always remain tough, can lead them to believe they must deal with mental health issues on their own, or lead to avoiding them all together. This is especially concerning when the perceived negative consequence of discussing mental health includes being rejected by coaches or teammates (Carr & Davidson, 2014). Therefore, it is important that athletic staff members recognize that being mentally tough does not mean that mental health issues do not exist, and stigma still affects an individual's willingness to disclose such challenges (Carr & Davidson, 2014). The following activity will help participants understand the power of resilience.

Resilience Exercise (modified from Maddi and Khosaba, 2005)

Directions: Answer each of the following questions. Ask participants to share and discuss.

1. Think about a time you had a negative emotional reaction to change (e.g., a co-worker being promoted over you)
2. Identify an example of where you were resilient in the face of change (e.g., filling in for a co-worker who was on sick leave for six weeks)
3. Think about why you may have reacted differently in each case

Mental wellness refers to a positive state of mind and mental health (Thompson & Sherman, 2007). It includes more than the absence of mental disorders and implies that one is functioning in an overall healthy manner. Individuals who maintain mental wellness often get adequate sleep, eat healthy diets, and connect with others. These individuals are physically active and have the necessary tools to manage stress appropriately. Mental wellness requires one to continuously change and grow, problem-solve, and think critically to reach their full potential. Below is an activity to help participants understand the dimensions of mental wellness.

Mental Wellness Activity (modified from Insel and Roth, 2012)

Directions: Fill in your strengths for each dimension of wellness. Examples are included with each dimension.

Physical wellness: To maintain overall physical health and engage in appropriate physical activity (e.g., stamina, strength, flexibility, body composition).

Emotional wellness: To have positive self-concept, manage your feelings appropriately, and develop positive qualities (e.g., trust, self-confidence, determination, optimism).

Social wellness: To develop and maintain meaningful relationships with family and friends and to contribute to the community (e.g., supportive, good-listener, friendly).

Intellectual wellness: To pursue and retain knowledge, think critically about issues, make sound decision, identify problems, and find solutions (e.g., common sense, creativity, curiosity).

Spiritual wellness: To develop a set of beliefs, principles, or values that give meaning or purpose to your life; develop faith outside yourself (e.g., religious faith, service to others).

Reflection Questions:

- Where there any dimensions that were difficult to fill in? Why?
- How can stigma affect overall well-being?
- What can you take away from this activity?

Although it is important for athletic staff members to distinguish between mental toughness and mental wellness, it is even more important that athletic staff members emphasize overall well-being. Possessing mental toughness can help student-athletes perform at a high level but trying to compete through mental health illness can have a negative impact on all areas of life. Understanding the effect that stigma plays in addressing mental health, can help athletic staff members promote mental wellness.

Learning the facts (modified from California Mental Health Services Authority, 2020)

Now that participants have learned about mental health and stigma, it is time to see what they have learned. Facilitators will divide participants into groups of 3-4 and pass out whiteboards and dry erase markers. The facilitator will read a series of questions and teams will write their answers on the whiteboard. The team who answers the most questions correctly wins. This activity will take approximately 10 minutes to complete. Below are the list of questions and their answers that the facilitator will ask.

Fact-check Questions

1. Being healthy includes:
 - a. Having a body that feels and works well
 - b. Having a healthy mind and body
 - c. Not being sick
 - d. All of the above**
 - The emphasis is on physical and mental health both being important to overall health. Being healthy includes more than just physical and wellness is more than the absence of illness.

2. If an individual who is experiencing mental health issue experiences “stigma” what does that mean?
 - Overall, the idea is for participants to understand that stigma is a negative label or stereotype associated with mental health issues and help-seeking.
3. Student-athletes rarely experience mental health issues
 - a. True
 - b. False**
 - Student-athletes are just as likely as anyone else to experience a mental health issue.
4. Name one reason it is important for athletic staff members to recognize stigmatized beliefs surrounding mental health and help-seeking.
 - The goal is for participants to understand how they can apply the information learned in this session. Any answers related to that will be accepted.
5. Experiencing a mental health issue can affect the way a student-athlete:
 - a. Behaves
 - b. Thinks
 - c. Feels
 - d. All of the above**
6. What leads to stigmatized beliefs about mental health in sport?
 - The notion that student-athletes are overall healthy individuals leads many to believe that they are immune to experiencing mental health issues. Other misconceptions such as student-athletes do not get burnt out and believing that

student-athlete have a built-in support network can also lead to stigmatized beliefs.

Final thoughts

The information presented in this session sheds light on the stigma associated with addressing mental health in sport. This is a great time for participants to ask questions and clarify information. Dialogue is encouraged, as the point of this session is to help participants identify stigmatized beliefs that may prevent student-athletes from seeking help.

Most valuable lesson: Do not feed into the stigma that surrounds mental health. Be the reason someone seeks help.

Session 3: Intentional Communication

This session builds on the information learned in session two. In session two, participants were provided with basic knowledge regarding stigma and why student-athletes may not want to talk about mental health. The purpose of this session is for participants to learn how to talk with student-athletes about mental health. This session provides communication strategies that will help participants initiate conversations about mental health.

Talking about mental health

Mental health is a crucial part of overall well-being. Nobody is immune to experiencing mental health issues – student-athletes included. Yet, mental health often is disregarded or a hushed topic of conversation (Thompson & Sherman, 2007). Coaches and athletic staff members can take the initiative to start conversations with student-athletes about mental health. Learning how to communicate effectively about mental health can help build rapport, trust, and create a sense of togetherness. Athletic staff members are not expected to treat mental health issues. However, their relationship with student-athletes puts them in an ideal position to recognize when something is off and start a conversation. Having conversations about mental health will help athletic staff members to plan for the unexpected; to know what to do if a student-athlete is experiencing a mental health issue. The following guide provides strategies to help athletic staff members start a conversation about mental health.

Talking About Mental Health: A Guide for Athletic Staff Members

Coaches and athletic staff members can take initiative to discuss mental health with student-athletes. It is important that student-athletes know that athletic staff members will treat a mental health issue no different than they would treat an injury. This guide modified from Le Moyne Wellness Center for Health and Counseling (2020) breaks down a variety of strategies that athletic staff members can implement to support student-athlete mental health.

1. Reach out to student-athletes. Have regularly scheduled check-in meetings with individual student-athletes, even those who are not experiencing mental health issues. It is not uncommon for student-athletes to feel ashamed or embarrassed to reach out due to fear of punishment or judgment. Set aside time to meet and ensure privacy. It will be more beneficial if neither party is preoccupied or must rush off. Say things like:
 - You are involved in a lot this semester. I am wondering how you are handling that.
 - I noticed you are taking a heavy course load this semester. Tell me about how your classes are going.
 - Tell me something you did to take time for yourself this week.
 - How can I help?
2. Express sincere concern in non-judgmental ways. Say things like:
 - I have noticed you have been a little sluggish during practice. Is everything ok?
 - I had not considered your situation that way before. How can I help?
 - I have experienced similar situations. Please know that you are not alone.
 - Everyone has bad days and that is okay. Help me understand what is going on.

3. Actively listen to student-athletes in an open and non-threatening way. Be aware of your body language. Try not cross your arms or legs and try not slouch. Let them share as much or as little as they want by letting them lead the discussion. It may be tough for student-athletes to express what is going on, especially if something happened recently or they have never experienced a mental health issue before. Examples of active listening responses include:

- **Building trust and establishing rapport:** Develop a strong connection and sense of understanding by identifying common ground (e.g., similar experiences, views, humor). Example: Tell me what I can do to help. I was very impressed by how you handled this situation.
- **Demonstrate concern:** I noticed you are going through something tough and I am here to listen.
- **Paraphrase:** So, you are saying that the uncertainty about whether you will pass your classes this semester is creating stress for you.
- **Brief verbal affirmations:** I understand, I see, thank you, I can relate.
- **Nonverbal cues:** Show understanding without speaking. Maintain appropriate eye contact, nod, and lean forward.

4. Be empathetic to student-athletes. Try to understand their point of view as best as possible. Be empathic by saying:

- I am sorry that this is happening.
- This must be really hard for you.
- Thank you for trusting me enough to share this with me. I really appreciate it.
- What I am hearing is that you are feeling said. Is that accurate?

- You are brave and I am proud of you.
 - I am happy to listen anytime.
5. Normalize the situation.
- Talk about mental health and the benefits of addressing it.
 - Compare good mental health with good physical health - going to see a therapist is not different than going to see your primary care physician.
 - Discuss expectations of regularly scheduled check-in meetings.
6. Avoid judging, evaluating, and criticizing the student-athlete. Doing so will make them less likely to seek help. This is extremely important for coaches and athletic staff members. It can be easy to brush off mental health issues as “not problematic,” but remember that college athletes do not live in a bubble; they have multiple facets (e.g., classes, family dynamics, social support, finances, personal characteristics, etc.) that affect their performance and social life.
7. Be supportive. Giving the student-athlete hope that things can get better, de-escalate the situation. Offer support by saying things like:
- You are not alone.
 - What do you need from me when you are feeling stressed out or upset?
 - Be comfortable with silence or not talking. Sometimes people just want to be heard or vent. That is okay.

Be knowledgeable about resources and suggest seeking support from family, friends, and professional services. **REMEMBER**, athletic staff members are **NOT** mental health professionals. They should focus on being supportive and refer to the appropriate individuals. Below are suggestions to offer support:

- A family member or friend they feel comfortable talking with or that can be called.
- Tell me your thoughts/feelings about talking with a therapist.
- If there is a counseling center on campus, provide information about location, hours, and services. Offer to make the appointment together in your office and accompany them if they want.

Tell them their options. Ultimately, it is their decision and athletic staff members should encourage autonomy by letting them know they have a choice.

Knowing what to say

In addition to knowing how to talk with student-athletes, it is important that athletic staff members have an idea about what to say. Mental health can be difficult to discuss for some, but the more prepared athletic staff members are, the more capable they will be of starting and maintaining conversations. The tips below provide examples of what helps and hurts the conversation.

What Helps	What Hurts
I know you have a real illness and that is what causes these thoughts and feelings.	It is all in your head.
Although I may not understand exactly what you are going through, I care about you and want to help.	It could be worse. Just deal with it.
You may not believe it now but the way you are feeling will change.	Just think happier thoughts.
You are not alone. I am here for you.	You will be fine. You need to stop worrying.

Tell me what I can do to help you now.	How do you expect me to help you? I cannot do anything about your situation.
Talk to me. I am here to listen.	You need to take my advice if you want to get over this.
You are important to me. Your life is important to me.	You have so much to be grateful for. You are just doing this for attention.

Case scenarios

Ask participants to consider the following scenarios adapted from California Mental Health Services Authority (2020) and write down how they would respond using the information in the figure above.

Scenario 1: You just found out that a student-athlete was diagnosed with a mental disorder.

What do you say?

Scenario 2: Imagine that you are a first-year student-athlete living with anxiety. You feel very shy and it is difficult for you to meet new people and make friends. How could someone respond in a way that suggested acceptance of you and helped you feel more connected with your team?

Discussion:

- Was it difficult to know what to say? Why or why not?
- How comfortable would you be starting a conversation with a student-athlete?

Practice exercise

Now that participants have learned how to talk about mental health with student-athletes, it is time to apply the strategies learned to real-life scenarios. Participants will break into groups of 3-5 and get one case study. Groups will read their case study amongst themselves and discuss how they would handle each situation, using information learned in this session. Once groups

have completed these tasks in their small groups, one member from each group will share their group's plan with everyone. Each group should answer the following questions:

1. Identify signals that the individual is struggling and explain what the overall issue may be.
2. What can you do to address the situation?
3. Review the strategies discussed in this session. Which ones could you apply? Name at least 3.

The case of Lisa

Lisa is an 18-year-old women's basketball player at a Division I public institution. She is a first-generation student from a rural area with a 2.7 GPA at the end of her first semester. Lisa's parents put a lot of pressure on her to make it to the WNBA to help support their family. Lisa started the season off strong, getting a decent amount of playing time. More recently during practice, you notice that Lisa is short tempered and unable to complete basic skills that she has been completing all season. Lisa yells at her teammates for her mistakes and even gets mouthy with you.

The case of Joanna

Joanna is a golfer, competing in her final season as a collegiate athlete. Joanna has been one of the best golfers on the team since her first year. She has set school records and often is featured in the local newspaper for her accomplishments. Halfway through the season, Joanna's performance starts to decline. She cannot make it through a practice without crying and has lost all ability to focus on the game.

The case of Trey

Trey is an offensive lineman in his second year at a large public university. Trey purposefully sits in the front row of each of his classes; he does not wear the team sweat suits to class and he makes a point to visit individually with each instructor every semester. He currently has a 4.0 GPA which he is wants to maintain. He received a full scholarship to play football and although he is good, football is not his dream. You notice other teammates making fun of him for caring more about his grades than football. They constantly call him names and single him out. You notice Trey is not as talkative as he once was and keeps to himself. One day, you walk into the lock room and see Trey cleaning out his locker.

Final thoughts

During this session, participants learned how to be more intentional discussing mental health with student-athletes. The goal of this session was to help participants conceptualize that treating a mental health concern is no different than treating an athletic injury. Strategies were provided to demonstrate how athletic departments can take initiative and make mental health a priority at their institution.

Most valuable lesson: Support mental health by making it a priority to discuss it with student-athletes.

Session 4: Recognizing Signs and Symptoms of Common Mental Disorders

The goal of this session is for participants to learn how to recognize the signs and symptoms of common mental health disorders faced by student-athletes. It is important to note that it is not within the scope of this workshop to provide in-depth information about every mental disorder. For detailed information, participants are encouraged to refer to *NCAA Mind, Body, and Sport – Understanding and Supporting Student-Athlete Mental Wellness*. It can be downloaded for free from the following website: <http://www.ncaapublications.com/p-4375-mind-body-and-sport-understanding-and-supporting-student-athlete-mental-wellness.aspx?CategoryID=0&SectionID=0&ManufacturerID=0&DistributorID=0&GenreID=0&VectorID=0&>

Common Mental Disorders

Approximately 41 million people over the age of 18 have experienced a mental disorder in the United States and nearly 9 million people reported experiencing a mental disorder that impaired daily functioning (Davoren & Hwang, 2014). Student-athletes are no exception. Nearly 30% of college students, including student-athletes, completed the American College Health Association survey and reported feeling depressed within the last twelve months and over half reported experiencing anxiety at the same time (Davoren & Hwang, 2014). Given the demands of being a student-athlete, it is no surprise that student-athletes' mental health can be impacted. While it is not in the scope of this workshop to define all mental disorders, this session will introduce common disorders faced by student-athletes. These disorders include depression, anxiety, substance use, and eating disorders. To begin, participants will complete the activity below.

Mental Health Awareness Activity (modified from National Library of Medicine, 2020)

The purpose of this activity is to help participants become aware of common mental disorders faced by student-athletes. In small groups, participants will use smartphones to research a specific mental health disorder, gather reliable information, and present their findings to the whole group.

Directions:

- Split participants into groups of 3
- Give each small group 3 research team role cards – place them facedown (facilitators will do this)
- Ask group members to select one card, look at it, and read the role description
- The card they have selected is their “role” for the rest of the activity
- Provide each group with a disorder card (facilitators will do this)
- Explain role card instructions
- Allow groups 15 minutes to research and organize their findings
- Ask each group to answer discussion questions and share their findings

Research Team Role Cards

Each group will get three cards (see below), that will be placed upside down. Participants will randomly select a card and the card they select becomes their role for the remainder of the activity.

Patient

As the patient, you are responsible for researching the symptoms associated with the mental disorder. Consider how you would feel, think, and act.

Resource Provider

As the resource provider, you are responsible for researching resources on campus or in the community for the mental disorder.

Support System

As a support system for the individual experiencing a mental health issue, you are responsible for researching ways you can support them.

Role Card Instructions:

- Patient:
 - Use your smartphone to research signs/symptoms of the mental disorder your group was assigned
 - Research how one might think, feel, and behave
 - Write down the information you find
- Resource Provider
 - Use your smartphone to research available resources for the mental disorder your group was assigned
 - Include basic information (e.g., location, hours, services provided)
 - Write down the information you find
- Support System
 - Use your smartphone to research ways you can support an individual experiencing the mental disorder your group was assigned

- Locate 3 examples of support
- Write down the information you find

Anxiety

Depression

Eating
Disorders

Substance
Use

Discussion Questions:

- What signs/symptoms might indicate a student-athlete is struggling with your assigned mental disorder?
- What resources are available for a student-athlete experiencing your assigned mental disorder?
- How can athletic staff members support a student-athlete experiencing your assigned mental disorder?

Reflection Questions:

- What was your reaction to the role you drew?
- Would you feel comfortable distinguishing between a student-athlete who feels sad and a student-athlete with depression?
- What are stressors student-athletes can face that can lead to anxiety?

- How might you discuss body composition and weight with student-athletes?
- How would you differentiate between casual substance use and problematic substance use?

Depression. Depression is a critical issue to address with student-athletes because it can impact most areas of an individual's life including physical, psychological, and social well-being (American Psychiatric Association [APA], 2013). Those who experience depression may feel fatigued, demonstrate little interest in activities that were once pleasurable and experience significant changes in weight and appetite. Athletic performance can also decline and be impacted by the above symptoms. Adding cognitive and emotional disruptions such as lack of motivation, poor concentration, and negative self-talk also contribute to mental unwellness (APA, 2013).

Signs and Symptoms	What you can do
<ul style="list-style-type: none"> • Low or sad moods • Irritability or anger • Feeling hopeless, helpless, or worthless • Changes in appetite, weight, or sleep • Decreased energy or fatigue • Isolation or social withdrawal 	<ul style="list-style-type: none"> • Recognize signs/symptoms • Reach out • Listen • Encourage help-seeking behaviors • Help decide if sport participation is in the best interest of the student-athlete • Make a referral and follow up

Anxiety. While it is not uncommon for people to experience anxiety symptoms from time to time, it becomes an issue when symptoms persist. The factors of anxiety vary depending the individual and the circumstance (APA, 2013). If anxiety is not managed properly, it can lead to

poor concentration and cause individuals to become distracted and irritable, making it difficult to complete everyday tasks.

Signs and Symptoms	What you can do
<ul style="list-style-type: none"> • Excessive worry or fear • Disturbance in sleep • Changes in appetite, including an increased need to eat when anxious or difficulty eating due to anxiety • Uneasiness or immobilization • Increased heart rate, perspiration, or blood pressure • Difficulty concentrating • Feeling out of control • Disruption to daily life 	<ul style="list-style-type: none"> • Reach out • Listen • Treat it no differently than a physical injury • Encourage help-seeking behaviors • Understand student-athletes experiencing anxiety will likely welcome assistance • Make a referral and follow up

Eating disorders. Eating and feeding disorders are described as a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food, that significantly impacts physical health, psychosocial functioning, and exercise regimens (APA, 2013). It is important that athletic staff members can recognize the signs and symptoms of an eating disorder before it becomes clinically significant. Student-athletes who are living with a feeding or eating disorder are presumably not functioning in a healthy manner, resulting in poor performance, both on and off the court. It is not uncommon for those with these disorders to be malnourished, dehydrated, anxious, depressed, or obsessed with eating and weight (APA, 2013). Due to these symptoms, student-athletes may not perform with emotion and display poor concentration. Extreme diets can also negatively impact overall well-being. Although a variety of feeding and eating disorders exist, it is out of the scope of this workshop to provide the thorough

discussion needed to identify them all. Therefore, general signs and symptoms of disorders prevalent among college students will be addressed (APA, 2013).

Signs and Symptoms	What you can do
<ul style="list-style-type: none"> • Dehydration • Gastrointestinal problems • Significant weight loss • Muscle cramps, weakness, or fatigue • Excessive exercise • Social withdrawal • Difficulty concentrating • Fear of eating in public • Fear of gaining weight 	<ul style="list-style-type: none"> • De-emphasize weight • Be aware how you communicate about weight and performance • Keep an open dialogue about the importance of nutrition • Recognize the body composition and training required for optimal health and performance are not the same for all athletes • Make a referral • Follow up

Substance use. For the purpose of this workshop, the term “substance” refers to a variety of drugs, supplements, or chemicals, including those that are legal, illegal, sold over the counter, prescribed, or performance enhancing. Performance and overall well-being are bound to be impacted in some fashion if a student-athletes is using substances. It is important to note that each type of substance can have varying effects. For example, alcohol is a depressant that impacts the central nervous system (APA, 2013). It can decrease concentration, coordination, reaction time, endurance, strength, and power. Alcohol can also impede how the body absorb nutrients. If alcohol is consumed, it will negatively affect performance and normal functioning. The extent of the effect will depend on the type of alcohol consumed, body weight, gender, tolerance, and amount consumed (APA, 2013). Stimulants tend to speed up the nervous system and cause individuals to feel more energetic and alert than normal. This can lead to jitters, nervousness, increased heart rate and blood pressure, and poor concentration, which can result in

poor performance (APA, 2013). Marijuana use affects performance similarly to alcohol, diminishing reaction time, eye-hand coordination, and timing. Finally, anabolic steroids are used to increase muscle mass which can lead to an increase in power, strength, and agility (APA, 2013).

Signs and Symptoms	What you can do
<ul style="list-style-type: none"> • Neglecting responsibilities • Avoiding activities that used to be pleasurable • Agitation or irritability • Consumption of substance in larger amounts over longer periods of time • Craving or strong urge to use substance 	<ul style="list-style-type: none"> • Reach out • Let them know you are concerned about them • Do not argue with them • Do not try to convince them they have an issue • Make a referral • Follow up

While participating in sports has several positive effects on student-athletes (e.g., discipline, teamwork skills, decision-making skills) the unique demands of being a student-athlete can lead to mental health issues (Etzel, Watson, Visek, & Maniar, 2006; Harris, 1993). Athletic staff members play an important role in helping to address potential issues before they become clinically significant. The purpose of this session is to provide basic information that aid athletic staff members in their helping roles. Again, while athletic staff members are not expected to make a clinical diagnosis, they can help detect when a student-athlete is struggling. The figure below can be used as a cheat sheet and participants are encouraged to keep a copy on hand.

Common Disorder Quick Guide (modified from Thompson & Sherman, 2007)

<u>Disorders</u>	<u>Signs/symptoms</u>	<u>Impact on performance</u>	<u>Impact on well being</u>
Depression	<ul style="list-style-type: none"> - Low or sad moods - Irritability or anger - Feeling hopeless, helpless, or worthless - Changes in sleep, appetite, or weight - Fatigue - Social withdrawal or isolation 	<ul style="list-style-type: none"> - Decrease in performance - Lack of motivation - Poor concentration - Negative self-talk - Increased risk of injury 	<ul style="list-style-type: none"> - Decreased energy - Unproper nutrition - Inadequate sleep - Unable to get out of bed - Poor hygiene - Isolation
Anxiety	<ul style="list-style-type: none"> - Excessive worry or fear - Sleep disturbance - Changes in appetite - Feeling uneasy or immobilized - Increased heart rate or blood pressure - Feeling out of control 	<ul style="list-style-type: none"> - Poor concentration - Distracted before, during, or after practice/competition - Second guessing performance 	<ul style="list-style-type: none"> - Fatigued - Unproper nutrition - Inadequate sleep - Disruption in daily functioning
Substance Use	<ul style="list-style-type: none"> - Neglecting responsibilities - Avoiding activities that were once pleasurable - Agitation or irritability - Craving or strong urge to use substance 	<ul style="list-style-type: none"> - Difficulty concentrating - Decreased coordination - Slower reaction time - Less endurance, strength, and power - Jitters or nervousness - 	<ul style="list-style-type: none"> - Hinder how the body absorbs nutrients - Disruption to the brain affecting thoughts, behaviors, and feelings

	<ul style="list-style-type: none"> - Consumption of substance in larger amounts over longer periods of time 		<ul style="list-style-type: none"> - Increase in stress and anxiety
Eating Disorders	<ul style="list-style-type: none"> - Dehydration - Excessive exercise - Significant weight loss - Difficulty concentration - Social withdrawal - Fear of gaining weight - Fear of eating in public - Muscle cramps, weakness, or fatigue 	<ul style="list-style-type: none"> - Poor concentration - Decreased stamina and energy - Lack of emotion during practice and competition - Increased risk of injury 	<ul style="list-style-type: none"> - Intensified emotions, behaviors, and feelings - Unproper nutrition - Inadequate sleep - Low self-esteem

Case Studies (modified from American Psychological Association, 2016)

To help participants digest the information provided in this session, participants will work through the following case studies. The goal is for participants to identify the signs/symptoms occurring in each example. Facilitators will read each example and participants will write down their answers on a sheet of paper. Once all participants have something written down, they will be asked to share their answers with the group. Facilitators will conduct a brief discussion after each example.

Case study 1: Simon is a 21-year-old male who reports that his biggest problem is worrying. He worries all the time and about “everything under the sun.” For example, he reports equal worry about his mother who is undergoing treatment for breast cancer and whether he returned his book to the library. He recognizes that his mother is more important than a book and is bothered that both cause him similar levels of worry. Simon is unable to control his worrying. Accompanying this excessive and uncontrollable worry are difficulty failing asleep, impatience with others, difficulty focusing in class and practice, and significant back and muscle tension. Simon has had a lifelong problem with worry, recalling that his mother called him a “worry wart.” His worrying does wax and wane and worsened when his mother was recently diagnosed with breast cancer.

Case study 2: Anna is a 20-year-old Caucasian woman who has struggled with alcohol use for most of her teenage and young adult life. She began drinking in high school, at age 15, and was suspended from the collegiate women’s soccer team partway through her first year because she was missing so many classes and practices due to alcohol use. She has attempted to rejoin the team twice since then but has been unsuccessful each time due to relapses. Anna reports multiple attempts to stop drinking but has only been able to maintain sobriety for 2-4 weeks at a time. Whenever she tries to stop drinking, she gets nauseous, shaky, and disoriented. Her appetite has

decreased, but her alcohol use has continued to increase, and she is currently consuming approximately half a “fifth” of vodka per day.

Case study 3: Emma’s coaches are worried about her after learning about the strict diet she has been following for over a year. They didn’t understand why she was on a diet because she had never been overweight, and it didn’t seem as though she had secured any happiness from her diet. Emma’s coaches noticed that her dieting behaviors made her more withdrawn, depressed and anxious. Every time her coaches expressed their concerns, she burst into tears or shouted at them. She had stopped attending team dinners and spent most of her free time in her dorm room. She was still going to class and doing extremely well in her exams, but her friends and teammates are worried about her.

Debrief Questions:

- How comfortable are you in supporting student-athlete mental health?
- Was it difficult to identify signs/symptoms?
- What are some examples of how you might approach a student-athlete who is struggling?

Final thoughts

This session addressed signs and symptoms of common mental health disorders faced by student-athletes. Given the relationship between athletic staff members and student-athletes, it is important that participants can recognize signs and symptoms of these disorders

Most valuable lesson: Having the knowledge to intervene supports mental wellness and can save lives.

Session 5: Reaching Out

This session focuses on how participants can reach out to student-athletes who are experiencing mental health concerns. Participants will learn why it is important to reach out, the necessary skills needed to reach out, and practice implementing the skills learned in small groups. Skillsets that will be covered include active listening, open-ended vs close-ended questions, and invitational skills.

Importance of reaching out

It has been stated throughout this workshop just how important it is for athletic staff members to reach out to student-athletes regarding mental health. The amount of time spent together, and the trust gained between players and athletic staff, put athletic staff members in a perfect position to encourage and support student-athletes' mental health (NCAA, 2016). If athletic staff members can recognize signs and symptoms early on, they can help limit the effect a mental disorder can have on an athlete. Student-athletes can be at risk of experiencing mental health issues for a variety of reasons. Some of these reasons include age, significant transitions (e.g., attending college, leaving home for the first time, etc.), and some mental disorders can be triggered or intensified by pressure (NCAA, 2016). Having the ability identify when an individual is struggling, along with the appropriate skillsets, allows athletic staff members to be proactive in supporting mental wellness.

Skillsets

There are several skillsets that can be utilized when reaching out to student-athletes. These include *invitational skills*, *active listening skills* and *questioning skills* (Young, 2017).

Invitational skills. These are referred to as basic means by which a person (i.e., athletic staff members) invites a student-athlete into a mutual relationship, and where bonds and trust begin to

form (Young, 2017). These skills allow people to open up without feeling pressure to do so. Examples include eye contact, body posture, and tone of voice. Eye contact is the first and often most important indicator of inviting someone to have a conversation. It lets an individual know that the listener is involved in what they are saying. Athletic staff members should make direct eye contact with a student-athlete but take occasional breaks to ensure the student-athlete is comfortable (Young, 2017).

It is also important for athletic staff members to be aware of their body language when speaking with student-athletes. It is no secret that actions can speak louder than words. Athletic staff members should demonstrate a posture that is relaxed, alert, and involved. Sprawling out or lounging may indicate that the listener is not interested in what is being said (Young, 2017). Athletic staff members must also be cognizant of their tone of voice. It is crucial that athletic staff members display empathy and calm concern through their voices. Doing so can help stabilize the situation, if a student-athlete is distressed or in crisis (Young, 2017). Below is an activity for participants demonstrating how important body language can be.

Wordless Acting (modified from Fleming, 2018)

This activity will show participants how much we “speak” with our body language and facial expressions.

Instructions:

1. Separate your group into pairs.
2. Assign one participant in each pair to be Partner A and the other to be Partner B.
3. Give each participant a copy of the script (copied below).
4. Instruct Participant A to read his or her lines out loud but instruct Participant B to communicate his or her lines in a nonverbal way.

5. Provide Participant B with a secret emotional distraction written on a piece of paper (e.g., Participant B is in a rush, is really bored, or is feeling guilty).
6. Have each pair work through the script.
7. After each pair has finished working through the script, have the “A” participants guess what emotion their partner was feeling.

This is the script you will give each participant:

A: Have you seen my book? I can't remember where I put it.

B: Which one?

A: The murder mystery. The one you borrowed.

B: Is this it?

A: No. It's the one you borrowed.

B: I did not!

A: Maybe it's under the chair. Can you look?

B: Okay—just give me a minute.

A: How long are you going to be?

B: Geez, why so impatient? I hate when you get bossy.

A: Forget it. I'll find it myself.

B: Wait—I found it!

Reflection:

After the activity, guide a discussion on how much information we can pick up from nonverbal communication and how important it is to regulate our bodies and our facial expressions when communicating, even if we're also using verbal communication.

Active listening skills. *Active listening* is the ability to focus completely on what is being said, rather than just passively hearing (Young, 2017). It involves being seen listening, by utilizing non-verbal signs, such as nodding, smiling, and giving minimal encouragers (e.g., mhm, sure, I see). Doing these things will help the speaker to feel more comfortable and hopefully speak more open and honestly (Young, 2017). *Active listening* also means refraining from making any judgements, staying neutral, and being patient. It also includes providing verbal feedback such as asking for clarification, summarizing key points, and reflecting what has been said to demonstrate comprehension. While these skills may sound basic, they take time and practice to master. To practice active listening, participants will complete the following exercise.

Stop Listening Exercise (modified from Norman, 2018)

This exercise, will show participants the emotional consequences of not listening and— hopefully—encourage them to practice better listening skills.

Directions:

- Split participants into two smaller groups of equal size and take one group outside the room.
- Tell them that they are instructed to stop listening to their partner after about 30 seconds, and to be open in showing their disinterest.
- Tell the other group to think of something that they are passionate about and be prepared to tell their soon-to-be partner a meaningful or personally relevant story about this topic.
- Bring the other group back in, put all the participants into pairs, and tell them to get started.
- Observe the behavior from the listeners and the reactions from the speakers until you're sure each speaker has picked up on what's happening.

- Stop the conversations at this point and explain the instructions that were given to each group.

Reflection:

- Facilitate a group discussion on the importance of listening, how to use active listening, and what indicates that someone is truly listening.

Questioning skills. Knowing what questions to ask and how to appropriately ask them is a beneficial tool when discussing mental health. *Close-ended questions* seek specific information and often are answered with a “yes” or “no.” This type of question is important when facts need to be sorted out, especially in a crisis (Young, 2017). *Open-ended* questions are the opposite and allow more freedom of expression. For easy understanding, think about the comparison between multiple-choice and essay questions. Multiple-choice questions check one’s knowledge of the facts. Essay questions require one to demonstrate a deeper level of understanding (Young, 2017).

Examples of open-ended questions include:

“Could you tell me more about the problems you have been having?”

“What makes you think it is time to make a change in your life?”

“You say you have been experiencing anger issues. What do you mean by that?”

Examples of close-ended questions include:

“How old are you?”

“Do you like college?”

“Are you planning to hurt yourself?”

It is important to note that these are only two basic skills when it comes to asking questions. Yet, given the role of athletic staff members, knowing how to ask both types of

questions can make a huge difference. Complete the following exercise to practice using open versus closed questions.

Open versus Closed-ended Question (modified by Young, 2017, p. 82)

Each member should individually turn the following closed questions into open questions. Write your answers on a sheet of paper. Remember, an open question can expand a topic beyond the original closed question. For example, the closed question, “Are your parents still married?” can be “opened” by changing it to “Can you tell me something about your family?” Share your open questions with others and consider how you might answer your own open questions. Do they give you room to expand and disclose?

- Where are you from?
- What is your problem?
- Why do you need help?
- When did all of your problems begin?
- Do your mom and dad fight?
- Did you have fun on the class trip?
- How old is your daughter?

Tying it all together

For this exercise, modified by Young (2017), participants will break into groups of 3. One person is the helper (i.e., athletic staff member), one person is the student-athlete, and one person is the observer. The individual playing the student-athlete will act out a scenario and helpers will respond using the skills learned in this session. Observers will write down what they see, using a checklist on invitational skills, active listening skills, and open and close-ended questions. Participants will play each role and there will be time to debrief at the end.

Scenario 1: A student-athlete is stressing out over life and is over-eating to deal with all of the stress. They report to you that their friend says things like “You are so grossing me out, aren't you worried you will get fat!”

Scenario 2: You notice that a student-athlete has anxiety so bad that she throws up or gets sick to her stomach for no particular reason during practice. You hear a teammate say “You are such a drama queen, everyone knows you are totally faking it.”

Scenario 3: A student-athlete has been sad and depressed the last week for no apparent reason. You overhear another person on the team say to them “You are being too much of a downer. I don't think I can hang out with you anymore.”

Scenario 4: You notice a student-athlete has been overly happy the last four days and exhibiting some atypical behavior during practice.

Scenario 5: During a meeting, a student-athlete discloses they been having a tough time sitting in class and paying attention.

Debrief questions

- What went well during this exercise?
- What was difficult?
- What would you do differently?
- Which role did you like the most and the least? Explain.

Checklist (modified from Young, 2017, p. 81)

1. What does the body position of the helper look like? Check all that apply
 - Openness
 - Stiffness
 - Relaxation
 - Interest
 - Tension
 - Aloofness
2. Evaluate the helper's ability to maintain appropriate eye contact. Check one.
 - Avoids
 - Occasional
 - Consistent with break
 - Stares
3. Evaluate the helper's tone of voice. Check all that apply.
 - Too loud
 - Too soft
 - Confident
 - Hesitant
 - Warm
 - Cold
 - Soothing
 - Interested
 - Bored
4. Did the helper use open or close-ended questions? Give examples.

Other comments:

Final thoughts

It can feel awkward and overwhelming as the helper (i.e., athletic staff member) to be identified as the person being asked to reach out to student-athletes experiencing mental health issues. Therefore, it is important that participants use this time to reflect on their experiences as the helper, student-athlete, and observer. Helpful feedback from each group member is encouraged and participants are reminded that it can be uncomfortable for some to initiate a conversation about mental health. It is the hope of the facilitators that by this point in the workshop, most will feel competent with the information and skills they have learned. As always, participants are encouraged to ask questions and gain clarity on the information and skills learned in this session.

Most valuable lesson: Communication is key. Take time to practice these skills to make a difference in someone's life.

Session 6: Referring Student-athletes

The purpose of this session is for athletic staff members to learn how and when to refer student-athletes. Having this information ensures athletic staff members are knowledgeable about the available resources on their campus and in their community and can intervene when they notice a student-athlete is struggling.

Knowing when to make a referral

In many instances, it may be difficult for athletic staff members to distinguish the difference between personal and performance issues (NCAA, 2016). For example, an athlete experiencing pre-game jitters before every performance is different than an athlete experiencing anxiety related to self-worth and acceptance. Although coaches tend to ask questions to get to know their athletes, they may be reluctant to ask personal questions or feel uncomfortable discussing personal issues that are outside their scope of practice. Therefore, it is important for athletic staff members to know how and when to make a referral. The following sections provide guidelines for athletic staff members to follow and help determine if a referral is necessary.

Interfering with daily functioning. Throughout this workshop, participants have learned that mental health exists on a continuum. Therefore, considering the duration, frequency, and severity of impairment is necessary (Hullinger & DiGirolamo, 2018). If the issue interferes with daily functioning (i.e., professional, personal, and social) make a referral. Daily functioning refers to a variety of activities for self-care, such as, eating, hygiene, leisure, and attending to school and athletic responsibilities (Hullinger & DiGirolamo, 2018).

The issue persists. If the issue lasts over a prolonged period, a referral should be made (Hullinger & DiGirolamo, 2018). If the student-athlete is participating in daily activities but is

not making any progress, there may be underlying issues that could be worked through in therapy.

Signs/symptoms of common disorders. In session 4, participants learned the signs/symptoms of common mental health disorders that included, depression, anxiety, eating disorders, and substance use. If athletic staff members notice signs/symptoms of any of these disorders, a referral is necessary. Any unusual emotional reactions (e.g., anger, hostility, losing control) can also warrant a referral.

It is important to note that the above criteria do not have to occur simultaneously and that meeting just one may warrant a referral (Hullinger & DiGirolamo, 2018). While athletic staff members are not expected to treat or diagnose, they are expected to use their professional judgement about when to make a referral. Below is a cheat sheet for participants. They are encouraged to keep a copy in their office, where it can be easily accessed.

Knowing when to refer – Quick Guide

- How long has the issue existed? Is it recent or has it persisted over time?
- How severe is the issue? Is it impacting the student-athletes' daily functioning? Are they missing class or practices? Do they seem unmotivated or fatigued more than usual?
- Is the student-athlete demonstrating any unusual emotional reactions? For example, anger, hostility, or little to no patience?
- If any of the above are occurring, make a referral!

Locating local resources exercise

To help participants get familiar with resources offered on their campus and in the community, participants will break into small groups and use their smart phones to identify available resources. Each group will be assigned a resource topic to research and report back on.

Topics include campus resources, community agencies (in-person), online resources, and phone resources. Groups will have approximately 20 minutes to research and then share with the group. Facilitators will compile a list of all resources reported and distribute the list to all participants at the end of the session. Each group will identify three resources within their assigned topic. For each resource, groups should report the following information:

- Location (building, office suite #, address) (in-person, online, phone)
- Hours
- Contact information (email, phone number)
- Services offered
- Cost to students, if any (this is often a main reason people do not seek treatment)

How to refer

After determining that it is within the best interest of the student-athlete to be referred, approach the matter with positivity and support. Be sure to remember that treating and diagnosing mental disorders is not the athletic staff member's role. Rather, their role is to offer support, present options, and identify available resources. Be sure to have a list of reliable resources on hand. The following section provides a step-by-step guide that can be used to make an effective referral.

Step-by-step Referral Guide (modified from Hullinger & DiGirolamo, 2018)

Step 1. Make an appointment to meet privately with the student-athlete. Ensure that neither party is rushed or preoccupied.

Step 2. Set a positive tone and voice your concern. Start the conversation by stating their safety and well-being is your priority. Speak in a calm tone and be supportive, patient, and non-judgmental.

Step 3. Stay focused and be direct. Point out specific signs, behaviors, or changes you have noticed. Again, be sure to do this calmly and restate your concern for their well-being.

Step 4. Ask and listen. Use open-ended questions to gather information and actively listen to them by recognizing, acknowledging, and validating what you heard. Allow silence. Give the student-athlete time to tell the story and be comfortable not speaking.

Step 5. Ask them how they feel. Encourage autonomy and ask them to share their thoughts/feelings about your suggestion.

Step 6. Restate your concern. Make it clear that you care about them and want to help in any way you can. Do not pressure them to decide or force your personal beliefs on them.

Step 7. Identify resources. Share information (e.g., services offered, licensure) about the referral you are suggesting and explain how therapy can be beneficial to them. Gently suggest therapy.

Step 8. Keep open communication. Make sure the student-athlete knows it is ultimately up to them whether they attend therapy. End the conversation that leaves the door open to revisit the topic another time if they wish. Be sure reinforce that their safety and well-being is important to you and they can come to you at any time.

Case Illustrations (modified from Thompson & Sherman, 2007)

For this exercise, participants will be divided equally into two groups. Each group will receive a sport-specific case study to read, discuss, and practice referring, using the information learned in this session. Groups will be asked to identify factors that lead them to a referral and how they would go about it, using the step-by-step referral guide.

Case illustration 1

Mary's athletic trainer mentioned to her coach that she often gave excuses about why she could not eat while on road trips. She would say that she could not eat before a competition because she would feel ill or too heavy to run well. Mary's teammates noticed that when she did eat, she often went to the restroom shortly afterward. Mary was not overweight, but she often referred to herself as being "fat." Her performance had decreased during the past year. She maintained that in order to perform well, she needed to be "leaner."

Case illustration 2

Allison's softball coach was concerned about her lack of concentration. She had errors in the outfield and was making mental errors in games and practices. She seemed distracted. In the dugout, at team meetings and traveling to away games, she had difficulty sitting still and was often — as her parents called it — "fidgeting." When her coach asked if she was worried about something, Allison said she had always been a "worrier" and sometimes had difficulty falling asleep because her mind was "racing." Allison also admitted that she specifically worried that she sometimes felt as though something "awful" was going to happen. When that feeling occurred, she worried that she might die from a heart attack because of her racing heart and shortness of breath. Allison admitted that she was worried that this "thing" would happen again,

and she felt powerless to stop it. She said that she had mentioned it to her mother, who admitted that she had experienced the same problem.

Final thoughts

After completing this session, participants have a better understanding about why referring is important, who they can refer to, and what it feels and looks like to refer a student-athlete in a real-life scenario. Participants should use this time to reflect on their personal feelings about referring and ask any clarifying questions regarding the referral process. It is important that participants can take the skills learned in this session and apply them at their institutions. It should be noted that some institutions may already have protocols in place when it comes to addressing mental health issues and making referrals. Participants are encouraged to consult those protocols and consider how the skills learned in this session apply.

Most valuable lesson: Being prepared to act quickly is critical to student-athlete mental health and can even save lives.

Session 7: Remaining Supportive

The goal of the final session is for participants to learn how to remain supportive of student-athletes who are experiencing or have experienced a mental health concern. This session draws upon the information and skills learned throughout the workshop to help participants understand the importance of remaining supportive after making a referral.

Skills to offer support

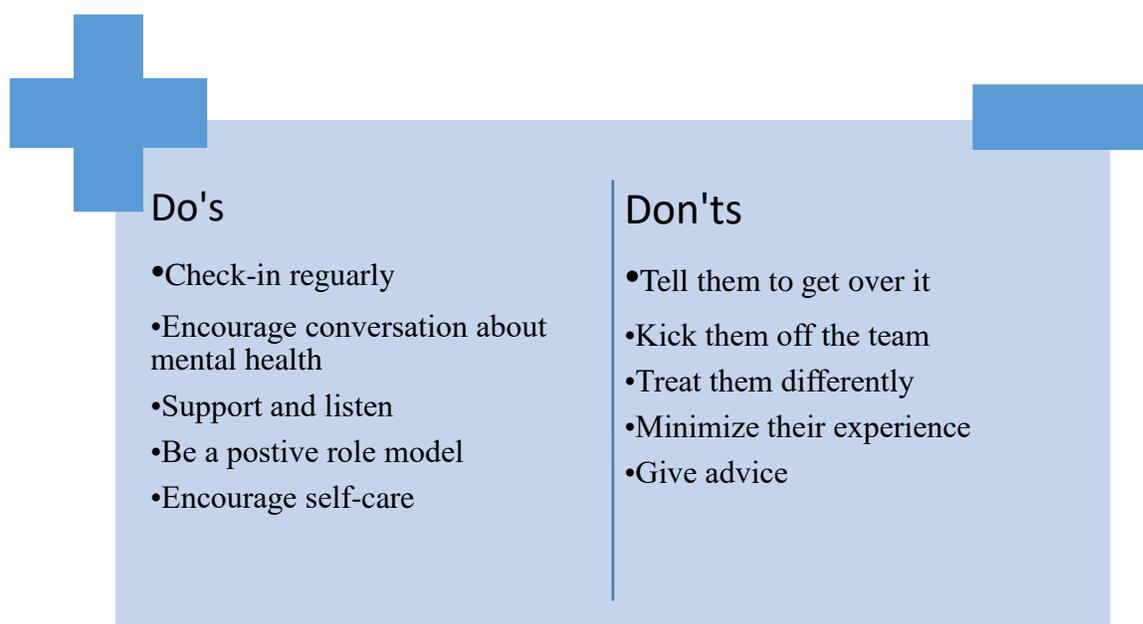
While participants have been taught that it is not the responsibility of athletic staff members to treat mental health disorders, they do play a significant factor in the recovery process. The nature of the relationship between student-athletes and athletic staff members is crucial to supporting student-athlete's overall well-being. Spending considerable time together, builds trust and helps coaches and athletic staff members recognize when signs and symptoms of common mental health disorders occur. Having these skills, puts athletic staff members in a position to help student-athletes. However, it is important that athletic staff members also use the skills learned throughout this workshop to continue being supportive after learning a student-athlete is struggling or making a referral. Just because a student-athlete experiences a mental health issue, does not mean that they should be shunned from the team. Even if athletic staff members feel uncomfortable reaching out, it is better to try to say the right thing, than to say nothing at all. Often, student-athletes will appreciate the effort and recognize when someone is trying to help. Below is a list of statements that athletic staff member can use to check-in with student-athletes who are experiencing a mental health challenge.

Touching base with student-athletes

- I know this has been a difficult time for you. I wanted to check-in to see how you are doing.

- I cannot imagine what you are going through but please know that I will be here every step of the way.
- Please tell me how I can continue to support you through this difficult time.
- I would like to continue to touch base with you regularly, is that ok?

In addition to this list, the figure below also offers quick suggestions for athletic staff members.



Practice exercise (modified from Young, 2017, p. 80)

For the final exercise, participants will partner up with two other members and practice the skills they have learned throughout the entire workshop. One participant will be the student-athlete, the other participant will be the helper (i.e., athletic staff member) and the third person will be the observer who provides feedback to their group members. The helpers will role play visiting with the student-athlete after they made a referral and demonstrate how they can be supportive. Participants are encouraged to refer to the skills learned in session six for a refresher on how to initiate a conversation about mental health. There will be time after the exercise to process and discuss. Each participant will play the helper, student-athlete, and observer. Groups

will complete three case scenarios, which will allow group members to rotate through all roles. When the exercise is completed, there will be time for participants to debrief and talk about their experience in each role.

Case Scenario 1

Student-athlete role: You are a member of the college swim team and have been missing morning swim practices and feeling unmotivated. You do not understand why you are unable to wake up in the mornings and state you are worried about your athletic and academic performance. You told one of your teammates that you would rather be dead than continue feeling this way. Your coach has scheduled a meeting to speak with you about this.

Helper role: You learn about this student-athlete and schedule a meeting with them to gather more information and determine an action plan. What will you do?

Observer role: Pay attention to the interaction. What did you notice? Did the coach take the appropriate steps? Is there anything you would have done differently? Explain.

Case Scenario 2

Student-athlete role: You were recently caught underage drinking during season. You were suspended from the team and your coach referred you to a therapist. You have not spoken to your coach since this happened one week ago and now, they would like to meet with you.

Helper role: You scheduled a meeting with this student-athlete to check-in and offer your support. They are reluctant to meet with you but ultimately agree. What do you say to them?

Observer role: Pay attention to the interaction. What did you notice? Was the coach offering support? Is there anything you would do differently?

Case Scenario 3

Student-athlete role: You recently had surgery for a torn ACL and spend a lot of time with the team athletic trainer getting treatment. You tell them that you are feeling angry that this happened to you and you often take your anger out on your teammates, yelling and swearing at them.

Helper role: You are the team athletic trainer and notice the student-athlete is very angry and irritable all the time. You have witnessed them snap on other teammates and feel that the student-athlete has briefly confided in you at times, but you did not know what to say. You decide that you are going to address it today while they are in your office getting treatment. What do you say?

Observer role: Pay attention to the interaction. How does the helper start the conversation? Was it awkward or tense? Why or why not? Is there anything you would do differently?

Discussion Questions

- Which role did you enjoy the most? Why?
- Which role was your least favorite? Why?
- How did it feel providing feedback to your group members?
- What was hard about this exercise for you?
- What came easy to you?

Final thoughts

During this session, participants learned how to remain supportive of student-athletes after making a referral for treatment. It is important that athletic staff understand how their support can impact treatment in a positive way. Participants are encouraged to ask questions and gain clarity on any information regarding this session. During this time, participants will also be

asked to reflect on the workshop as a whole and engage in dialogue about what was learned, suggestions for the future, and how they can implement the information learned. It should be noted that more time may be needed for this section and planned in advance.

Most valuable lesson: Love, kindness, and support can go a long way, for ourselves and for others.

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Appendix. Addressing Mental Health within Sports

Abstract

When one thinks about a collegiate student-athlete's health, physical and medical health probably come to mind first, along with how physical injury can affect an athlete's playing time and athletic performance. It is not uncommon that a student-athlete's mental health is considered secondary to physical health. However, a student-athlete's mental health is just as important. It is important for those working with student-athletes to recognize that physical and mental concerns are connected and can affect one another. For example, some studies suggest an elevated risk for injury and decreased athletic-performance with student-athletes who experienced symptoms of depression, eating disorders, and substance abuse (Mountjoy et al., 2014; Wiese-Bjornstal, 2010; Yang et al., 2014). As a result of these psychological issues, student-athletes can also face medical consequences. To address the gap of available services addressing the physical and mental wellbeing of student-athletes, the National Collegiate Athletic Association (NCAA) released the *Mental Health Best Practices* guidelines (NCAA, 2016). However, the guidelines alone do not solve the mental health crises occurring within athletic departments on college campuses. The following sections provide a review of literature about the importance of addressing mental health within collegiate sports and the need for an applied program. Student-athlete's mental health is reviewed, along with mental health prevalence rates, common disorders, misconceptions about seeking help, and resources available to student-athletes.

Addressing Mental Health within Sports

The National Collegiate Athletic Association (NCAA) is made up of over 1,000 institutions that are home to over 400,000 collegiate student-athletes in the United States (Sudano, Collins, & Miles, 2017). With mental health concerns among student-athletes on the rise, the NCAA has taken accountability and started researching ways they can understand and support student-athlete mental health. Statistics show that one in five adults will experience a mental health illness each year, with adolescents being the most susceptible (NCAA, 2016). Additionally, suicide is the third leading cause of death among student-athletes, following accidents and heart issues (Born, 2017). In 2016, the NCAA released the *Mental Health Best Practice* guidelines, to address these issues. These guidelines acknowledged that mental health exists on a continuum within college sports, with one end made up of resilience and thriving and mental health disorders impacting athletic and academic performance on the other (NCAA, 2016). To aid student-athletes, the *Mental Health Best Practice* guidelines suggests that universities across the United States employ staff members that are qualified to treat mental health disorders through a performance lens. It is slowly becoming more common for universities to hire sport psychologists or clinical mental health counselors, to serve as a resource for student-athletes (NCAA, 2016). However, not all universities are financially equipped to do so, prolonging the process of student-athletes receiving help.

According to Velasco (2017), nearly 33% of student-athletes experience symptoms of anxiety and depression during their collegiate career. Student-athletes represent a special population that includes risk factors exclusive to them. Travel requirements, physical injury, performance anxiety, and career termination, are only a few of the many stressors that student-athletes endure. In addition to these risk factors, stigma surrounding mental health remains one

of the biggest reasons that treatment is avoided (National Institute of Mental Health, 2006).

While the topic of mental health within college sport is gaining recognition within the literature, several barriers to addressing these issues still exist. The purpose of this project is to address the importance of mental health in college sports, by providing a literature review and addressing the need for an applied workshop, that defines the barriers surrounding seeking help, provides psychoeducation about mental health literacy to athletic staff members, and offers an evidence-based intervention to prevent and combat mental health concerns among college athletes.

Significance of Addressing Mental Health in College Sport

Traditionally, student-athletes have been overlooked when it comes to addressing mental health concerns. Due to the prestige and image upheld by competitive sports, student-athletes are thought to be a special population of individuals, who always remain mentally and physically healthy (Walton, Purcell, & Rice, 2019). There is conflicting evidence that supports both sides of the spectrum. In some studies, participation in sport and physical exercise have been shown to decrease mental health symptoms and serve as a protective factor (Armstrong & Oomen, 2009; Biddle, Gorley, Mutrie, 2015; Brown & Blanton, 2002). In other studies, the opposite has been demonstrated, citing sport-specific risk factors (e.g., injury, travel, performance anxiety, etc.) as predictors of mental health issues (Bauman, 2016; Bovard, 2008; Donohue et al., 2007). Due to the inconsistency in athletic programs and lack of knowledge about mental health issues and who can treat them, student-athletes pay the price. Student-athletes are expected to manage the role of being a successful student, on top of a collegiate athlete. Educating athletic staff members about mental health issues (e.g., depression, anxiety, eating disorders, substance use, etc.), and the factors that contribute to them, will allow student-athletes to utilize resources and seek out services.

Stressors Collegiate Student-Athletes Face

The psychological concerns of college student-athletes have been ignored for quite some time. The NCAA recently has acknowledged the importance of addressing mental health issues with student-athletes and the benefits that counseling services can offer (Hosick, 2005). A growing body of research implies that the severity and range of presenting concerns student-athletes have are extensive, likely representing a mental health crisis that exists on campuses (Benton, Robertson, Tseng, Newton, & Benton, 2003; Brent et al. 2006; Etzel, 2003, Grayson, 2006; Hinkle, 1994; Kadison & DiGeronimo, 2004).

Maniar, Carter, and Smith (2003) studied student-athletes who sought psychological services at a large mid-western university. Over the course of two years, student-athletes reported experiencing concerns with the following: adjustment to college and athletics, substance use, anxiety, depression, eating disorders, and physical injury. In addition, student-athletes reported significant issues with interpersonal relationships (i.e., peers, coaches, intimate), time management, academics, career selection/termination, and performance anxiety (Etzel, 2003).

Academic Demands. Student-athletes must quickly learn to manage academic responsibilities (e.g., attending classes, completing homework, mandatory study tables, etc.) based on a schedule that differs vastly from their non-athlete peers (Etzel, 2009). Completing these daily tasks often become overwhelming and consequently get pushed to the backburner, due to athletic commitments and training requirements (Etzel, 2009). In 2007, the NCAA along with member intuitions, implemented the “Academic Progress Rate” (APR) in an effort to improve academic success and graduation rates of student-athletes (Thompson & Sherman, 2007). As a result, academic progress of student-athletes is closely monitored by athletic compliance offices and coaches. Not performing well in the classroom may have significant

ramifications for student-athletes (e.g., loss of athletic scholarship or financial aid, academic probation, or suspension from the athletic team) (Berg, 1989), which can lead to high levels of stress in student-athletes.

Physical Injury. Sport-related injuries are another common source of distress among collegiate student-athletes (Etzel, 2009). Each year, nearly 40-50% of NCAA student-athletes experience an athletic injury during practice or competition (Sallis et al., 2001). During the 2009-2010 to 2013-2014 athletic seasons, data from the NCAA found that nearly 210,674 sport-related injuries occurred (Kerr et al., 2015).

Additionally, the frequency and severity of injuries that student-athletes face vary depending on the sport and time of year (Etzel, 2009). For instance, in golf and rifle, injury rates tend to be lower, while contact sports such as football, gymnastics, and soccer have much higher injury rates (Thompson & Sherman, 2007). Brown (2002) found that nearly 50% of collegiate football players in the United States lose playing time due to injury and one in ten collegiate female basketball and soccer players suffer an ACL tear.

Li, Moreland, Peek-Asa, and Yang (2017) examined the effect of preseason anxiety and depressive symptoms on the risk of injuries, among 958 NCAA collegiate athletes. Participants included student-athletes from four men's sports and five women's sports, from two NCAA Division I universities. The researchers found that 389 (40.6%) of student-athletes sustained a total of 597 injuries. Student-athletes who reported preseason anxiety symptoms had a significantly higher injury rate compared to student-athletes without anxiety symptoms (Li et al., 2017). Perhaps screening for preseason anxiety and depression symptoms may help prevent student-athletes from experiencing an injury.

Role Conflict. Athletic identity is referred to as the degree that which an individual identifies with that role and seeks acknowledgment of that role from others (Brewer, Van Raalte, & Linder, 1993). It is proposed that athletic identity is made up of three components that include social identity, exclusivity, and negative affectivity (Brewer, Van Raalte, & Linder, 1993). Social identity places emphasis on how an individual occupies the role of an athlete through the eyes of others. Exclusivity requires the individual to self-evaluate, to examine the execution of the athlete's role from one's own perspective. Negative affectivity refers to an individual's concerns about not fulfilling the role of an athlete, how it affects performance, and how those negative affects impact the individual's overall wellbeing (Burns, Jasinski, Dunn, & Fletcher, 2012).

It is not uncommon for student-athletes to over identify with their role as an athlete, by investing more time and effort into sport than academics (Lally & Kerr, 2005; Miller & Kerr, 2003). However, not identifying the discrepancy between each role, can have a negative effect on a student-athlete's overall wellbeing (Killeya-Jones, 2005; Settles, Sellers, & Damas, 2002). Some common issues that can come from a strong athletic-identity are burnout and the development of a negative athletic-identity. In other words, athletes can become emotionally and physically exhausted by placing too much time and effort into sports. Overall functioning can then become a problem, making it difficult for athletes to complete routine tasks (e.g., get out of bed, attend classes, eat lunch, etc.) (Lee, Kang, & Kim, 2017).

Time Management. At Division I and Division II universities, the NCAA bylaws state that student-athletes may not participate in more than twenty hours per week of in-season training and competitions (NCAA.org, 2020). The bylaws also state that student-athletes may not participate in more than eight hours per week of out of season training. These numbers don't include the other "voluntary" activities that student-athletes are encouraged, and often times

pressured, to attend (e.g., compliance meetings, extra meetings with coaches, study tables, student-athlete advisory committee, voluntary weight training, etc.) (NCAA.org, 2020). While the NCAA has procedures in place to protect student-athletes from being overworked, enforcement is at the discretion of each institution, making it difficult to accurately track the amount of time spent on athletics (Etzel, 2009). It is also important to note that at this time, Division III schools do not enforce the same guidelines and restrictions.

At the 2020 NCAA convention, results from the Growth, Opportunities, Aspirations, and Learning of Students in College study (GOALS study) were discussed with athletic faculty and staff members (GOALS study, 2020). Over 22,000 male and female student-athletes from all divisions (i.e., Divisions I, II, and III) completed the GOALS survey that asked questions about academics, athletics, and social experiences. Female student-athletes across all three divisions reported concerns about the amount of time spent in athletic practices and competitions, indicating less hours would improve time management skills. Division I baseball student-athletes reported an increase in the number of hours dedicated to their sport, while student-athletes across the board reported a decrease in taking personal and social time (e.g., socializing with friends, getting adequate sleep, and taking time for themselves) (GOALS study, 2020). This can lead to a variety of physical and mental health issues for student-athletes. Isolation can cause individuals to feel alone or sad. Not getting enough sleep can impact athletic and academic performance, as individuals can experience a decrease in energy and overall functioning. Student-athletes may miss class or perform poorly in practice due to a lack of energy (GOALS study, 2020).

It is no secret that being a collegiate student-athlete at any division (i.e., Division I, II, or III) requires individuals to devote a significant amount of time to athletic development and

careers. By doing so, student-athletes are forced to make decisions about how they spend their time, often sacrificing academic success (Etzel, 2009).

Prevalence of Mental Health Concerns Student-athletes Face

Entering adulthood is a significant and difficult transition for most adolescents. During this time, young adults embark on a new journey to college, where they are likely to face new life stressors (Etzel, 2009). The act of learning to balance schoolwork, a new environment, and taking on new responsibilities can pose a threat to the well-being of college students. Even more at risk, are collegiate student-athletes, who must learn to juggle the above responsibilities along with their obligations as a student-athlete. Not attending to these stressors may lead to the development of a mental health disorder (Etzel, 2009). Therefore, it is crucial that athletic staff members are knowledgeable about the predictors and prevalence rates of common mental health concerns that student-athletes face. Educating athletic staff members about prevalence rates and new life stressors that effect student-athletes, can encourage overall well-being and foster academic and athletic success (Etzel, 2009).

Depression

There is nothing unusual about feeling a bit down from time to time. Grieving over upsetting life experiences (e.g., life stressors, loss, or transitions) are normal experiences for young adults. If an individual is proactive and seeking out mental health services, their feelings may pass sooner than later. However, if these feelings persist, they may lead to disruption in daily functioning (e.g., eating, sleeping, or attending school/work). Yang and colleagues (2007) examined the prevalence of symptoms of depression, along with the factors associated with depressive symptoms in college athletes. There were 257 participants, both male and female Division I student-athletes, ages 18 and up who completed the Center for Epidemiological

Studies Depression Scale, the State-Trait Anxiety Inventory, and the Generalizing Estimating Equations scale, that measured factors associated with depression. The questionnaires were administered during preseason meetings with each team (Yang et al., 2007). Results revealed that four percent of the participants reported a history of clinical depression prior to this study. Student-athletes who experienced new life stressors, lack of support systems, and being fully committed to their collegiate sports (i.e., putting athletic requirements before academics and personal wellbeing) team were more likely to experience depression (Yang et al., 2007). Furthermore, female student-athletes reported higher symptoms of depression than male student-athletes did. This study suggests that there is a need for psychoeducation on the prevention and reduction of psychological stressors faced by student-athletes (Yang et al., 2007).

Armstrong and Oomer-Early (2009) compared the prevalence of social connectedness, self-esteem, and depression between student-athletes and non-athletes. The study included 227 participants, all college students, who completed the Center for Epidemiologic Studies Depression Scale, the Rosenberg Self-Esteem Scale, and the Social Connectedness Scale-Revised (Armstrong & Oomer-Early, 2009). Of the 227 participants, 104 were NCAA Division I athletes. Results indicated that student-athletes reported higher self-esteem and social connectedness compared to non-athletes. In addition, females reported higher rates of depression than males. The overall findings suggest that self-esteem and social connectedness are significant predictors to depression among college students and suggests that student-athletes represent a unique population. Researchers proposed that more attention needs to be placed on the mental well-being of student-athletes (Armstrong & Oomer-Early, 2009).

Another study conducted over the course of three years, measured the prevalence of depression symptoms among Division I student-athletes (Wolanin et al., 2016). 465 participants

representing 12 sports completed the Center for Epidemiological Studies Depression Scale, which measured symptoms of depression. Findings indicated that nearly 24% of participants reported clinical depressive symptoms, while 6.3% reported moderate to severe symptoms (Wolanin et al., 2016). There was a large fluctuation of reported depressive symptoms between male and female student-athletes, with females reporting much higher levels. Female student-athletes were 1.844 times more likely to endorse clinical symptoms of depression than male student-athletes. Although student-athletes are considered a unique population, they aren't exempt from experiencing mental health concerns. Furthermore, results suggest that female student-athletes are at a higher risk than male student-athletes to experience depressive symptoms, which is consistent throughout the literature (Wolanin et al., 2016).

Suicide

In 2014, Madison Holleran committed suicide at age 19, by jumping nine stories off a parking garage. She was a NCAA track athlete at the University of Pennsylvania, majoring in philosophy, politics, and economics (Born, 2017). Although she appeared to have it all together on the outside (i.e. attending classes, getting good grades, maintaining a social life), Madison masked the severity of her symptoms. As a first year student, competing at a prestige university, the pressure of balancing academics and sport were too much (Smith, 2014). Although this is only one example, Holleran's story had a great impact on the world of college sports regarding mental health. Since then, much attention has been placed on researching university policies and procedures regarding mental health services available to students.

Rao and colleagues (2015) examined the rate of suicide among NCAA student-athletes, examining data from 2003-2012. Results showed that over the course of nine years, 35 cases of completed suicide were reported. Other factors commonly experienced by college athletes that

may put them at a higher risk for suicide include perfectionism, anger or aggression, confusion, fatigue, and depression (Brown & Blanton, 2002). Baum (2005) examined medical literature over a 35-year timespan, as well as psychological literature over the length of 20 years. Within those time frames, Baum reported that 71 athletes considered, attempted, or completed suicide, at an average of 22 years old. Baum reported that males were more likely to consider, attempt, or complete suicide compared to females. Baum suggested that the stigma surrounding mental health and seeking mental health services, prevented athletes from getting help (Baum, 2005). It is imperative for athletic staff members to be knowledgeable about potential suicide risk factors.

Substance Use

Although the NCAA and universities have policies in place that aim to prevent substance use, student-athletes are more likely to misuse substances than their peers (Druckman, Gilli, Klar, & Robinson, 2015). Student-athletes reported higher rates than non-student-athletes of heavy episodic drinking, alcohol consumption, and experiencing the negative side effects of drinking (Martens, Dams-O'Connor, & Beck, 2006). Alcohol is a leading cause of morbidity and mortality among young adults. Excessive drinking has caused an economic burden of nearly \$223.5 billion in the United States alone, with binge drinking being the most problematic (Bouchery, Hardwood, & Sacks, 2011). Since sport serves as a central location for substance use (Wenner, 1998), it is essential for athletic staff members to recognize, understand, and promote an environment that abides by NCAA rules and regulations (NCAA, 2012).

To add to the growing body of literature addressing substance use within college sports, approximately 23,000 male and female NCAA student-athletes completed a national substance use survey conducted by the NCAA. The survey asked questions about alcohol, marijuana, tobacco/nicotine, prescription drugs, and other illicit drug use (NCAA, 2018). The NCAA has

been conducting a substance use survey on a quadrennial basis since 1985. Over 60% of NCAA schools participated in the study, with members of one to three teams from each school completing the survey. 77% of student-athletes reported consuming alcohol within the last year, while 36% of student-athletes reported drinking on a weekly basis (NCAA, 2018). Additionally, 42% of student-athletes reported binge drinking (e.g., 4 or more drinks for women and 5 or more drinks for men in one sitting). Student-athletes reported the most frequently used tobacco products were cigars (17%), cigarettes (11%), and hookah (10%). 24% of student-athletes reported inhaling marijuana, while 11% of student-athletes reported consuming edibles (NCAA, 2018). Illicit drug use reported by student-athletes included amphetamines (2%) and cocaine (4%), while 11% reported abusing prescription drugs.

The NCAA recognizes that substance abuse is an ongoing issue among collegiate student-athletes. In addition to proctoring the national substance use survey, the NCAA provides a list of additional substances that are banned in college sport (NCAA, 2018). These include anabolic agents, stimulants, street drugs, and large amounts of caffeine. While their efforts to reduce substance use among student-athletes may be appreciated, it still remains a risk factor that needs to be addressed regularly by athletic staff members (NCAA, 2018).

Buckman, Farris, and Yusko (2013) compared the use of performance enhancing substances between NCAA male student-athletes and non-athletes. A self-report survey addressed demographics, experiences and opinions on social and performance enhancing drugs and drug testing, and information regarding the distribution of drugs (Buckman, Farris, & Yusko, 2013). Results indicated that male student-athletes reported a higher use of all drugs examined, regardless of whether the drugs improved or hindered their performance, compared to their counterparts. Additionally, student-athletes reported higher prevalence rates regarding the misuse

of marijuana, cigarettes, narcotics, amphetamines, and permitted and unpermitted dietary substances. The findings from this study point to the importance of providing clear and concise education about the benefits and risks associated with substance use, in addition to reinforcing NCAA and university policies (Buckman, Farris, & Yusko, 2013).

In some sports, college athletes may indulge in substance use as an effort to maintain or meet specific weight requirements. Substances like diet pills, laxatives, or stimulants often are misused by student-athletes (Currie & Morse, 2005). Failure to keep a close eye on this, can result in serious health consequences for athletes, such as the development of an eating disorder. Research also suggests that student-athletes use steroids or cannabis to meet weight requirements (Nissen & Sharp, 2003). For example, a study was conducted to determine the predictive factors and prevalence rates regarding the use of high-risk dietary supplements, among 557 male and female NCAA student-athletes (Sassone, Muster, & Barrack, 2019). Participants competed on baseball, softball, basketball, volleyball, golf, tennis, water polo, soccer, cross-country, and track and field teams at their respective NCAA institutions. Researchers defined high-risk dietary supplements as any supplement that contained herbal ingredients and caffeine or supplements classified for weight loss, muscle building, or pre-workouts. Results indicated that 45.2% of participants reported using dietary supplements at least twice per week, within the past year and 8.3% of participants reported using higher-risk supplements (Sassone, Muster, & Barrack, 2019). The highest predictor of supplement use was motivation to improve athletic performance. Participants reported that they believed using supplements would assist in decreasing body fat and increasing muscles, along with increasing their athletic endurance. The overall findings from this study support the need for education on the risks and benefits of dietary supplements, in relation to athletic performance (Sassone, Muster, & Barack, 2019).

Eating Disorders

Student-athletes make up a unique eating disorder subculture, due to the requirements of specific sports (Reel et al., 2010). While all competitive athletes face some risk, collegiate athletes in particular are at a higher risk for developing maladaptive health behaviors and distorted body images that can have long-lasting physical and psychological consequence (Goldfield, Blouin, & Woodside, 2006; Sears, Tracy, & McBrier, 2012). Influence from peers, coaches, higher levels of competition, and having bodies that are still developing put college athletes at higher risk than non-athletes (Sears et al., 2012). Due to the intense pressure placed on athletes to perform well, it is not uncommon for athletes to spend more time exercising to achieve a desired physique and weight (Gaines & Burnett, 2014; McLester, Hardin, & Hoppe, 2014; Sears et al., 2012).

Sports have been viewed as social and group-orientated activities for quite some time and can influence positive or negative effects on individuals (McKay Parks & Read, 1997; Patel et al., 2003). Positive aspects may include team members capitalizing on their skillsets as a team, endorsing a teamwork mentality, and a healthy mindset. Negative effects can include pressure to win and engaging in behaviors that can lead to mental and physical harm in order to develop physical ability and a sense of team cohesion (Sears et al., 2012). Pressure from peers, coaches, or teammates can lead athletes to develop negative training habits and distorted thinking that can harm an athlete's sense of self and overall wellbeing. If an athlete places too much time and emphasis on reaching peak performance levels, they may be putting themselves at a higher risk to develop an eating disorder. Focusing an unhealthy amount of time on achieving specific muscle mass, a specific weight, or body type can lead to unsafe caloric practices, purging, or excessive exercise (Tiller, 2018).

In some studies, student-athletes reported specific triggers related to sport such as performance pressure, physical injuries, and fluctuation of coaching staff that led to the development of an eating disorder (Arthur-Cameselle, Sossin, & Quatromoni, 2017; Papatthomas, & Lavallee, 2006, 2014; Sundgot-Borgen, 1994). Much of the literature places an emphasis on comparison between female student-athletes and non-athletes because females are more likely to report an eating disorder than males (Giel et al., 2016). While non-athletes experience the same life stressors that student-athletes do, such as academic stress, there remains a distinct difference regarding the daily pressure student-athletes face to uphold a healthy image. Non-athletes are not required to solicit their bodies for competition (Arthur-Cameselle & Curcio, 2018). Within most women's sports, a highly desired body type is one that is lean. Fairburn, Cooper, and Sharfran (2003) pointed out that interpersonal environments (e.g., athletics) tend to magnify weight and appearance pressures that have a tendency to represent risk factors for disordered eating.

Arthur-Cameselle and Quatromoni (2014a) interviewed 16 female collegiate athletes, who reported experiencing an eating disorder. The researchers were interested in what initiated, assisted, and hindered participants from seeking help. The athletes expressed that the negative consequences associated with the eating disorder was the highest reported factor that led to seeking help. Other factors included the pursuit of a better quality of life, interventions, confiding in others, and enhanced self-esteem. The results of this study aim to bring awareness to factors that lead athletes to seeking help (Arthur-Cameselle & Quatromoni, 2014a).

A study conducted in 2004, found that 13.5% of elite athlete participants reported clinical or subclinical eating disorders including anorexia nervosa, bulimia nervosa, or another eating disorder not described (Sundgot-Borgen & Torstveit, 2004). This was approximately 9% higher than the control group, who reported 4.6% of participants experiencing the same clinical or

subclinical eating disorders. In addition, female athletes reported higher rates of eating disorders at 20%, while male athletes reported 8%. It is important for mental health professionals and athletic staff members to learn how to identify, prevent, assess, and refer for treatment of disordered eating in student-athletes (Sundgot-Borgen & Torstveit, 2004).

Attitudes Towards Seeking Help

A common barrier to seeking clinical services is the misconception that counselors only work with disturbed or crazy people (Etzel, 2009). This notion often can prevent student-athletes and athletic coaches from understanding the benefits of counseling and how it can positively impact student-athletes' success in the bigger picture. A three-month long study was conducted to examine the attitudes surrounding seeking treatment for mental health issues in college athletes and non-athletes (Barnard, 2016). Participants were selected from NCAA Division I, II, and III schools. Results showed that athletes reported their identity as an athlete (i.e., being healthy, competitive, and successful athletically) may shield them from the stigma surrounding mental health (Barnard, 2016). Additionally, athletes reported that they would rather seek help from a sport psychologist instead of a clinical mental health counselor because they believed sport psychologists focus on athletic performance and not mental health issues (Barnard, 2016).

Other attitudes towards seeking help held by college students is the lack of perceived need for help and the concept of resiliency (Czyz et al., 2013). A study of 165 participants, all college students, aimed to identify reasons that college students experiencing mental health issues don't receive treatment. At the time of the study, no participants were receiving help. Results indicated that lack of time, the perception that treatment isn't necessary, and preference for self-management were reported as reasons that college students don't seek help (Czyz et al., 2013). In another sample of college students, approximately 55% reported a preference of

wanting to solve their own problems, as the main reason for not seeking treatment (Eisenberg, et al., 2011). In another study, one third of participants experiencing depression and suicidal ideation cited resiliency (i.e., the emotional will to overcome barriers) as the reason they chose not to seek help (Gould et al., 2004). Research suggests that the general population of college students are unaware of the resources available to them (Czyz et al., 2013). College students also reported lack of time, privacy, and stigma as reasons why they didn't seek treatment (Czyz et al., 2013). Gulliver, Griffiths, and Christensen (2012), through focus group interviews, found athletes described being more reluctant to seek help compared to non-athletes. Student-athletes reported a lack of knowledge about mental health symptoms, negative past counseling experiences (i.e., not meshing with their assigned counselor or feeling judged), and fear of being portrayed as "weak" as top reasons for avoiding treatment. Furthermore, results indicated that male athletes endorse fewer positive attitudes than female athletes, regarding seeking treatment (Gulliver, Griffiths, & Christensen, 2012).

Stigma Through A Socio-ecological Lens

A socio-ecological lens is supported throughout the literature to aid in understanding the barriers that prevent college athletes from seeking treatment (Jeanes, Magee, & O'Connor, 2013). According to this viewpoint, the social environment that an individual is a part of, in this case the culture of athletics, influences the decision-making process (Dahlberg & Krug, 2006). More specifically, it is proposed that individuals make health related decisions that produce specific health behaviors within a social environment. In turn, the social environment impacts the individual and the individual impacts the environment (Dahlberg & Krug, 2006). While athletes uphold their own personal values and beliefs regarding mental health, other individuals such as family, friends, coaches, and teammates, influence those values and beliefs (Reis et al., 2015;

Eime et al., 2013). Therefore, the opinions and beliefs of an athlete's peers, coaches, or family may impact the athlete's personal judgement about seeking treatment for mental health concerns. In a larger picture, the sociocultural view that athletic administrators and staff members of all levels hold, also impacts an athlete's perception of addressing mental health issues (Sudano, Collins, & Miles, 2017, Brown, Hailine, Kroshus, & Wilfert, 2014).

Corrigan, Watson, and Barr (2006) describe stigma as public or personal. Public stigma refers to others' perceptions, while personal stigma refers to one's personal beliefs. Corrigan (2004) proposes that stigma is developmental, in that public stigma occurs first, followed by personal stigma. Individuals may refrain from seeking treatment due to either one of these stigmas. In a study conducted by Cooper, Corrigan, and Watson (2003) a sample of undergraduate students experiencing mental health issues were found unlikely to seek treatment, as a result of perceived public stigma. Furthermore, Eisenberg, Downs, Golberstein, and Zivin (2009) examined a sample of college students and found that perceived public stigma was more prevalent than personal stigma and higher rates of personal stigma correlated with less help-seeking. Similarly, Kaier and colleagues (2015) also found that athletes from NCAA Division I universities reported experiencing a significantly higher amount of stigma compared to non-athletes.

Misconceptions about Help-Seeking and Counseling Services

Several studies have examined whether college students are aware of the mental health resources available to them. For example, Benedict, Aspler, and Morrison (1977) found that only 14% of participants were knowledgeable about where the university's counseling center was located. Additionally, results indicated that some participants reported mistaking the counseling center for career counseling (Benedict, Aspler, & Morrison, 1977). Yorgason, Linville, and

Zitzman (2008) conducted a study to examine college student's knowledge about mental health symptoms, knowledge about mental health services available, and utilization of services.

Participants included 266 undergraduate college students, who completed an online questionnaire. Results showed that 37% of participants reported not knowing about mental health services available to them, along with not knowing how to contact the appropriate services (Yorgason, Linville, & Zitzman, 2008). In addition, 30% of participants reported being completely unaware of services available, while 38% reported being aware of services but knowing nothing about them. When participants were asked to provide reasons for not utilizing services, lack of time, uncertainty about what to expect, embarrassment, and the belief that services wouldn't be beneficial. The overall findings from this study suggest several barriers that prevented participants from seeking help. First, not knowing the benefits of counseling prevented individuals from seeking out services. Participants reported apprehension about counseling due to a lack of information and negative thoughts about counseling. Next, not having the time due to busy schedules, traveling, and athletic commitments kept participants from taking the time to address any issues. Finally, participants reported the distribution of mental health services on college campuses was confusing (Yorgason, Linville, & Zitzman, 2008).

Kroshus (2016) examined institutions from all NCAA divisions, to determine if policies were in place to address student-athletes' mental health. Participants included 365 supervising clinicians (i.e., head athletic trainers, mental health clinicians, team doctors, and sport psychologists) from NCAA universities. Participants completed questions regarding departmental policies, athlete pre-participation screening, screening initiatives, and institutional characteristics (Kroshus, 2016). Results indicated that Division I universities employed more qualified individuals (i.e. clinical mental health counselors and sport psychologists) to handle

mental health crises compared to Division II and Division III universities. The additional resources available to Division I universities (e.g. larger budgets, more staff, support from higher-ups), played a significant role in the creation of policies and staff members employed. Division I universities were more likely to employ a clinical counseling psychologist via the athletic department, compared to Division II or III universities. The overall findings found that the presence of policies, resources, and appropriate made access to treatment more readily available to student-athletes (Kroshus, 2016).

Sudano and Miles (2016) examined what practices, if any, were in place to assist student-athletes attending to mental health issues. Participants included 127 Division I head athletic trainers. Data were collected via a web-based survey that took approximately ten minutes to complete. Results showed that 98% of athletic trainers were knowledgeable about student-athletes having the right to mental health services on campus (i.e. knowing about counseling services on campus offered to students at no cost) (Sudano & Miles, 2016). Over 50% of participants reported knowing about counseling centers located on their respective campuses, while almost 21% reported resources were available within the athletic training room. Additionally, 73.1% of participants reported that their institution employed professionals with the appropriate credentials to treat mental health issues, through the athletic department. The remainder of participants reported that other departments on campus had more financial freedom to employ mental health professionals. The results from this study suggest that while resources may be available to student-athletes, there is uncertainty among head athletic trainers regarding how to access them (Sudano & Miles, 2016). Given that athletic trainers spend a significant amount of time with student-athletes, it is important they are knowledgeable about available resources. Being knowledgeable about resources may help prevent a mental health crisis, help

student-athletes get connected with a counselor, or allow athletic trainers to start a conversation about mental health (Sudano & Miles, 2016).

While there is an apparent need for mental health services to be more accessible to student-athletes, universities may not be able to provide the necessary resources due to limited finances. Hunt, Watkins, and Eisenberg (2012) investigated the decision-making implemented by administrators, regarding funding for mental health initiatives. The researchers interviewed directors of counseling services, at ten universities who partook in the 2007 Healthy Minds Study (HMS). The HMS is designed to address factors that impact mental health including the prevalence of symptoms associated with depression, anxiety, disordered eating; frequency of medication use and counseling services; facilitators and barriers to receiving services; and the effect of mental health issues on other important areas of life (Hunt, Watkins, & Eisenberg, 2012) Researchers identified four themes regarding the decision-making process for mental health resources. These included the occurrence of a mental health crisis (e.g. depressive episode, substance use, attempted suicide, etc.), internal and external data (e.g. recruiting and retention strategies, finances, and academic success), activism (e.g. faculty, staff, coaches, university president, etc., standing up for mental health resources) and upper-level leadership (e.g. university president, cabinet members, stakeholders, and donors). Participants reported that all these factors contribute to allocating more funds towards mental health services at universities. However, the results from this study suggest that something extreme often occurs, such as a crisis, or support from upper officials before action is taken (Hunt, Watkins, & Eisenberg, 2012).

Resources for Student-Athletes

Being involved in sports at the collegiate level does not have to negatively influence addressing mental health with student-athletes (Brown, Hainline, Kroshus, & Wilfert, 2014). In fact, student-athletes are in a great position to address these concerns compared to non-student-athletes. By being a member of an athletic team, student-athletes have a built-in support system, made up of teammates and athletic staff members they regularly interact with. Coaches, athletic trainers, sport psychologists, and sport medicine staff members meaningfully engage with student-athletes and often are attentive to indicators of distress (Brown, Hainline, Kroshus, & Wilfert, 2014).

Due to the amount of time student-athletes devote to perfecting their craft, it is no surprise that athletic trainers and sport medicine staff members interact with student-athletes the most. Tunick, Etzel, Leard, & Lerner (1996) suggest that because athletic trainers spend a lot of time with student-athletes, they are often first to recognize changes in student-athletes' emotional state when suffering from an injury. When this occurs, athletic trainers and sport medicine staff members should make a referral to a qualified mental health provider (e.g., licensed professional counselor, psychologist, psychological consultants, etc.) (Etzel, 2009).

In addition to athletic trainers and sport medicine staff members, coaches also spend a lot of time with student-athletes. Coaches often maintain consistent relationships with student-athletes and are able to identify changes in emotional wellbeing and behavior (Etzel, 2009). For example, in an NCAA survey on eating disorders, 68% of coaches reported referring student-athletes to psychological consultants on campus, 60% reported educational materials about eating disorders were helpful, and 59% of coaches reported having adequate referral information was helpful (Klossner, 2005). This is important because if coaches know how to refer, student-athletes may be more likely to seek treatment. Given the nature of the relationship between

athletes and coaches, student-athletes may feel more comfortable discussing mental health issues with coaches. Therefore, coaches must know how to discuss such a sensitive topic in a positive manner.

Coaches can play a very important role in creating and supporting a culture that encourages student-athletes to partake in prevention and treatment of mental illness or emotional distress. Coaches can work to create a stigma-free team environment, learn how to recognize when student-athletes are struggling, and encourage student-athletes to seek help from qualified professionals (Kroshus, Wagner, Wyrick, & Hainline, 2019). To do this, coaches must maintain the same attitudes and beliefs about mental health themselves. The *Mental Health Best Practice* guidelines recommends that coaches receive information annually, about mental health, along with prevalence and signs and symptoms of mental health issues that student-athletes experience (NCAA, 2016).

Sport psychology consultants work with student-athletes to provide educational sport performance enhancement skills (AASP, 2014). Sport psychology consultants who have extensive academic training in sport science, such as kinesiology, work with athletes to development mental skillsets. These skills can include visual imagery, goal setting, motivation, self-confidence, or goal-setting. Those who take a psychology route, may become qualified as a licensed professional counselor (LPC) by completing master's and/or doctoral training from accredited universities and by passing a national licensure exam in the state they wish to practice in (American Counseling Association, 2007). Counselors focus on development and growth over the lifespan, by utilizing prevention and interventions to help individuals lead meaningful lives. In addition, an LPC can help student-athletes advocate for their mental wellbeing and treat

common mental health disorders (e.g., depression, anxiety, eating disorders, substance use, etc.) (American Counseling Association, 2007).

The Game Plan: An Applied Program for Athletic Departments

To support the well-being and mental health of student-athletes, Sebbens and colleagues (2016) developed the Mental Health in Sport (MHS) intervention. The intent of MHS is to provide those who work closely with student-athletes with a brief, applied intervention that addresses mental health literacy (Sebbens, Hassmen, & Wensley, 2016). Mental health literacy refers to the “knowledge and beliefs about mental disorders which aid in their recognition, management, or prevention” (Jorm et al., 1997, p. 182). Given that coaches, athletic trainers, and other athletic staff members spend much of their time with student-athletes, these individuals are in a position to promote mental health. However, there are currently no regulations that require coaches or athletic staff members to be trained on mental health literacy, leaving both student-athletes and athletic staff members uneducated (Sebbens, Hassmén, & Wensley, 2016). The MHS workshop will educate individuals working with athletes about individuals qualified to treat mental health issues, and mental health issues, along with instilling confidence to aid student-athletes, who may be experiencing a mental health concern. Each step of the MHS action plan is explained and implemented, throughout multiple sessions, via sport-specific cases, role playing, and presentations. MHS uses an action plan framework, while emphasizing the importance of prevention and follow-up interventions (Sebbens, Hassmén, & Wensley, 2016).

MHS is structured around an action plan known as *recognize, reach out, refer, and remain supportive* (Sebbens, Hassmén, & Wensley, 2016). During the *recognize* stage, facilitators address prevalence rates of depression, anxiety, and suicide, along with signs and symptoms of each (Sebbens, Hassmén, & Wensley, 2016). Transitioning out of sport and

athletic injury are some of the unique risk factors exclusive to athletes. These topics, along with other unique risk factors are presenting during this stage, to bring awareness to athletic staff members. Psychoeducation about warning signs also is an important part of the workshop, along with addressing the impact of mental health on individuals, families, and communities. The purpose of psychoeducation is to help athletic staff members recognize signs and symptoms of the mental health issues, most commonly seen in student-athletes (Sebbens, Hassmén, & Wensley, 2016). It is important to note that only depression, anxiety, and suicide are addressed in this model, due to high prevalence rates supported throughout the literature (Gulliver et al., 2015; Rice, et al., 2016). Future adaptations to this model could include more disorders.

The next stage is known as *reach out*. This stage emphasizes the importance of learning how to start a conversation about mental health concerns (e.g. depression, eating disorders, substance use, etc.), with student-athletes (Sebbens, Hassmén, & Wensley, 2016). Due to the existing issues that prevent student-athletes from seeking help, it is essential that athletic staff members know how to appropriately begin a conversation about mental health. In this phase, skills such as active listening and consideration are taught. The goal of this stage is for athletic staff members to learn how to communicate with student-athletes, as well as employ active listening skills to help student-athletes feel heard (Sebbens, Hassmén, & Wensley, 2016).

The third stage, *refer*, aims to help athletic staff members become knowledgeable about how, who, and when to refer student-athletes. Due to limited accessibility and lack of funding on college campuses, mental health professionals may not be available to student-athletes (Sebbens, Hassmén, & Wensley, 2016). At this stage, the leader provides information about individuals who are considered mental health professionals, in and out of the athletic department. Psychoeducation about other community resources will also be addressed. In addition, role

playing is utilized to practice referral skills. Finally, information about referring against an individual's wishes also is addressed (Sebbens, Hassmén, & Wensley, 2016).

The final stage is known as *remaining supportive*. This stage provides information about the importance of following up with student-athletes after a referral is made. Due to the amount of time spent with student-athletes, it is important that athletic staff members continue to provide support, during and after a student-athlete experiences a mental health concern (Sebbens, Hassmén, & Wensley, 2016).

To determine the benefits of the MHS, Sebbens, Hassmén, and Wensley (2016) examined the effectiveness of the program. Participants included 166 coaches and athletic support staff members, working with elite athletes in Australia. Over 50% of participants reported earning a bachelor's degree or higher, 24.1% reported previous mental health training, and nearly 31% reported personally experiencing a mental health concern (Sebbens, Hassmén, & Wensley, 2016). Confidence levels of participants were examined (Griffiths et al., 2004; Gulliver et al., 2012b). Confidence levels of participants were measured using specific questions tailored to this study, regarding how confident participants were to recognize, reach out, refer, and support individuals experiencing mental health issues. Results indicated that participants who completed the workshop were more likely to feel equipped to address mental health issues among student-athletes (Sebbens, Hassmén, & Wesley, 2016).

Several other studies have demonstrated that brief interventions similar to MHS, are beneficial in increasing mental health literacy. For example, Griffiths and colleagues (2004) conducted a study with 525 participants, aimed to increase mental health literacy via two online interventions. Participants completed an online depression literacy intervention, along with an online cognitive behavioral intervention. Results indicated that participants who completed the

interventions reported decreased stigmatized attitudes (e.g., negative thoughts/beliefs) towards depression (Griffiths et al., 2004). Another study by Gulliver and colleagues (2012b) examined the implementation of three internet-based interventions addressing help-seeking attitudes, intentions, and behaviors in adolescent athletes. Results showed that brief mental health literacy interventions, along with de-stigmatization, improves knowledge and lessens stigma (Gulliver, et al., 2012b).

In addition to mental health literacy, an individual's competence level regarding the information they are presenting has an impact on how they deliver the information. Dimoff, Kelloway, and Burnstein (2016) conducted a study to address mental health literacy in organizational leaders. Results showed that leaders who are knowledgeable about mental health concerns such as depression and anxiety, endorse fewer stereotypes and are more likely to be supportive of employees experiencing these concerns. Another study found that coaches reported being more likely to intervene during a mental health crisis (e.g., ask questions, refer student-athletes, or talk about mental health) if they felt capable of doing so (Mazzer & Rickwood, 2015).

The MHS is derived from the success of the Mental Health First Aid program (MHFA; Kitchener & Jorm, 2002). MHFA aims to increase mental health literacy among the general public. It is a two-day program that teaches first-aid techniques to individuals who may need to assist during a mental health crisis (e.g. attempted suicide, depressive episode, substance use, etc.). The program is designed to be community-based and has demonstrated effectiveness in different populations, including sports (Bapat et al., 2009; Anderson & Pierce, 2012). For example, Bapat, Jorm, and Lawrence (2009) investigated the effect of a training program, known as Read the Play, with 40 coaches. The program focused on mental health literacy, coaches

completed pre-and-post questionnaires on knowledge, confidence, attitudes regarding mental health disorders, and help-seeking behaviors. Participants had an increase in knowledge about mental health disorders, improved confidence in aiding with a mental health situation, and more positive attitudes towards mental health at pre-and-post intervention (Bapat, Jorm, & Lawrence, 2009). The overall findings from this study demonstrate that Read the Play was successful in helping coaches better understand mental health literacy and improved their confidence and attitudes towards addressing mental health issues. These findings are important for athletic departments because they support the need for more education and training programs on mental health within athletics.

Conclusion

After examining the current literature, there is an obvious need for an applied program that strives to increase knowledge about mental health issues that student-athletes commonly face. Whether a student-athlete is experiencing stress and anxiety due to trying to balance sport and academics or depression because they moved away from home, they may be more likely to be exposed to unique risk factors, that lead to a mental health issue. Frequent travel schedules, eating disorders, and substance-use also are issues that an applied training program may help athletic staff members be competent to handle.

The purpose of this project is to adapt concepts from the MHS program, to provide a seven-week workshop to athletic staff members about how they can help student-athletes address mental health. Each week, athletic staff members will attend one, 60-minute session that addresses a variety of topics relevant to collegiate student-athletes mental health. Through education, active dialogue, and hands-on interventions, participants should complete the workshop with the knowledge and skills needed to appropriately address mental health with

student-athletes. With the combined knowledge and tools to intervene, athletic staff members can work together to create an environment that encourages and supports mental health.