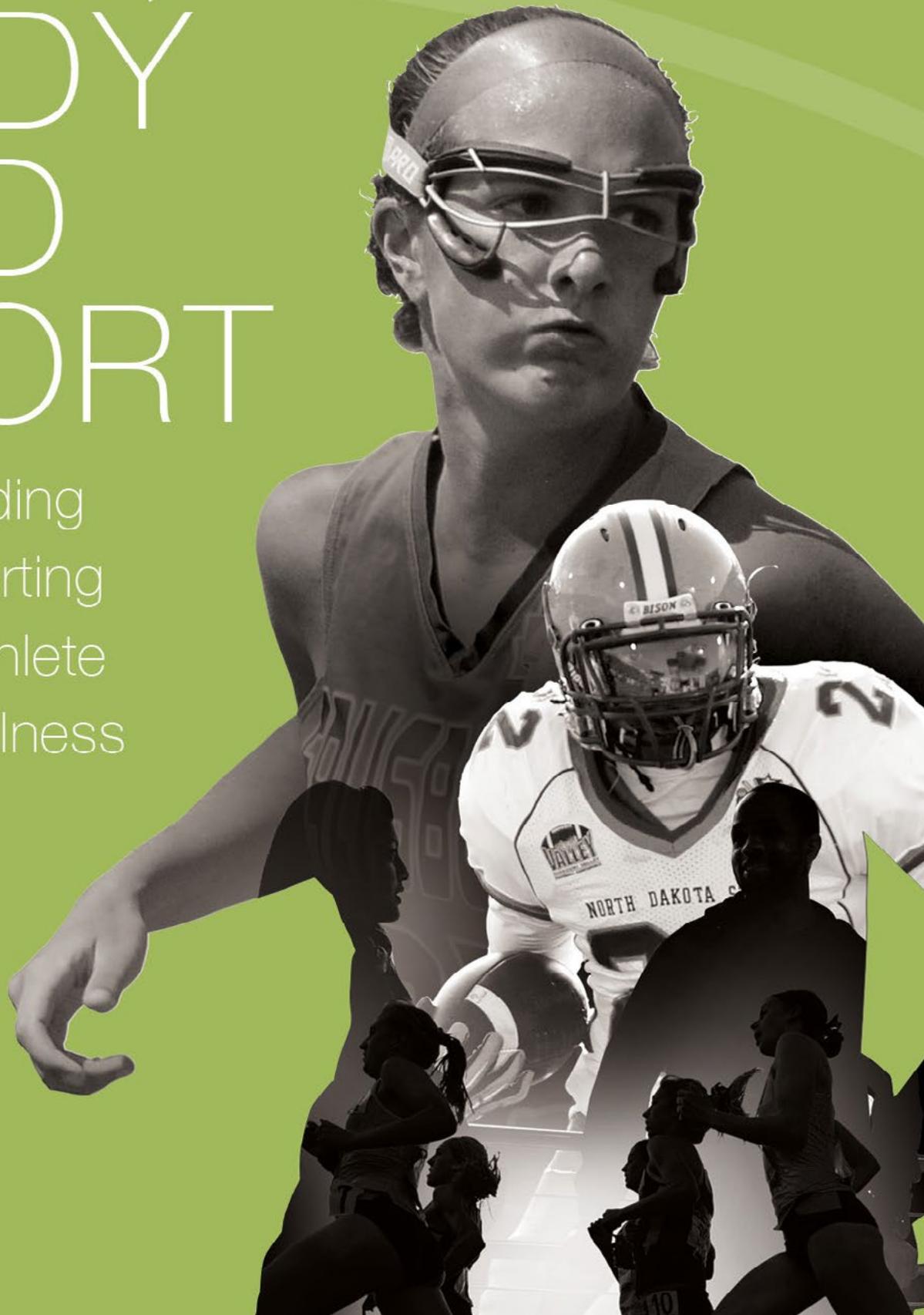


MIND, BODY AND SPORT

Understanding
and Supporting
Student-Athlete
Mental Wellness



MIND, BODY AND SPORT UNDERSTANDING AND SUPPORTING STUDENT-ATHLETE MENTAL WELLNESS

October 2014

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NCAA MENTAL HEALTH TASK FORCE

NCAA Chief Medical Officer Brian Hainline convened nearly two dozen scientists, clinicians, policy experts, team physicians, administrators, coaches and student-athletes in November 2013 to discuss the myriad mental health issues facing today's NCAA student-athletes. Those discussions from the Mental Health Task Force prompted development of this publication, and several task force members contributed articles.

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1) Prevention and preparation; 2) Managing a nonemergency mental health issue;
3) Managing an emergency mental health issue; and 4) After managing a mental health issue.

Introduction

When I began my tenure as NCAA Chief Medical Officer in January 2013, my first task was to connect with NCAA stakeholders and constituents to understand their concerns. I have since met with hundreds of student-athletes and dozens of student-athlete groups to ask them their primary challenges from a health and safety standpoint. Almost to a person, the No. 1 response is student-athlete mental health and wellness.

That may surprise people whose only contact with student-athletes is from watching them compete on television. It's just a game, after all – what could be so hard about that?

But those of you in the trenches working with student-athletes on a daily basis know the challenges they face – and you know that while student-athletes may play games, being a student-athlete isn't a game at all.

Student-athletes are college students, with all the challenges and opportunities presented to emerging adults, and with an additional role – as sports performer and in many cases campus celebrities, wearing the colors of their school and representing hopes and expectations of their campus and community.

College students in general represent a healthy cohort among same-aged peers, and student-athletes an even healthier subpopulation, buttressed by a discipline, commitment and attention to exercise and nutrition required to meet the demands of their sport. As such, and rightly so, athletics departments have developed sports medicine services that increasingly engage a multitude of resources and expertise to address student-athletes' injuries and illnesses to ensure they are in the best condition to compete.

But there's more to being a student-athlete than just physical preparation and performance. As more media coverage, commentary and public scrutiny are devoted to what student-athletes do off the field, along with the accompanying pressures to perform (and win games) on the field, student-athletes are inundated with factors that may affect their mental health and wellness. And the “culture” of athletics may inhibit student-athletes from seeking help to address issues such as anxiety, depression, the stress associated with the expectations of their sport, and the everyday stress of dealing with relationships, academic demands, and adjusting to life away from home.

Student-athletes themselves have begun to speak out about issues and resource needs. Consider the insightful words from former Notre Dame football player Aaron Taylor. Aaron completed his undergraduate degree in three and a half years, was a two-time All-American, won the esteemed Lombardi Trophy as college football's top lineman, and was a first-round NFL draft pick.

As Aaron says, his was the classic story of the quintessential overachiever whose success was the result of equal amounts of talent and hard work. But in his words, his experience wasn't as rosy as it appeared. Hidden just behind the accolades, trophies and championships was a young man suffering from anxiety and depression.

Here's what he told us:

“I later discovered that many of my issues stemmed from the internal pressure I placed on myself to reach some unattainable level of greatness as a way to mitigate the effects of an early childhood divorce and a variety of other challenges. I brought these issues with me to campus, but no one was the wiser, as my ‘game face’ helped hide my condition with relative ease...even from myself.

“Beginning in college and throughout my professional career, I battled depression with the same regularity as blitzing defenses, but the external opponents were much easier to deal with than the internal ones. Due to fear of looking weak or being judged, I hid my condition from those closest to me, including my coaches and teammates. Even though I lived my life in the spotlight, I was suffering in silence.”

Aaron is not alone, which is why we have developed this resource to present a comprehensive look at

*There's more to being a student-athlete than just
physical preparation and performance.*

the student-athlete experience from a mental health perspective – from the relationships with faculty, peers, administrators, coaches and fans to the struggles student-athletes may face in their sport. Some struggles are immense, including pain and injury that preclude competition; criticism and blame for poor sport outcomes; and prevailing attitudes that asking for help demonstrates weakness of spirit and drive.

We've selected Aaron's story to lead off the publication as a first-person account of the inner life underneath the toughness that student-athletes are conditioned to show on the surface. We've also sought advice from dozens of experts in the field. In all, this publication is designed to help athletics departments, campus mental health providers, and all sport stakeholders promote and develop effective strategies to understand and support student-athlete mental wellness. The chapters address:

- Stressors specific to student-athlete identify, such as transition, performance, injury, academic stress and coach relations
- Overview of clinical diagnoses, including depression, anxiety, eating disorders, substance abuse and gambling
- Key components in developing best practices for constructing mental health services for student-athletes
- The role and perspective of sports medicine staff in identification and referral
- Cultural pressures and impacts on minority groups
- How sexual assault, hazing and bullying affect mental health

This publication is the most comprehensive overview to date of college student-athlete mental health, and we hope this becomes a springboard for addressing mental health in the continuum from youth sport to intercollegiate sport and beyond. NCAA member institutions have committed to supporting student-athlete health and safety and ensuring that athletics departments are an integral part of the institutional mission for more than 100 years. But only recently have we begun to fully understand the mental health component of being a student-athlete.

I hope that you join us in our journey of understanding and supporting student-athlete mental wellness, and that you'll benefit from the best practices our experts provide in the following chapters. The contributing authors suggest dozens of recommendations for institutions to consider based on the individual circumstances and needs of the campus.

Our intent is for this publication to become a living and breathing document through social networks and online discussions that help break down the topics – and the barriers – to providing student-athletes the help they need. Remember that the student-athletes have spoken: Mental health is their No. 1 concern – and it is our responsibility to provide the services and care to help each student-athlete reach his or her full potential.



*Brian Hainline
NCAA Chief Medical Officer*



CHAPTER 1
FIRST-PERSON PERSPECTIVE

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Game Face Is Not the Only Face

BY AARON TAYLOR

I was 17 when I arrived on Notre Dame's campus in August 1990 as a prep All-American offensive lineman. By the time I graduated and left South Bend three and a half years later, I had a B.A. in sociology, was a two-time All-American, won the Lombardi Trophy as college football's most outstanding lineman, and was a first-round draft pick of the Green Bay Packers.

It was the classic story of "local boy does good," with me playing the quintessential overachiever whose success was the result of equal amounts of talent and hard work.

Unfortunately, all was not as rosy as it appeared. Hidden just behind the accolades, trophies and championships was a young man suffering from anxiety and depression.

I later discovered that many of my issues stemmed from the internal pressure I placed on myself to reach some unattainable level of greatness as a way to mitigate the effects of an early childhood divorce and a variety of other challenges. I brought these issues with me to campus, but no one was the wiser as my "game face" helped hide my condition with relative ease ... even from myself.

Beginning in college and throughout my professional career, I battled depression with the same regularity as blitzing defenses, but the external opponents were much easier to deal with than the internal ones. Due to fear of looking weak or being judged, I hid my condition from those closest to me, including my coaches and teammates.

I was in my prime and supposed to be living my childhood dream, but I was slowly spinning out of control. I drank heavily in a desperate attempt to cope with the pressure I felt, but as my play stayed at a high level and my grades didn't suffer, all was seemingly well in my world. Even though I lived my life in the spotlight, I was suffering in silence.

Looking back over the course of my career, I wasn't alone. Many of my former collegiate and professional teammates have since shared with me that they suffered similar fates, for many of the same reasons. But there are steps all of us can take to keep that from happening.

To minimize the chances of a negative consequence in a football game, defensive players are taught a heightened awareness for critical situations such as a big third down or short yardage/goal line plays. Making an "Alert!" call was a reminder that danger lurked. From a student-athlete mental health perspective, I say danger lurks in the following areas, and all in the athletics department should make an "Alert!" call when they see trouble.

THE LOCKER ROOM IS A SACRED PLACE, BUT NOT A SAFE PLACE. Locker-room banter is one of the

things that I miss most about playing football. At its best, it's a way to find some relief from the sports pressure cooker. At its worst, though, it can be detrimental to those involved, as illustrated by the well-publicized hazing story involving two Miami Dolphins teammates, Richie Incognito and Jonathan Martin. It doesn't pay to be vulnerable in the locker room, so athletes quickly learn to keep their emotional armor on well after the pads are off.

In sports like football, toughness is celebrated and weakness is despised. We do what's necessary to navigate this

I battled depression with the same regularity as blitzing defenses, but the external opponents were much easier to deal with than the internal ones.

"manly" environment, and that means masking our feelings. Players learn to "suck it up," "rub some dirt on it" and "gut it out," usually with positive results. We're so conditioned to doing this that we often default to such behavior in our everyday lives. Unfortunately, masking emotional issues doesn't work as well in the game of life as it does helping us play through a high ankle sprain.

It also helps explain why so many emotional and mental health problems go unnoticed. Players become masters at keeping their game faces on all the time, often until it's too late.

COPING WITH ATHLETICS MORTALITY. While there's much more on how injuries affect mental health later in this publication (see Chapter 4), I want to share with you how injury affected me.

Toward the end of my career, I used to pride myself by saying, "Football is what I do, but it's not who I am." That was a lie. In reality, football *was* my life. Every thought, effort and action was somehow related to helping me continue to develop as a player.

That's why it shook my world to the core when I ruptured my patella tendon during a pass-blocking drill in only my fourth practice with the Packers. As I lay there holding my knee and the "lollipopped" quadriceps just above it, I was scared to death that my childhood dream of an NFL career had ended before it had even begun.

When I sustained my injury, I was in a lot of physical pain, but the emotional pain of that day and the ensuing months was even more excruciating. Even though I was quickly told I'd be able to play the following season, on a gut level I knew my body, and therefore knew my career would never be the same. As a result, unbeknown to me at the time, my psyche had been as damaged as my failed kneecap.

Making matters worse, as my ability to play football came to a screeching halt, the Packers didn't skip a beat. The drill we were doing was moved 10 yards away, and practice continued as usual for everyone ... except for

me. It was the most alone and vulnerable I'd ever felt as an athlete, and this brutal first encounter with my athletics mortality is when I took my "frosty beverage" coping strategies to the next level.

Athletes often identify their self-worth with their ability to perform, so to become injured is much more impactful than something detectable by an MRI. Our teams often become our expanded family – a place of familiarity, significance and consistency. For many athletes, an injury leaves us feeling "apart from" versus "a part of" the team. We're inside getting treatment, when all we want to do is

HOW YOU CAN HELP

Looking back at my situation, I'm glad it happened the way it did, as it's given me the experience and perspective needed to serve as a mentor. I'm now a transition specialist for a company the NFL Players Association contracts with to provide support services for athletes in transition. In this capacity, some best practices have emerged that may prove helpful in many of the areas I've noted in this article.

From my perspective, athletics department personnel should strive for the following to address the mental health challenges student-athletes invariably face:

- **TREAT THE PERSON, NOT JUST THE INJURY.** Be mindful that student-athletes will keep their game faces on. Remember that looks can be deceiving, and there's often more going on than athletes are able or willing to discuss. Continue to stay interested in their emotional well-being as much as their physical rehab.
- **HELP DEVELOP EMOTIONAL INTELLIGENCE.** In an appropriate and safe setting, discuss some of the potential emotions that can accompany injuries. I've found that Elisabeth Kubler-Ross's Five Stages of Grief (denial, anger, bargaining, depression and acceptance) is an appropriate and applicable model.
- **BE VULNERABLE FIRST.** Relating a personal story of when you were thrown a professional curve ball or got hurt playing sports yourself can often be the permission a student-athlete needs to open up. Noting how you felt and what helped you cope can help stimulate the student-athlete's own development of a healthy coping strategy. If appropriate, it may also help to share what *didn't* work. The more honest and relatable you are, the more honest student-athletes will likely be with themselves.
- **CREATE AN EMOTIONALLY SAFE TRAINING ROOM.** When possible, create a training room culture where student-athletes are allowed to take off their emotional armor. If the situation permits and protocol allows, tell student-athletes about the benefits (and mandated privacy) of a licensed sport psychologist or campus therapist. Be empathetic whenever possible, and remind student-athletes that acknowledging their feelings takes a tremendous amount of courage and toughness that the average person doesn't have.
- **MANAGE EXPECTATIONS.** Student-athletes are inherently driven and accustomed to knowing what to expect. Leverage this innate skill by being honest and realistic with them, yet optimistic when appropriate.
- **LEAD THE CHARGE.** As primary caregivers, take the initiative to educate your colleagues and other institutional stakeholders (such as coaches, administrators and athletic trainers). Consider implementing a mental health awareness program and corresponding protocols in your athletics department. University of Tennessee team physician Chris Klenck does a good job of suggesting how to do this in Chapter 6 of this publication.

There's no fail-safe method to preventing student-athletes from experiencing mental health issues, but there are plenty of opportunities for us to help them navigate the tough times and emerge as the success story we've encouraged them to be.

be part of the practice outside.

The nature of team sports, much like the military, requires closing ranks and marching on; no one has time to stop and worry about the fallen warrior because there's still a job to do, a game to win, a hurdle to surpass. While injured players are often missed, human nature and the culture of sport dictate that the team moves on without them. The corresponding feeling of being "left behind" often manifests itself in unhealthy behavior.

Athletes often identify their self-worth with their ability to perform, so to become injured is much more impactful than something detectable by an MRI.

THE EMOTION OF DEMOTION. Although I can never say a player beat me out, I sure know what it's like to be replaced. The day after my injury, the Packers acquired a longtime veteran, a guy I watched play as a kid for my

beloved 49ers, former All-Pro Guy McIntyre. To say that experience was surreal (and devastating) is like saying a screen door on a submarine could be a bit of an issue.

To players, a demotion is a personal blow to their psyche and sense of self-worth. Imagine if you arrived at work and were unexpectedly told that someone else would be taking over, someone who was believed to be better equipped to handle the job.

It's no different for athletes who lose their starting job or are forced to contribute to their teams in a diminished role. "Helping the team any way I can" is good coach-speak, but it can have much greater effects on athletes than they often acknowledge.

RIDING OFF INTO THE SUNSET. Most athletes don't think about the fact that they'll be ex-athletes much longer than they'll be current athletes. Few among us ever take the time and effort to explore this reality and devise a "Plan B."

Regardless of how an athlete's career ends – retirement, graduation, injury, etc. – the transition into "private life" can be rough. Many athletes find themselves unprepared for what comes next, both fiscally and emotionally, because they don't have a post-career plan in place. Most of us just don't want to think about a reality that doesn't include the games that we've dedicated our entire lives to playing.



Aaron Taylor was an offensive lineman at the University of Notre Dame from 1990 through 1993. The San Francisco native was a unanimous first-team All-America selection in 1992 and 1993 and won the 1993 Lombardi Award as college football's most outstanding lineman. He was drafted by Green Bay Packers in the first round of the 1994 NFL draft, playing on the team that won the Super Bowl in 1997. Taylor played for the San Diego Chargers in 1998 and 1999 before retiring from professional football. He has since been a television analyst for CBS College Sports and ABC Sports. He currently provides player transition services for the NFL Players Association.

Living the Dream – and Waking Up To Reality

BY CATHY WRIGHT-EGER

When I was in junior high school, I knew I wanted to be a teacher and a coach. I played sports, took specific classes – especially in college – and chose work experiences to prepare me to be the best teacher/coach I could be.

At 27 years old, after coaching at the club and high school level and being an assistant college coach, I landed my first NCAA Division I head coaching position and was living the dream.

But the dream has its unexpected twists and turns. Most coaches are well prepared to execute the X's and O's of their sport and to motivate their athletes. But dealing with the mental health side of athletics is something you generally have to learn on your own, and often on the fly. That learning curve can be huge.

What is the protocol if a student-athlete needs help with mental health issues? There is seemingly a policy for everything academic- and athletics-related, but nothing in place for mental health.

I am not a prideful person, so if I don't know an answer or how to deal with something, I ask for help. The first years I coached, I felt like that little bird in the book "Are You My Mother?" I just changed the words to "Are You My Counselor?" And I asked everyone: "Where do I send a student-athlete in need of counseling?"

The answer changed depending on the person I spoke with and the issue at hand. Over time, I felt like I was spending 90 percent of my energy and efforts with 10 percent of my student-athletes. As a recruiter who sat with families in their living rooms and gave them my word that I would be there for their children, I found myself slowly drowning.

Here's an example of one month of my life as a Division I coach. The semester started with a parent calling after midnight, asking me to please go to the athlete's apartment. The mother needed me there while she explained that the student-athlete's father had committed suicide that night. It's a night I'll never forget.

The following week, one of the best freshmen we had ever signed asked for a meeting with her parents to discuss transferring because of lack of success. (After only one semester – really?)

The week after that, during a swim meet, someone screamed that one of our athletes was bleeding badly in the locker room. I left the contest and found the student-athlete was self-mutilating with a razor blade. I stayed calm, had someone call 911, got our student train-

er to assist me until the paramedics arrived, and then continued coaching the meet.

When was I trained for all of this? Where in my training or my college classes did I learn how to identify and deal with these types of issues? I felt like coaching looked very different than it had when I began pursuing it as a career. I actually found myself wishing I had double-majored in *counseling*. I was confused, angry and mystified why there was such an increase in mental health issues the longer I coached. But no one talked about this part of coaching, no matter how many clinics I attended.

One of the most insightful periods in my 23 years of Division I coaching was in my 15th season when a small group of coaches decided to "get real" with some of the

I was confused, angry and mystified why there was such an increase in mental health issues the longer I coached. But no one talked about this part of coaching, no matter how many clinics I attended.

troubling issues our student-athletes were facing. Motivation, nutrition, training and recruiting were topics we'd discussed for years, but these were different.

It started with one coach asking if we ever had an athlete with an eating disorder. Of course we had all experienced and witnessed the affliction. We traded horror stories and shared how much one person's disorder affected the entire team and coaching staff.

Then the floodgates opened. Did anyone have a "cutter" on their team? How about an athlete who had been sexually assaulted during their college days or before? Why were binge drinking and date rape so prevalent? What about depression, anxiety and bipolar disorder? Addictions, prescription drug use, recreational drug use, divorced parents with opposing agendas – we discussed all of those, too.

It was a wonderful discussion – open, honest and educational. We put aside the fact that we all recruited against each other. For hours we shared stories on mental

health issues (of course without disclosing names). We expressed how many of the issues were over our heads, and as coaches, we didn't know where to turn for help. The team doctors and sport psychiatrists seemed to be part time and booked solid.

The bottom line is that student-athletes need professional assistance with mental health issues, and the coaches/athletics departments need protocols and re-

sources to ensure that those student-athletes receive proper help when needed.

I am glad to know that so many athletics administrators and medical professionals are now devoting time and resources to an issue we coaches have known about and struggled with for many years. The X's and O's of student-athlete mental health and well-being should be in everyone's playbook.



Cathy Wright-Eger spent 21 seasons as the head women's swimming and diving coach at Purdue University before becoming an academic adviser there in 2008. She sent competitors to the NCAA championships in 20 seasons and compiled a .616 winning percentage in dual meets during her career. She was named the Big Ten Conference coach of the year in 1990. In 2007, Wright-Eger helped manage the U.S. national team that participated in the Pan American Games in Brazil. The Ball State University graduate coached her high school alma mater's team for two years before becoming an assistant for two years at the University of Iowa. She joined Purdue in 1987.

Resilience, Empathy and True Toughness

BY MOLLY MCNAMARA

Cross country is a gritty sport. There's a certain level of tenacity necessary to tell yourself to maintain pace for another mile, or three. But long-distance running demands toughness outside competition as well.

A lot of people define "toughness" as the mental and physical discipline, under pressure, to do your best and fullest every time. That is feasible when you're at the top of your game. Pouring your heart and soul into training, into holding on in a six-mile progression run, into a race, requires more strength when no matter how much you give you still feel like you're at only 60 percent.

Over my past three years, I've learned a different kind of toughness than the grit I learned as a fourth-grader on the track. I learned the capacity to do everything you can, even when "everything you can" has a different result than you're used to. Toughness when things aren't perfect requires discipline and courage to overcome discouragement. Toughness when things are not perfect is ... life.

But how do you survive those less-than-perfect situations when discipline isn't enough? When grittiness gets you through the workouts but can't seem to get you through the rest of the day? As a runner, you're highly in tune with your body, and you know its highs and lows; you know your normal aches and pains, and you know when you should probably see the athletic trainer. Learning the highs and lows of your mind is much harder.

My freshman campaign at Stanford was a dream come true. I was coming off a great senior year in high school track, I loved my new teammates, and I raced on our varsity team all fall. Except for one race – nationals. I found out I had mono. Being handed the mono diagnosis just two days after the season ended tempered my disappointment of not participating in the championships meet, but it presented its own host of problems. I survived getting mono during "dead week" (the study period before finals), but it hurt my grades that quarter. It was even more lethal to my confidence.

A few weeks later, when I was cleared to start physical activity again, I promised to shake off the experience and get back on my feet. I was determined to tough this one out like I did my training. Two weeks into winter quarter at Stanford, though, I got a call from home saying my mom had been diagnosed with breast cancer. I was devastated. Her own mother had died of cancer when my mom was my age. I was 3,000 miles from home, struggling with the collegiate adjustment, and now I was absolutely terrified of losing my mom.

Running has always been my escape. I found comfort in long leisurely runs along the boardwalk or the trails of the Northeast. I found equal respite in the rhythmic drowning of clicking off laps on the track. Once I was cleared to run, I couldn't maintain my normal training routine. Less running, more stress: A breaking point was coming. And break it did. I was diagnosed that spring with a sacral stress fracture.

I began struggling with depression. I felt like I was sinking deeper into a hole that I couldn't get out of. I unconsciously formed disordered eating habits as a result of my efforts to control the screeching halt from

As a runner, you're highly in tune with your body, and you know its highs and lows. ... Learning the highs and lows of your mind is much harder.

60-mile weeks to nothing. I felt like no one understood what I was going through, but it was a Catch-22 because I struggled to open up about what was going on. Part of depression is feeling worthless and guilty. People want you to "let them know if you need anything," but I just felt like I was a nuisance.

After recouping that summer, I entered my sophomore year and began to realize I was not unique in what I went through. I saw more student-athletes who, while they may not have been suffering from depression, were trying to cope with stress in other ways. I am well plugged into the athletics community at Stanford, so I knew this was not just a "runner issue." Additionally, I have friends competing in collegiate athletics all over the country, so I knew these issues weren't unique to Stanford, either.

I declared my major as human biology, which is an interdisciplinary program that focuses on both the biological and behavioral dimensions of people, and how these dimensions are relevant in real life. I built my area of concentration around athletics mental health because I saw a need, as fellow student-athletes were having similar experiences to mine. I realized, "I'm not imagining this. ... This is actually a big issue."

I started paying particular attention to the way stress manifested in athletes who were injured. Sometimes it was through depression, an eating disorder, substance abuse or other issues. Often, people weren't aware the issues could be related to their injury.

As part of my curriculum, I interned in the physical therapy clinic in Stanford sports medicine to learn more about the medical and psychological implications of injury. I conducted a survey on athletes' psychological response to injury, asking numerous questions about perceived social support, emotions and changes in behavior, and feelings of isolation from their teammates.

I also asked whether they changed their eating habits, and whether they worried about their weight or physique. You'd be shocked about how many (male and female) student-athletes share anxiety over the inability to complete their normal training regimen. You can't easily go from being devoted to doing this day in and day out, to not caring the next week because you're injured. There's no power switch for that.

This past April, I was asked about building an initiative to address student-athlete mental health at Stanford, and I jumped at the opportunity. It gave me the chance to involve more students and increase the potential for impact. I am now the director of a new program we just built called Cardinal RHED (Resilience, Health, and Emotional Development), which is an entirely student-led group that collaborates with the athletics department to initiate programs and resources for Stanford student-athletes.

Cardinal RHED already encompasses about 30 student-athletes from an array of sports: cross country and track, football, basketball, wrestling, crew, volleyball, swimming, field hockey, softball and gymnastics. We have athletes working in six action squads to focus on the following six need-based areas:

- Sports Nutrition (holistic nutrition vs. disordered eating)
- Injury
- Emotional Support and Resilience
- Collegiate Transition (into and out of college)
- Team Development
- Overall Thriving (everyday stresses like balancing academic and athletics demands)

We have high aspirations for this program as we launch it this year. Among projects we're hoping to begin include a peer-to-peer mentoring system for athletes (where you're connected with someone who's been through the

same injury as you); resources or workshops for coaches on mental health; open workshops for athletes on being an empathetic teammate, approaching someone on a sensitive topic, etc. We hope that these resources will not only provide information for athletics purposes but also tools that are pertinent in the "real world."

I think there's a lot of value in peer-based efforts when it comes to mental health. No, peers can absolutely not provide or replace the clinical expertise that a psychologist or psychiatrist gives. But I think they are a great complement to well-balanced clinical services. Brené Brown, a well-known sociologist and author, talks about the power of vulnerability in driving connections. That is where I see the work of peers being invaluable; once I open myself up and tell you about something I've been through – how I've struggled, the ways I am not perfect – you then have the reassurance that I'm not judging you. It gives you the social permission to be vulnerable with me, too.

I've been asked why it's necessary to design athlete-specific programming. Here's a scenario I often give as an example. If you are struggling with an eating disorder and you go to the campus counseling center and speak with a counselor who's not familiar with the athletics culture, one of the first pieces of advice you usually get is to avoid weighing yourself and don't pay attention to the "numbers" involved with weight. But if

We don't feel shame over having to go to physical therapy for a stress fracture – why should we feel any different about allowing time and treatment to heal anxiety or depression?

you're a member of your school's lightweight crew or wrestling teams, you're going to get weighed at least once or twice a week.

Also, attempting to alleviate distress by telling student-athletes "it's just a game" is not as effective as working through the stresses of injury, retirement, loss of starting positions or the end of careers. To devote such a percentage of your college life to athletics, it's more than

just an extracurricular activity for most. For some, it may even be a serious career pursuit. The “caring” switch does not flip on and off that easily.

Drawing on the previous analogy of mental and physical ailments, sometimes it just takes a few weeks of heat and stim or “scraping” to get your muscles feeling normal again. More serious injuries require more time and treatment. But we don’t feel shame over having to go to physical therapy for a stress fracture – why should we feel any different about allowing time and treatment to heal anxiety or depression? I think there is a misconception about mental health that you can “control” it. That may be true when we are talking within the realm of normal thoughts and emotions, but how do you know where the line is drawn? Controlling depression, controlling an eating disorder, requires a different medical kit than the tools we use on the field and the well-intended mantras of “tough it out” or “don’t let them see you sweat.”

I hope that someday Cardinal RHED will be less of a “program” and part of a comprehensive umbrella system of serving student-athletes. Universities can help their student-athletes by providing professional mental health resources, but athletes can be contributors to the system, in addition to recipients. In my survey on psychological responses to injury, student-athletes were asked whether they would use a psychologist, a sport psychologist, or a peer mentor who had gone through the same injury, if these resources were available. A significant number of those who said “no” to both psychologists said “yes” to meeting with a peer. While a preference for peer-based

help could indicate that there is still the perception of judgment about seeking clinical help, I think it’s important to notice that these student-athletes didn’t respond “no” to both types of help. Peer mentoring cannot replace professional help, but it could be an effective gateway.

Hopefully, we won’t always have to give so much consideration to stigma, but while we do, we need to find ways to work around it. You can provide world-class resources, but if you don’t present them the right way, they won’t be effective, no matter how efficacious they are in theory. Peers, in their courage and vulnerability, can help break down that stigma.

As for my own situation, after sitting out sophomore fall to fully recover from the stress fracture, I raced junior year on our varsity team. I’m grateful and thrilled to say that after surgery, my mom is cancer-free. The highlight of my Stanford career was last fall at our regional meet, when we bounced back from a poor performance at the previous meet to place a shocking (to everyone else) second, only 10 points out of first. We truly found our rhythm that day as a team and it was one of the coolest moments to be a part of.

But I had a private moment that left me in tears after the race. Our second-place finish meant we were qualified for nationals – the one meet I had missed two years prior. It wasn’t about getting to travel or personal motives, though. It was a precious moment for me because after two years of “fall-down, get-up,” I realized I had really gotten through it all. And though there will certainly be trials ahead, resiliency is a tool, once learned, that sticks with you.



Molly McNamara is a senior cross country and track student-athlete at Stanford University. McNamara is a human biology major with a self-developed concentration in athletics mental health, and she plans to pursue a graduate degree in clinical psychology with a specialization in athletics populations, particularly collegiate. Her research interests include depression, anxiety, eating disorders, substance abuse, cognitive appraisal of injury, collegiate transition, and retirement from sport. McNamara is the director of Stanford’s student-athlete group, Cardinal RHED (Resilience, Health, and Emotional Development), which collaborates with the athletics department to initiate new programs and resources, and to effectively market them to Stanford student-athletes. McNamara can be contacted at molly.mcnamara@stanford.edu.

One Coach's X and O: Pay Attention, Give Permission

BY MARK POTTER

I am an advocate for helping student-athletes with mental health issues because I've gone through them myself.

In 2005 – 19 years into my coaching career – I came to grips with depression after masking it for years. I denied the signs because I was embarrassed and ashamed of not being able to cope with what I thought should be normal. I thought only people “who couldn't handle life” were depressed.

As it turned out, I was diagnosed with a chemical imbalance, as is the case for so many others who suffer symptoms of depression and anxiety.

But because I've experienced it firsthand, and because I know the tendency to hide the stigma of what others might regard as being “abnormal” or “crazy,” I have taken my message to the streets that it's OK to seek help. I speak regularly to youth groups, high school kids, church groups – anyone I can find who needs to know that depression and anxiety aren't so abnormal after all.

There are so many stressors on the college student-athlete that we as coaches tend to overlook them and expect the kids to be mentally tough and “suck it up.” And the hardest part for anyone who hasn't gone through it is to recognize it in others. Most coaches haven't been educated enough to help in that area, or they haven't been educated about the resources available on campus so they can direct the student-athlete to get the help he or she needs.

What you need to look for are signals such as changes in behavior – even subtle ones – that indicate the student-athlete may be struggling with more than just time management or acclimating to college life.

One sign in particular is that so many people with a mental health issue will try to self-medicate rather than address the root issue – when you start seeing that or hearing things their peers say, consider that as a sign of a deeper problem. If they're using alcohol or drugs, *why* are they using it? Coaches are usually the last to know. Try to notice strange or different behaviors and pay attention to what is happening.

Because I am now so open about my condition, other Newman coaches have used me as a first reference when dealing with their own student-athletes who show signs of struggling, and that's OK. I talked with one student-athlete for more than an hour and made him promise two things – that he'd see a doctor, and that he'd do exactly as the doctor ordered.

Much later, we had a chance encounter on campus. I

asked the young man how he was doing. And he knew it was more than the casual “How're you doing?” people tend to exchange as small talk.

The student-athlete told me he had gotten the help I advised and was “doing fine.” It was a short conversation, but enough to convince me that the young man had gone in the right direction.

A short time after that, my AD called me into the office without telling me why. And as a coach you're always a little nervous when that happens. But when I came in,

Student-athletes are conditioned to not let anyone know if they're struggling, and sometimes we as coaches – perhaps even unknowingly – fortify that behavior because we're trying to build character and mental toughness in game situations.

this young man was with the AD, and the AD said the student-athlete had something he wanted to show me. Well, it turns out that he was an artist, and he had done a painting of me as a way to show his gratitude.

That painting – which hangs in my office above my desk to this day – is the most precious thing I've received from anyone because it is a daily reminder of how important help is for people suffering with depression or anxiety or any other mental health issue. That young man just graduated in May and is getting on with his life now. I can't tell you how rewarding that feels.

I have dozens of other stories like that, too. After almost every group session I conduct, a handful of people will come up afterward saying how liberating the message was. And there likely are more who feel the same way but aren't ready to disclose it – but perhaps they will later on in their own way once the message sinks in. And that message is that it's OK to get help. In most cases, the person suffering from the issue just needs *permission to go get help*.

It certainly was a permission thing for me. Here I was 19 years into my coaching career, and you're telling me

I have a mental health issue and can't deal with my daily life? Are you kidding? I mean that's not easy to handle. That internal turmoil of – gosh, what if people find out I can't handle my daily life? But my getting help allowed me to get back to my normal self, and because of the medication I have not been back to the “other” self now for nine years.

Student-athletes are conditioned to not let anyone know if they're struggling, and sometimes we as coaches – perhaps even unknowingly – fortify that behavior because we're trying to build character and mental toughness in game situations.

But coaches should also be aware of what the

student-athletes are encountering from all directions and be sensitive to situations in which they may find all of it difficult to manage.

Coaches who have not gone through some type of mental health issue themselves will probably find it difficult to understand what it is. Before I went through it, I might not have recognized it myself. But if you see your players' behavior start to change, don't assume it's just something they can “shake off” by being tough.

It's OK to talk about these things. In fact, that's where the “mental toughness” comes in. That permission to talk it through and to get help will do more for their mental toughness than any practice or drill.



Mark Potter is in his 16th year as Newman University's head men's basketball coach, where he has compiled an overall record of 281-163. Potter led the Jets to their best season during the 2012-13 season when Newman earned its first bid to the Division II tournament and finished the season with a 20-8 record. Potter was named Heartland Conference Coach of the Year and the Greater Wichita Area Sports Commission Coach of the Year. A former Newman player and assistant coach, Potter has compiled the highest winning percentage in Newman basketball history. Potter also has been on a mission now for nine years to get the word out about depression. He went through severe depression nine years ago and missed eight games and 25 practices while recovering from the disease. Since that time, he has been working to spread the word through speaking engagements, and letting people know the importance of getting help. You can contact him at potterm@newmanu.edu.

Make the Experience Positive

BY BRADLEY MALDONADO

The transition from high school to college is a fragile period. The moment after a student-athlete waves goodbye to loved ones on that first day, he or she will face pressure to acclimate athletically, academically and socially.

ATHLETICALLY, most student-athletes go from being one of the best players on their high school teams to sitting on the bench that first year in college. At the same time, the commitment that being a collegiate athlete requires is twice as much as in high school. That's a daunting task and in many cases requires "the rookie" to adjust to a whole new way of life.

ACADEMICALLY, college coursework is much more rigorous than high school. Students in their first year of study will notice the difference right away. You now have less time in the classroom, but more work to complete. As such, you've got to manage your time effectively. That additional stress, compounded by the new athletics-related responsibilities, can affect your mental health.

SOCIALLY, it's the first time many student-athletes have been away from home – and home could be 10 minutes or 10 hours away. And for many, the college population is twice as large as their high school class, which means they'll expand their contacts and meet people from all different kinds of backgrounds. While that's an exciting proposition, these contrasting cultures can cause student-athletes to question aspects of their own lives.

With all of that on their shoulders, it shouldn't be a surprise that mental health issues could arise.

To cope, student-athletes rely heavily on their "support staff" to navigate the new landscape. Primary among that group is the coach. For many student-athletes, the coach is the main reason they chose to attend that school, so it's natural that in times of need – whether it's athletics, academic or social – they'll seek out the coach first.

Your coach molds you. Your coach teaches you how to confront challenges and reach your potential. Your coach becomes almost like a second parent. There must be trust and understanding between the coach and the student-athlete for the relationship to flourish. If neither is present, then problems may arise.

A disagreement about coaching philosophy can cause issues when it comes to playing time. Some student-athletes may disagree with the way the coach runs practice or training. That means good communication is vital. If the two can't be on the same page, it places additional stress on both parties in an athletics setting.

While the coach is the student-athlete's primary point

of contact, the team is the cocoon. Whether you participate in an individual sport like tennis or a team sport like soccer, you'll always be part of the greater whole known as the team.

And team dynamics play a huge role in the student-athlete experience. At its best, the team can empower you, but at its worst, the team can put you down. It all depends on the dynamic and chemistry among team members. That's a stress factor unique to athletics.

Most of the time the team offers you protection, but in cases when you're already showing signs of mental health issues, the team isn't always equipped to buffer them for you. Sometimes, in fact, the team adds to the mental health stress by encouraging or even pressuring new student-athletes to engage in behaviors that aren't in their best interests, such as alcohol and drug use. To be sure, your relationship with your teammates can influence your mental health.

Other members of a student-athlete's "support group" are the professors. Most understand the commitment that participating in athletics requires and will work with you to accommodate your practice schedule. But not all instructors are alike in this regard. That's another path student-athletes must manage, and it can cause stress if it isn't handled properly.

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Your success in this regard can vary depending on your preparedness and devotion to academics. Standards that professors set can be taxing for student-athletes who have been conditioned to ask "how high?" when told to "jump." Our competitive nature doesn't stop when we step off the field and into the classroom.

In the first part of this chapter, Aaron Taylor talked about the devastating effects of injury on a student-athlete's mental health. He is absolutely right. More than

likely, athletes have participated in their sport all their lives, and being sidelined by an injury throws off the “norm” to which they have been accustomed.

And lengthy rehabs complicate the student-athlete’s already packed schedule. We’re also aware of our teammates’ perception of whether we’re “fighting through it” enough. That can make you feel excluded from the team. The injury has already kept you from participating in something you’ve done most of your life. You don’t need the added pressure of feeling isolated.

Most of the time, the student-athlete experience is a positive one, and the “support group” works to keep it that way. In addition to coaches and teachers, athletic trainers, athletics directors and academic affairs folks are there for you as well.

But there are things you can do on your own to cope with the challenges of athletics participation and keep the mental health stressors at bay. Here’s what I do:

EXERCISE DAILY. It’s a great way to relieve pressure. Sure, you “exercise” every day in practice, but if you can develop your own routine, it gives you some time by yourself to think and stay active.

SET GOALS. As competitive people, student-athletes are most likely goal-oriented to begin with. Setting them in all aspects of your experience – whether it’s making good grades or being a starter on the team – can help you shake off the stress that comes with balancing your

athletics and academic commitments.

FIND A ROUTINE. Routine can be another safeguard for your mental health. The consistency of daily practice and class schedule often provides a support system in and of itself. Having the day planned keeps you focused and prevents the anxiety of uncertainty from creeping into your life.

BE A TEAM PLAYER. We talked about the importance of the team dynamic, so make sure you contribute to it. After all, your team is who you’ll eat, sleep, suffer and succeed with, and they’re part of your support system. Make sure they’re on your side – and that you’re there for them as well.

THERE’S MORE THAN ATHLETICS. College campuses have a bevy of people who can help you in just about any situation. Seek out academic and student affairs groups, take advantage of career counselors and mentors, find other groups that share your interests. And don’t forget your family – they can be your lifeline.

And as for my advice for the “support group” that includes coaches, athletic trainers, athletics directors and others, the most effective method to understanding what it is to be a student-athlete is to talk to the person who wears the colors of your institution. Get to know the individuals and what drives them to do what they do, and your relationship will flourish. Knowing the student-athletes will not only enrich your life but also theirs, and that connection will make a lasting impact for years to follow.



Bradley Maldonado graduated from Lincoln Memorial University after spending four years there as a cross country student-athlete. He also chaired the Division II Student-Athlete Advisory Committee in 2013-14, which is the primary student-led governance group in Division II. Maldonado garnered all-Southeast Region honors following a 22nd-place finish in the 2012 NCAA Division II Southeast Regional. He was also a first-team all-South Atlantic Conference honoree after a sixth-place finish in the 2012 SAC championship.

Solving the Mental Health Puzzle

BY RACHEL SHARPE

I know the story of a talented young football player who played at South Carolina right before I got here. After an outstanding college career, he was selected in the fifth round of the NFL draft. In just his second year as a pro, though, he was sidelined with two knee injuries in eight months.

While recovering from his second surgery, he returned to his alma mater for a game and stood waving from the field to all his college fans. The infectious smile on his face is a lasting but misleading image for many, as only a few days later he was found dead in his apartment from a self-inflicted gunshot wound. The ensuing investigation led authorities to believe that the athlete felt so overwhelmed by an enormous gambling debt and the need to provide for his 1-year-old son that he believed suicide was the only option.

For weeks, I watched this young man's former teammates and friends mourn his loss, and I experienced for the first time the immediate reality and consequences of mental health issues in athletes. Even during the time it took for me to write this article, one of my former student-athletes attempted to take his own life, further emphasizing that student-athlete mental health needs to be addressed.

Mental health in intercollegiate athletics is a large and complicated puzzle. While athletic trainers (ATs) are only one piece of that puzzle, we're a pretty vital one. We are hired as athletics departments' primary medical professionals, but along the way we find ourselves as confidants, motivators, encouragers and even friends to the hundreds of student-athletes we serve. ATs in fact interact with student-athletes about as often or sometimes even more than anyone else on campus, except perhaps their teammates.

That leads to a unique level of trust. Athletic training rooms are similar to locker rooms – they're a place of comfort and camaraderie. Here, players let their guards down, and for a brief time they're not worried about impressing their coaches, performing for their teachers or obligingly smiling for their fans. Such close interaction allows us to notice subtle changes in student-athletes' behavior. And as Aaron Taylor said in the first article of this chapter, it's our responsibility to help establish the locker room as a safe place.

As a member of the team dedicated to student-athlete wellness, it also is our responsibility to keep our eyes and ears open for conversations or changes in behavior suggesting that a deeper mental or emotional issue may be present.

Helping student-athletes maintain their mental health is part of our job, but it's a complex task filled with speed bumps along the way.

Speed Bump No. 1

Connecting at-risk student-athletes with the right people who can help

It's hard to design a template or referral approach that fits a diverse NCAA membership ranging from larger institutions with an army of support staff and resources to smaller schools with limits in both. Some schools – even some athletics departments – retain mental health professionals on campus, while others provide expertise through the campus health system or community. And while some schools' athletic training structures allow referrals to come directly from the AT, others prefer the team physician as the tip of the funnel. These various scenarios – as well as the lack of a model structure and the fact that not all schools have access to the same resources – can make efficient and timely referrals difficult.

Speed Bump No. 2

The atmosphere surrounding athletics

The very culture of athletics tends to discourage athletes from expressing any kind of mental health issue, since it is often construed as a weakness. Miami-based sports reporter Dan Le Batard noted, "Outside of the military, there may be no workplace less conducive to treating mental illness than sports. The culture works against someone who has the misfortune of being combustible in any way. ... Explanations are excuses, and feelings aren't explored amid all the testosterone. Sensitive equals soft. Asking for help is viewed as weakness."

A large part of the mental health battle is creating an environment that counteracts this stigma. But it's no wonder that athletes have an incentive – often a financial one – to mask their issues. Take basketball player Royce White, for example. The Iowa State product slipped down the first round of the 2012 NBA draft because of a well-publicized anxiety disorder. Royce himself told Huffington Post Live host Marc Lamont Hill that NBA higher-ups wanted him gone, "because business is about convenience, not about doing what's necessary. It's about cutting overhead. ... And a lot of times, what's best for us as human beings doesn't meet the criteria for business people."

With stories like this, can we blame our student-athletes for not disclosing their issues and concerns?

Speed Bump No. 3

Once there is disclosure, who needs to know?

Who all needs to know if a student-athlete is experiencing a mental health issue, and to what extent? Coaches, parents, the AT, the team physician, and in some cases the psychologist, are all involved in the student-athlete's life, but is it necessary for all of them to know? What about patient confidentiality – or the notion that knowledge of a mental issue could affect playing time?

ATs are the medical liaisons for our team, so should we know? And if so, how much information should we share with the coaches?

Speed Bump No. 4

The hidden risks

It's hard to convince people of a potential problem when they can't see it. Mental health issues do not present with swelling, bruising, obvious pain or other evidence that accompanies physical injuries. You just have to trust the word of the student-athlete in this case.

Hopefully, the current conversation surrounding concussions will help. Although not overtly visible, recent research on concussions continues to show that they are definitely worth our attention.

So, how best to navigate all these speed bumps?

First, we need to start the conversation. Mental health has a tendency to be overlooked in the student-athlete's total wellness package. Let's do our part

to change this. Begin with a discussion among your own medical staff. How are you currently meeting your student-athletes' mental health needs? Is your referral structure adequate and efficient? What resources are available to you?

We can also initiate these conversations with our colleagues and within our professional organizations. Determine ways to make the topic more comfortable in conversation with, around and among our student-athletes. What role can we play in changing the negative attitude associated with mental health issues?

Also, we need to look at our individual institutions and how we handle mental health concerns. Have you evaluated the resources available at your institution or within the local community? It is important to identify a licensed mental health professional, and then determine who else should be a part of your mental health team.

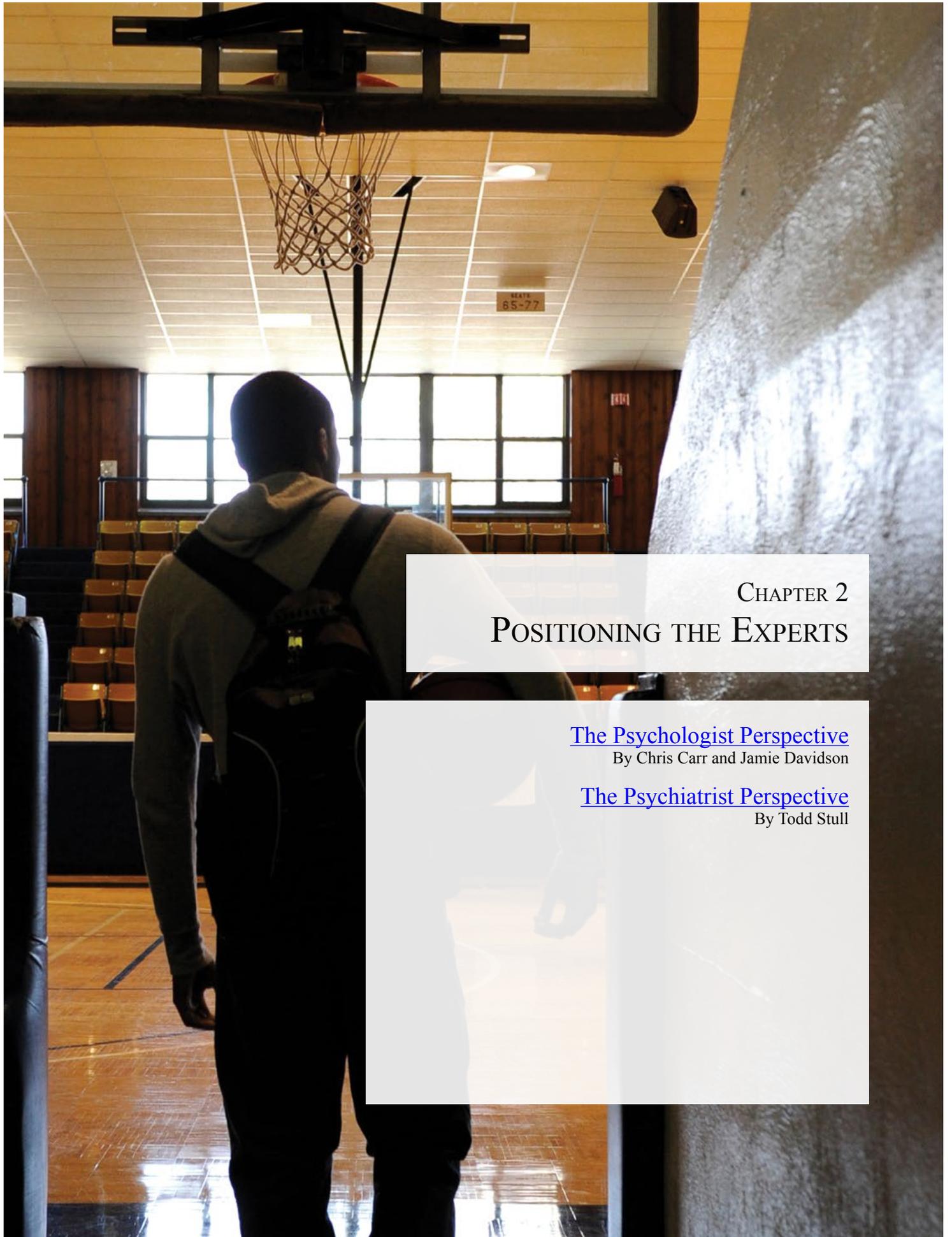
And finally, let's continue to encourage more research in this area. It's a great opportunity to facilitate studies concerning the effect of injury on a student-athlete's mental health state. Mental health inventories could be included in a student-athlete's pre-participation exam to obtain a baseline and address any initial issues when the student-athlete arrives on campus.

ATs have a responsibility to fulfill our role and affix our piece in the mental health puzzle. There is still much that needs to be decided and discovered, but someone has to initiate the conversation.

Why not us?



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CHAPTER 2
POSITIONING THE EXPERTS

[The Psychologist Perspective](#)

By Chris Carr and Jamie Davidson

[The Psychiatrist Perspective](#)

By Todd Stull

The Psychologist Perspective

BY CHRIS CARR AND JAMIE DAVIDSON

Intercollegiate athletics embodies a unique and demanding culture. The pressures and demands on 18- to 21-year-old student-athletes are great. Their wins and losses are seen by many, questioned by many, and often criticized publicly.

Even within the athletics environment, student-athletes' time demands are enormous – daily practices, competitions that may involve travel (some across time zones), a full academic course load, strength and conditioning programs, and sports medicine/rehab appointments present a demanding schedule indeed. Social interactions and relationships often take a back seat to the athletically related challenges and commitments.

It is no surprise that these pressures can affect a student-athlete's mental health. A well-trained psychologist with expertise in sport psychology is an ideal resource to provide care and services. But over the past 20 years, the sports psychologist's role in college sports has evolved more slowly than student-athletes' needs.

The ways colleges and universities use sport psychologists also vary, often depending on resources and how well the athletics department understands how to incorporate these services.

The following explains both the challenges related to the integration of sport psychologists within college athletics, and the models schools currently use when they do take advantage of such expertise.

* * * *

First, here are the challenges related to the slow growth of psychologists in the arena of student-athlete mental health care.

THE ONGOING “STIGMA” WITHIN THE SPORT CONTEXT. Student-athletes, coaches and staff tend to minimize mental disorders or psychological distress because of the expectations of strength, stability and “mental toughness” inherent in the sports culture. As a result, student-athletes often avoid disclosing a mental health concern, especially if the perceived negative consequence includes being rejected by teammates or coaches due to the disclosure. In many ways, this stigma further exacerbates the problem of student-athlete mental health as it inhibits effective dialogue, education and development of resources to address these issues.

ONCE A MENTAL HEALTH ISSUE IS IDENTIFIED, RESOURCES MAY BE LIMITED OR DIFFICULT TO ACCESS. As sports medicine and athletic training have

evolved, it is now common for a Division I athletics department to employ four or more full-time certified athletic trainers. Some schools even have in-house sports medicine physicians specifically providing medical care for student-athletes. Additionally, more and more athletics departments employ registered dietitians/sport nutritionists to provide optimal nutritional care for their athletes. However, not many programs employ full-time or even part-time licensed psychologists. Instead, they

Student-athletes often avoid disclosing a mental health concern, especially if the perceived negative consequence includes being rejected by teammates or coaches due to the disclosure.

depend on campus resources such as student counseling centers to refer for mental health issues. The problem there is that few student counseling centers employ a psychologist who has the training/education to address student-athletes' unique psychological needs.

THE ISSUE OF “SPORT” PSYCHOLOGY VS. “CLINICAL/COUNSELING” PSYCHOLOGY IS OFTEN CONFUSING TO ATHLETICS DEPARTMENT PERSONNEL.

In most of the 50 states, if not all, the term “psychologist” (in any form) is protected as a licensed profession. If professionals identify themselves as “sport psychologists,” then they should be able to produce their license number within their state of practice. The “sport” designation, for those licensed psychologists, should denote a competency in their training. Competency, as defined in most states, includes academic preparation, training, supervision and experience within a specific domain (for example, child psychology, forensic psychology). Therefore, a licensed psychologist identifying as a “sport psychologist” should also be able to demonstrate training (such as graduate coursework, or perhaps a master's degree in physical education and ongoing supervised experiences) in sport psychology. Further clarifying this distinction in training and competency is a key element in enhancing the ongoing development of providers for collegiate student-athletes.

THE COMPETENCY OF LICENSED MENTAL HEALTH PROVIDERS/PSYCHOLOGISTS TO UNDERSTAND THE UNIQUE NATURE OF THE COLLEGIATE ATHLETICS ENVIRONMENT.

Whether it be a Division I, II or III athletics department, it is important for the provider to understand the culture of the athletics environment to best understand the external stressors, motivations and dynamics (team, for example) within that athletics environment. This often requires that a licensed provider have previous experience as perhaps a student-athlete or coach, or a prior role within an athletics department (like an academic adviser), or have supervised experience during their training (for example, as a pre-doctoral intern with a rotation in sport psychology/athletics). This immersive experience offers observational and experiential learning opportunities for the psychologist, which builds competency to provide care for the athlete.

LACK OF TRAINING MODELS FOR PSYCHOLOGISTS AND MENTAL HEALTH PROVIDERS IN THE DOMAIN OF SPORT AND PERFORMANCE PSYCHOLOGY.

As the role of psychologists within collegiate athletics has increased, it is important to note that many clinical/counseling psychology programs do not typically offer graduate coursework in the domain of sport and performance psychology. However, a few programs train students to be doctoral-level psychologists and provide graduate training/experience in the domain of sport psychology (the University of North Texas and Indiana University, Bloomington, do so, for example, both in counseling psychology).

PROFESSIONAL “CONTAMINATION” AND DISRUPTION OF CURRENT SERVICES.

Because collegiate athletics continues to focus on concepts such as “performance excellence” and “mental toughness,” the realm of “motivational gurus” and “mental coaches” finds college athletics a prime target for their services, and they may very well ignore, minimize or neglect the real issues of psychological health. Individuals not trained in mental health/psychology often say they will refer any athlete with a personal issue, but if they are not trained in diagnostic interviewing, then they are not likely to identify potential issues. Thus, the athletics administrator must struggle with the challenge of providing effective mental health services for student-athletes, as well as providing a resource to teach coaches and student-athletes psychological skills to enhance sports performance. Competent and well-trained licensed psychologists can often provide *both* services within a collegiate athletics department. They also may be able to supervise and coordi-

nate an effective “sport psychology team” for both performance and personal counseling services.

* * * *

With those challenges as a backdrop, here are the models college athletics departments currently use to provide student-athlete mental health services. The depth and breadth of these models of course depend on the commitment of the athletics administration, sports medicine, academic services, compliance and coaching staffs to optimize psychological resources for their student-athletes.

The most common models include:

FULL-TIME ATHLETICS DEPARTMENT SPORT PSYCHOLOGIST. This position is typically held by a licensed counseling/clinical psychologist with graduate training (often a master’s degree) in physical education/sport psychology. The sport psychologist usually provides:

- Individual counseling for student-athletes (mental health concerns such as anxiety disorders, mood disorders, and performance-related counseling

Because collegiate athletics continues to focus on concepts such as “performance excellence” and “mental toughness,” the realm of “motivational gurus” and “mental coaches” finds college athletics a prime target for their services, and they may very well ignore, minimize or neglect the real issues of psychological health.

for issues related to performance anxiety and confidence issues);

- Coordination of substance abuse/eating disorder services for student-athletes (often being involved with NCAA and institutional drug-testing referrals); team consultations for both clinical (for example, grief counseling) and performance

(for example, team-building) issues;

- Staff education and consultation; and
- Consultation with athletics administrators on psychological care issues within the athletics department (for example, establishing postgraduate support programs for former student-athletes).

These positions are typically housed in the athletics department, either within sports medicine, academic services or an office affiliated with athletics.

Schools that have incorporated this model include Oklahoma, Virginia, Ohio State, Virginia Tech, Arizona, Southern California, Washington, Iowa, Arkansas, LSU, Missouri, Kansas and New Mexico.

PART-TIME CONSULTATION MODEL. Some athletics departments retain external consultants or counseling center staff psychologists who are given time to work within the athletics department. These people typically provide the same services as their full-time counterparts, though with less time per week (about 10-30 hours as opposed to 40-50), there is less service provision.

Athletics departments wanting to develop sport psychology/psychological care for their student-athletes but do not have the budget to develop a full-time position with benefits often choose this model. It's economically more efficient and allows an athletics department with limited funds or resources to provide "in-house" services for their student-athletes.

A skilled provider on a part-time consulting contract may also be able to coordinate a sport psychology services "program" that identifies specific individuals (for example, substance abuse counselor at counseling center, mental skills consultant in physical education department) to be part of the team that the primary consultant coordinates, supervises and directs.

Most of these providers have an office within athletics to provide the services, and the department often will market this position within its department website/directory.

Among schools incorporating this model include Purdue, Wisconsin, Stanford, Oregon State, Minnesota, Nevada, Maryland and Oklahoma State.

REFERRAL MODEL OF SERVICES. This model does not employ or retain an "in-house" provider; rather, it identifies a specific provider within the community or counseling center that will take referrals for student-athlete psychological issues.

This model tends to be more of an "intervention" (rather than prevention/education), as the student-athlete

often has to present with psychological distress or self-referral in order to access this system.

The provider typically does not have an "in-house" office, so the student-athlete is referred to the provider's office for services. This is not an immersive model of care, but rather a "referral" model in which the athletics department can indicate that it provides services, but only through external referral. (For more on how to make the referral model effective, see Chris Klenck's article in Chapter 6.)

* * * *

So, which of these models is the best fit? It is important that schools explore all the options for a psychological services model for their student-athletes.

Clearly, an immersed program with full-time or part-time licensed psychologists allows for better service, communication and delivery of services. Having an immersed sport psychologist allows the athletics department to best address the variety of psychological issues (individual, team, staff) that may be present. Providing a psychologist as part of the support staff also helps to de-stigmatize and normalize the issues related to student-athlete mental health.

Just as having a full-time sports medicine physician and athletic training staff does not eliminate musculoskeletal injuries, having an immersed full-time/part-time sport psychologist will not eliminate mental health issues. However, as sports medicine care has greatly enhanced prevention, intervention and rehabilitation of athletics injuries, an immersed and comprehensive sport psychology program can enhance the prevention, intervention/counseling and care of student-athlete mental health/psychological issues.

A key element in improving student-athletes' emotional well-being is to establish a strong working alliance with the university counseling center, regardless of whether an athletics department has the services of a sport psychologist available.

University counseling centers offer unique services and benefits to student-athletes, including professionals who are highly skilled in treating the mental health concerns common to college students and who are of diverse backgrounds and embrace all walks of life. Counseling centers also offer student-athletes a high level of confidentiality.

To properly address student-athletes' psychological

concerns, it is best to incorporate the services of a sport psychologist into your mental health team. Student-athletes will reap the benefit of this collaboration through improved emotional well-being.

The good news in all of this is that the role of the licensed counseling/clinical psychologist in the mental health care of collegiate student-athletes continues to evolve in a positive direction.

As more athletics departments create sport psychologist positions (either full-time or part-time) that are immersed within the department, there will be greater education opportunities, greater awareness of student-athlete mental health concerns, greater opportunities for coaches/staff to have positive interactions with psychologists, and greater training opportunities in the future for aspiring psychologists who desire to work with athletes as clients.



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Jamie Davidson is a licensed psychologist with more than 20 years of clinical practice in higher education. He serves as the associate vice president for student wellness at the University of Nevada, Las Vegas, after having previously been the director of student counseling and psychological services there. Under Davidson's leadership, the UNLV student wellness center has received national and regional awards for innovation and excellence in the delivery of integrated medical and mental health services. Most recently, UNLV was one of only 30 universities in the country to receive an award for providing comprehensive mental health services and suicide prevention programming from the Jed Foundation.

The Psychiatrist Perspective

BY TODD STULL

Many changes are taking place in our culture that influence the mental and emotional well-being of today's student-athletes. The pressure associated with student-athletes' daily routine can create intense emotional responses. The time, energy and effort put into developing skills in a given sport can result in imbalances in other areas of life. Developmental and environmental influences shape emotional, motor and social aspects of the brain. Eating patterns, impulse control and interpersonal relationships are also affected.

The psychiatrist's role in working with student-athletes is to optimize health, improve athletics performance and manage psychiatric symptoms while operating within an interdisciplinary team.

While many colleges and universities have employed sport psychologists – or at least have access to such services – to help student-athletes navigate their unique stressors, it's also helpful from a psychiatrist perspective to describe factors contributing to adolescent brain development and mental health and substance problems in today's student-athletes.

The psychiatrist's role in working with student-athletes is to optimize health, improve athletics performance and manage psychiatric symptoms while operating within an interdisciplinary team. Medical problems and substance-induced conditions need to be ruled out before the psychiatric diagnoses are made.

The most common psychiatric disorders in student-athletes are represented in the following categories:

- Anxiety disorders
- Mood disorders
- Personality disorders
- Attention deficit hyperactivity disorder
- Eating disorders
- Body dysmorphic disorder
- Adjustment disorders
- Substance use disorders
- Impulse control disorders
- Psychosomatic illnesses

ANXIETY DISORDERS are among the most common psychiatric problems in student-athletes. Performance anxiety, panic disorder and phobic anxiety after an injury are more likely to be sports-related. Generalized anxiety disorder and obsessive-compulsive disorder are less likely to be sports-related but are still common.

Many athletes can experience anxiety that is either related to a medical problem or induced by a medical problem or substance use. The typical presentation is with physical symptoms and the psychological symptoms of worry and obsession. Feeling "overwhelmed" or "stressed" are frequent terms used at the time of presentation.

Performance anxiety is connected to the anticipation of the act and becoming overwhelmed during specific components of performance. Panic attacks are intense feelings of being overwhelmed with many physical symptoms such as racing heart, shortness of breath, shakiness and sweating that surface quickly. Phobias may be related to an injury, recovery and return to play.

Generalized anxiety disorder often presents with excessive worry or apprehension that is difficult to control. Obsessive-compulsive disorder presents with intrusive ideas, thoughts, urges or images that come into one's mind with a ritualized behavior to try to undo or dissipate the obsession.

MOOD DISORDERS include major depressive disorder (clinical depression), bipolar disorder, substance-induced depression (such as alcohol) and a mood disorder secondary to a medical problem (for example, thyroid disorder).

Fifteen to 20 percent of the population will suffer an episode of depression in their lifetime, and it is among the most common conditions a sports psychiatrist will treat.

The average age for onset of depression is approximately 22, but it is decreasing. Symptoms of depression include depressed mood, loss of interest, sleep and energy disturbance, appetite and weight changes and impaired concentration. Anxiety is a common symptom. A low frustration tolerance, isolation from teammates and lack of enjoyment with deterioration in performance is a part of the presentation with depression as well. Males are more likely to present with anger and excessive alcohol use.

To meet the diagnosis of bipolar disorder, an individual must have had some degree of mania in his/her life. Initial presentation for bipolar is an episode of depression. Other defining features of bipolar disorder include a strong family history of a mood disorder, chronic sleep

problems, irritability, erratic performance, stormy relationships and impulsivity. A substance use disorder commonly co-occurs with bipolar disorder.

PERSONALITY DISORDERS are fairly common in athletes. The most common personality traits in student-athletes associated with performance are extraversion, perfectionism and narcissism. Individuals with personality disorders experience interpersonal difficulties, impulse control problems, misperception of comments or situations and affective instability. Individuals with personality disorders have maladaptive coping skills.

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) is common in athletes and presents with problems focusing, concentrating, learning, attention shifting and sustained attention. ADHD is probably the most common psychiatric condition that sport psychiatrists treat. Males tend to be more hyperactive. Females more likely will have the inattentive type.

The number of student-athletes with ADHD appears to be increasing and may be related to the influences of social media and a rewiring of the brain. This condition carries over into adulthood in about half of the cases. The symptoms can change with age and can be temporary.

The severity of the symptoms can result in limitations in a number of areas of life and result in performance slumps or interpersonal conflict. Males often present with denial, while females present tired and exhausted.

EATING DISORDERS occur in both sexes but are more common in females, and in sports in which lower body weight/fat improves performance or weight is divided into classes. The triad of impaired eating, amenorrhea and osteoporosis are the classic features in females.

Full-symptom presentation usually occurs as the eating disorder progresses; however, disordered eating is more common at presentation. As the condition worsens, more impairment occurs. Individuals affected with eating disorders have decreased energy and a special relationship with food.

Eating disorders are more common in gymnastics and swimming/diving, which are judged on aesthetics, and in wrestling, cross country and distance running. Eating disorders can be life-threatening, especially anorexia nervosa.

BODY DYSMORPHIC DISORDER is a preoccupation with an imagined defect in appearance that causes distress. It is more common in males. Muscle dysmorphia is a subtype that is characterized by an unhealthy preoccupation with muscularity, mirror checking and dieting. Student-ath-

letes in sports in which large physical size and physique are emphasized are more susceptible to the disorder.

ADJUSTMENT DISORDERS are emotional and behavioral responses to a perceived stressful situation that exceeds the athlete's ability to adapt. The most common emotions are anger, anxiety, sadness and guilt. The most common behaviors include aggression, arrests, insomnia, social isolation, substance use, relationship conflicts, quitting and poor performance.

SUBSTANCE USE DISORDERS in student-athletes are different than in the general population. Student-athletes most commonly use alcohol, marijuana, opiates, stimulants (such as Adderall), caffeine, tobacco and performance enhancers.

Alcohol and drug use is more common in males and more common in the offseason for all student-athletes. Some of the consequences related to substance use include academic problems, vandalism, assault, injury, driving under the influence, sleep deprivation, sexual abuse and, in severe cases, death.

The brain pathways involved can be reinforced from use and create fundamental changes in the brain. Over time, the effects can hijack the brain. Alcohol and drug use commonly co-occur with mental health problems. Since alcohol is difficult to detect on a drug screen, the effects of alcohol often present with performance problems. Cannabis can be perceived as "safe," but is detectable for longer periods of time on a drug screen.

Stimulant use [for example, amphetamine/dextroamphetamine (Adderall), methylphenidate (Concerta and Ritalin)] is an increasing problem for student-athletes, especially since they are used for a number of non-medical reasons. Student-athletes who begin using an opiate [for example, hydrocodone (Vicodin), oxycodone (Percocet and Oxycontin)] may continue to use it after their medical problems have been resolved.

IMPULSE CONTROL PROBLEMS can manifest in erratic behavior and performance. An individual who suffers from an impulse control problem might exhibit episodes of aggression, fighting, and risky sexual behavior.

PSYCHOSOMATIC ILLNESSES and presentations include pain without supporting evidence, prolonged recovery from injury, frequent injuries and performance problems. Symptoms are often manifestations of an emotional issue and occur more commonly in collision sports.

Individuals with pain are at increased risk for de-

pression, post-traumatic stress disorder, substance use problems and adjustment reactions. A serious injury that leads to chronic functional impairment (or pain) in a student-athlete may manifest as a psychosomatic condition.

In addition to all of these, pain presents another challenge with today's student-athletes. There may be pressure to play through the pain for fear of loss of a position or status. An athlete who is injured may experience a loss of identity.

Pain, injury and recovery, sleep, traumatic brain injury, suicidal ideation, transition and ending one's athletics career bring challenges that have multiple associations to physical health, mental health and emotional well-being and substance use.

Over-training can look like clinical depression. Sleep disturbances are associated with decreased performance and mental health problems (like depression and ADHD).

Suicide presents another challenge and often is a part

of a psychiatric illness with a strong connection to substance use, mental illness and perfectionism. Many warning signs emerge before suicide attempts that are often missed. More than two-thirds will have alcohol in their system at the time of the suicide attempt.

The challenge for any athletics department is to be aware of mental health issues and be trained to spot them when they emerge. Emotional well-being is important to any athlete's success academically, athletically, socially and spiritually. Untreated mental health problems result in undue suffering, diminished positive affect and balance in life.

Most psychiatric disorders in student-athletes improve and resolve with proper treatment. Early recognition is important to shorten the time between illness onset and treatment, thus improving the mental health and emotional well-being for our student-athletes.



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CHAPTER 3
DISSECTING THE DISORDERS

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Eating Disorders

BY RON THOMPSON

Participation in sports has a number of positive effects on student-athletes. They tend to live healthier lives than non-athletes, and they gain skills in teamwork, discipline and decision-making that their non-athlete peers may not.

However, some aspects of the sports environment can increase the risk of disordered eating (and eating disorders). That means student-athletes and those who oversee athletics must be vigilant to detect signs of trouble.

Disordered eating and eating disorders are related but not always the same. All eating disorders involve disordered eating, but not all disordered eating meets diagnostic criteria for an eating disorder.

As first conceived, the term “disordered eating” was a component of the female athlete triad – a syndrome that also includes decreased bone mineral density and osteoporosis – and defined as “a wide spectrum of harmful and often ineffective eating behaviors used in attempts to lose weight or attain a lean appearance.” The term was later supplanted by “low energy availability” to reflect the role insufficient energy plays in accounting for all physical activity, as well as to fuel normal bodily processes of health, growth and development.

Eating disorders are not simply disorders of eating, but rather conditions characterized by a persistent disturbance of eating or an eating-related behavior that significantly impairs physical health or psychosocial functioning. The eating disorders most often diagnosed are:

ANOREXIA NERVOSA is characterized by persistent caloric intake restriction, fear of gaining weight/becoming fat, persistent behavior impeding weight gain, and a disturbance in perceived weight or shape.

BULIMIA NERVOSA is recurrent binge eating, recurrent inappropriate compensatory behaviors to prevent weight gain (for example, induced vomiting and excessive exercise), and self-evaluation unduly influenced by shape and weight.

BINGE-EATING DISORDER is recurrent episodes of binge eating without compensatory behaviors but with marked distress with the binge eating.

Why student-athletes are at risk

PREVALENCE. Eating disorders occur in all sports, but not equally in all sports. As in society, eating disorders in sport occur more frequently in females than males. One area in which research findings are more definitive is for “lean” sports for which a thin/lean body or low weight is believed to provide a biomechanical advantage in performance or in the judging of performance. Women in these sports are considered to be at the highest risk.

GENETICS. Epidemiological and molecular genetics studies suggest a strong genetic predisposition to develop an eating disorder, and that these disorders aggregate in families in part due to genetics. Family and twin studies have found heritability estimates of 76 percent for anorexia nervosa and 83 percent for bulimia nervosa. Not all individuals with a genetic predisposition develop the disorder, as other factors are involved.

SOCIOCULTURAL FACTORS. Before genetics-related findings, the primary explanation for the development of eating disorders involved sociocultural factors. Certainly, from a sociocultural perspective, most individuals are exposed to societal or cultural pressures regarding weight or appearance, but again, not all will develop an eating disorder. Most who do are female, and the disorder’s onset often occurs during adolescence.

A simple conceptualization is that genetics sets the stage for the disorder, but sociocultural pressures can precipitate it. Once the disorder begins, sociocultural pressures usually assist in maintaining the disorder. Also, from a sociocultural perspective, eating problems can begin or worsen during transition periods, which makes freshman student-athletes particularly vulnerable.

PHYSICAL/MEDICAL SIGNS AND SYMPTOMS

- Amenorrhea
- Dehydration
- Gastrointestinal problems
- Hypothermia (cold intolerance)
- Stress fractures (and overuse injuries)
- Significant weight loss
- Muscle cramps, weakness or fatigue
- Dental and gum problems

PSYCHOLOGICAL/BEHAVIORAL SIGNS AND SYMPTOMS

- Anxiety and/or depression
- Claims of “feeling fat” despite being thin
- Excessive exercise
- Excessive use of restroom
- Difficulty concentrating
- Preoccupation with weight and eating
- Avoidance of eating and eating situations
- Use of laxatives and diet pills

Treatment professionals working with student-athletes need experience and expertise in treating eating disorders and athletes, but more importantly need to understand and appreciate the importance of sport in the life of a serious student-athlete.

Additionally, student-athletes may experience more stress than non-athletes because they deal not only with the transition away from home and pressures related to academic demands of college but also the pressures associated with sport participation. Eating problems are often the way individuals deal with such stressors.

SPORT-RELATED FACTORS. Just as society and culture emphasize the “thin ideal,” similar pressures exist in the sport environment regarding being thin/lean and its purported positive effect on sport performance.

This emphasis on reducing body weight/fat to enhance sport performance can result in weight pressures on the student-athlete from coaches (or even teammates) that increase the risk of restrictive dieting, as well as the use of pathogenic weight loss methods and disordered eating. Even the student-athlete’s perception that her coach thinks she needs to lose weight can heighten weight pressures and increase the risk of disordered eating.

For some student-athletes, revealing uniforms can increase body consciousness, body dissatisfaction, and the use of pathogenic weight loss methods. One study found that 45 percent of swimmers surveyed reported a revealing swimsuit as a stressor. Another study in volleyball found not only that revealing uniforms contributed to decreased body esteem but also distracted players and negatively affected sport performance.

The relationship between body image and body dissatisfaction in female student-athletes is more conflicted and confused than in the general population. Sportswomen have two body images – one within sport and one outside of sport, and disordered eating or an eating disorder can occur in either context or both. Additionally, some female student-athletes are conflicted about having a muscular body that facilitates sport performance but may not conform to the socially desired body type and may be perceived as being too muscular when compared to societal norms regarding femininity.

Coaches have considerable influence with their athletes,

RISK FACTORS IN THE SPORT ENVIRONMENT

- Sport body stereotypes and belief that losing weight will increase sport performance
- Pressure (real or perceived) from coaches and others to lose weight
- Observed eating and exercise behaviors of teammates and competitors
- Revealing uniforms
- Similarity between “good athlete” traits and symptoms of disordered eating
- Presumption of health based on good performance

and it appears that their relationship with their student-athletes – and more specifically their motivational climate – can influence the risk of disordered eating. A relationship between coach and athlete characterized by high conflict and low support has been associated with increased eating pathology among athletes. Additionally, an ego/performance-centered motivational climate (vs. a skills-mastery climate) that some coaches use has been associated with an increased risk of disordered eating.

Another risk to student-athletes relates to aspects of the sport environment that make identification of disordered eating/eating disorders more difficult. In society and sport, athletes are often expected to display a particular body size or shape that becomes characteristic of a particular sport, such as distance runners being thin. Such “sport body stereotypes” can affect coaches’ perceptions of athletes, and athletes who fit the “thin” stereotype are less apt to be identified as having an eating problem. Identification by coaches is sometimes influenced by sport performance, and student-athletes are less likely to be identified if their sport performance is good.

Finally, eating disorder symptoms (such as dieting, weight loss and excessive training) may be misperceived as “normal” or even desirable in the sport environment, and

HEALTH CONSEQUENCES

- Purging behaviors that cause electrolyte imbalances with possible irregular heartbeats and heart failure
- Premature osteoporosis
- Peptic ulcers, pancreatitis and gastric rupture

PERFORMANCE CONSEQUENCES

- Restricting carbohydrates can lead to glycogen depletion, forcing the body to compensate by converting protein into a less efficient form of energy and increasing the risk of muscle injury and weakness.
- Intense dieting can negatively affect VO₂ max and running speed for some student-athletes.
- Because of inadequate nutrition, student-athletes with eating disorders tend to be malnourished, dehydrated, depressed, anxious and obsessed with eating, food and weight. These problems decrease concentration and the capacity to manage emotions.
- Behaviors such as vomiting, excessive exercise and restricting carbohydrates often lead to dehydration, which can compromise performance.
- Male and female student-athletes who are inadequately fueling their bodies may experience hormonal disruptions that lead to compromised bone density and increased risk of bone injuries, including stress fractures.

For more information, visit
<http://bjsm.bmj.com/content/48/7/491.full>

personality characteristics/behaviors similar to those of eating disorder patients (such as perfectionism and excessive training) may be misperceived as “good athlete” traits.

TREATMENT. As a special subpopulation of eating-disorder patients, student-athletes need specialized approaches to treatment. However, treatment per se is not different; that is, standard treatment approaches (such as cognitive behavioral therapy) work as well for athletes as for non-athletes.

Recommended treatment differences relate to treatment staff. Treatment professionals working with student-athletes need experience and expertise in treating eating disorders and athletes, but more importantly need to understand and appreciate the importance of sport in the life of a serious student-athlete.

WHAT CAN COACHES AND ATHLETIC TRAINERS DO?

- De-emphasize weight: Be aware of how you are communicating to athletes about weight and performance. Focus on ways for athletes to enhance their performance that don't involve weight (e.g., strength training and mental/emotional skills).
- Keep an open dialogue with athletes about the importance of nutrition and staying injury-free for optimal athletics performance.
- Recognize that the body composition and training required for optimal health and performance are not identical for all athletes.
- Screen student-athletes before the start of the season for risk factors of disordered eating.
- Ensure that all stakeholders (coaches, athletic trainers and athletes) are educated about the factors that put athletes at risk for disordered eating.
- Develop a plan with other stakeholders (university counseling services, sports dietitians) for how to identify and treat athletes with eating disorders.

Student-athletes often resist treatment for the same reasons as non-athletes but also for additional ones related to sport. Some resist because they assume they will gain so much weight that it will negatively affect sport performance. They may resist due to a concern that having a mental health problem will result in a loss of status or playing time. Some fear that being in treatment for a mental health problem will displease significant others (like family, coaches and teammates).

Also, student-athletes sometimes resist treatment because they fear their treating professional(s) will not value the importance of sport in their lives. Given these common reasons to resist treatment, motivation for treatment and recovery is particularly important. Regarding treatment motivation, research investigating factors that facilitated student-athletes' recovery from their eating disorder found the desire to be healthy enough to perform in sport to be most helpful.

Where do we go from here?

Given the prevalence of eating disorders in the college and sport populations, athletics departments are encouraged to develop a treatment protocol for student-athletes with eating disorders. Included in that protocol should be guidelines regarding how affected student-athletes are identified, managed and referred for evaluation and treatment by sport personnel. Sport personnel charged with

these responsibilities should be trained by health care professionals with experience and expertise regarding student-athletes and eating disorders.

The protocol should also include recommendations regarding education for both student-athletes and sport personnel. Education is the first step in prevention, but more is needed in the form of a program designed to change student-athletes' attitudes and behaviors that are associated with disordered eating/eating disorders. Some NCAA schools already employ such a program.

Early identification of "at risk" and affected student-athletes is most important. Eating disorders can be more easily treated early in the process. More importantly, timely and appropriate treatment can prevent medical and psychological complications of these disorders, thereby decreasing the risk to the student-athlete and decreasing time away from sport.

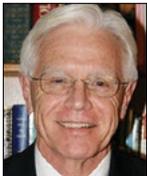
Coaches and other sport personnel are encouraged to improve their identification skills, as well as their skills in making an appropriate referral for an evaluation and treatment. Such training can be made available to coaches, athletic trainers and other sport personnel, and can be endorsed and strongly recommended by sport administrators. Such training opportunities are even more important for smaller colleges that may have fewer treatment options available on campus.

QUESTIONS FOR REFLECTION

1. Do you have a sense how to identify when a student-athlete is engaged in disordered eating?
2. Do you feel comfortable talking to student-athletes about weight and body composition?
3. Do you emphasize the importance of sound nutrition for optimal performance?
4. Do you communicate with other stakeholders about prevention, detection and treatment of disordered eating?
5. Do you know how to make a referral for a student-athlete with disordered eating?

The primary risk for developing disordered eating/eating disorders involves the emphasis on a lean body and its purported relationship with enhanced sport performance. Coaches and others in the sport environment are urged to recognize that such an emphasis on weight or leanness puts the student-athlete at greatest risk for developing eating problems.

Finally, the stigma associated with seeking mental health treatment must be eliminated. Those with influence in the sport environment can play a key role by recommending and encouraging timely and appropriate mental health treatment for their student-athletes.



Ron Thompson is a consulting psychologist for the Indiana University department of athletics and co-director of the Victory Program at McCallum Place, which offers a specialized eating disorder treatment staff to meet the unique needs of athletes. Thompson has served as a consultant on eating disorders to the NCAA and on the Female Athlete Triad with the International Olympic Committee Medical Commission. He can be reached at rthomps2@sbcglobal.net.

Anxiety Disorders

BY SCOTT GOLDMAN

As a licensed psychologist working in a number of sports at the collegiate level, I've had the opportunity to interact with all kinds of student-athletes, many of whom have experienced anxiety that has affected their personal lives, their academic efforts and their athletics performance.

This is not an uncommon experience. Nearly one in three adolescents in the United States (31.9 percent) meet criteria for an anxiety disorder. Of those, half begin experiencing their anxiety disorder by age 6. NCAA research shows that almost 85 percent of certified athletic trainers believe anxiety disorders are currently an issue with student-athletes on their campus.

Signs and symptoms of an anxiety disorder can include the following:

- Feeling apprehensive
- Feeling powerless
- Having a sense of impending danger, panic or doom
- Having an increased heart rate
- Breathing rapidly
- Sweating
- Trembling
- Feeling weak or tired

While everybody experiences some of these symptoms from time to time, student-athletes with anxiety disorders experience these symptoms frequently and severely enough to negatively affect their ability to function to their potential.

To best help someone with an anxiety disorder, it is recommended that the provider know the emotional construct of anxiety and understand basic treatments, interventions and referrals.

To best help someone with an anxiety disorder, it is recommended that the provider know the emotional construct of anxiety and understand basic treatments, interventions and referrals. (It also is recommended that the provider recognize Mowrer's two-factor theory of avoidance, which is discussed in the accompanying sidebar.)

SIGNS AND SYMPTOMS

- Feeling apprehensive
- Feeling powerless
- Having a sense of impending danger, panic or doom
- Increased heart rate
- Breathing rapidly
- Sweating
- Trembling
- Feeling weak or tired

TYPES OF ANXIETY DISORDERS

- **GENERALIZED ANXIETY DISORDER:** "Free-floating" anxiety because it seems to occur without a particular cause. Individuals with a generalized anxiety disorder often find it difficult to sit still, do nothing or relax. They also may be plagued with constant worries that interfere with concentration or daily functioning.
- **PANIC ATTACKS OR PANIC DISORDER:** Feelings of terror or impending doom that can occur without warning. These feelings usually are accompanied by consequent or complicating physical symptoms (such as racing/pounding heart, shortness of breath).
- **OBSESSIVE COMPULSIVE DISORDERS:** Recurring, redundant, ruminative or irrational thoughts (obsessions) and/or behaviors an individual feels compelled to perform (compulsions). If the affected individual is unable to practice obsessive thinking or perform compulsive behaviors, the anxiety can worsen.
- **PHOBIAS:** Exaggerated or irrational fear of a specific object or situation.
- **POST-TRAUMATIC STRESS DISORDER:** Reliving an intense physical or emotional threat of injury. Symptoms can include difficulty sleeping or concentrating, emotional withdrawal and angry outbursts.

Anxiety as an emotional construct

Whether discussing "performance" anxiety or anxiety disorder (a phobia or generalized anxiety), the construct of this emotion remains relatively similar. Specifically, anxiety has a unique set of properties that distinguishes it from other emotions. For athletes and non-athletes, the thoughts and feelings that induce anxiety tend to be about the future.

The future element causing anxiety for the individual is typically a perceived threat or danger. It should be noted

APPLYING MOWRER'S TWO-FACTOR THEORY OF AVOIDANCE LEARNING TO SPORT

A key for diagnosing anxiety in athletes lies in understanding that fear and avoidance are two different, but not independent, learning processes.

In the well-established Mowrer two-factor theory, fear was a product of sign learning. Specifically, an event occurs in which the individual connects a signal to a noxious event. For example, if someone was petting a dog (a signal) and was bitten by the dog (a noxious event), he/she may connect that petting all dogs induces being bitten, when in reality most interactions with dogs are innocent and likely beneficial.

The second factor of Mowrer's theory is that avoidance was a product of solution learning, trial-and-error learning, or response substitution. In other words, when someone avoids the noxious event, he/she feels a sense of relief. The sense of relief ultimately serves as a reward to the person, which reinforces the notion to avoid the noxious event.

Using the same example, the individual who has been taught to fear dogs will become anxious near dogs or dog-like scenarios, and he/she will feel a sense of relief when avoiding dogs. Further, the sense of relief will strengthen the avoidance response. In other words, the more the person avoids dogs, the more fearful he/she will become of dogs.

If an elicited fear for a student-athlete is never extinguished, then avoidance will continue to be reinforced because it provides relief. Thus, an elicited fear affects avoidance and avoidance affects an elicited fear. For example, if a student-athlete pairs shooting the basketball (a signal) with failure and public ridicule (a noxious event), he/she may develop a fear and avoid taking a shot.

When providing this example, it is important to note that emotions are not disorders. Emotional experiences fall on a quantitative spectrum (low to high intensity) as well as a qualitative spectrum (healthy to unhealthy). When an emotional experience is too frequent, too intense, lasts too long, or is too disruptive, it can become transformed into a disorder.

that two types of threats exist – a threat to safety (“that guy has a gun pointed at me”) and a threat to ego integrity (“if I lose, then I am a loser”).

Anxiety has cognitive and physiological elements. Physiological symptoms may include muscle tension, headaches, gastrointestinal issues, increased heart rate and difficulty breathing.

Treatments for student-athletes

Because the demands on student-athletes are somewhat unique, any fear and avoidance problems must be assessed differently. Thus, the functioning of a student-athlete with an anxiety problem may present differently than the functioning of a non-athlete.

For example, some student-athletes may be functioning well below their personal norm but may not meet the standard criteria for an anxiety disorder. Specific examples are found in the differences between post-traumatic stress disorder (PTSD) and the experience of a traumatic championship loss. PTSD may occur after a bobsled accident that critically injures one teammate and leaves two others hospitalized. The surviving, noninjured athlete may experience the incit-

RISK FACTORS IN THE SPORT ENVIRONMENT

- Symptoms of anxiety disorders often worsen under stress. A student-athlete may be experiencing stress because of the transition of being away from home and adjusting to a new living situation, or worrying about achieving academically, or meeting performance expectations in his or her sport.

WHY TREATING ANXIETY DISORDER MATTERS

- Anxiety disorders can affect the ability to function effectively. This could affect social functioning, academic performance and performance in sport.
- In the long term, individuals with an untreated anxiety disorder are more likely to have heart disease and to die of a heart attack. Individuals with higher levels of anxiety are also more likely to develop chronic respiratory disorders and gastrointestinal disorders.

ing event (the crash) with fear of ever competing again with sufficient speed to win or with avoidance of teammates who have been hospitalized. Personal failure deemed to account for the loss of a major championship, however difficult, may not meet the criteria for anxiety disorder. Sport psychologists are called on to distinguish this important difference, noting degree and the full scope of symptom expression.

Psychological intervention to reduce the impact of the

inciting stimulus – to teach effective coping – flows from intelligent diagnosis. There are many empirically validated treatments for anxiety and anxiety disorder. Licensed mental health professionals can work to adapt these treatments to the student-athlete’s unique needs and goals. For some student-athletes, their anxiety disorder may be grounded in the sport experience, and it may be useful to treat it within the framework of sport performance.

WHAT CAN YOU DO?

- Treat mental health disorders the way you would treat a physical injury: as a health problem in need of diagnosis, treatment and potentially ongoing management by a specialist health care provider.
- Understand that student-athletes with an anxiety disorder are likely to welcome an offer of assistance. Individuals with such disorders are often tired or even exhausted by their symptoms and are looking for some relief.

QUESTIONS FOR REFLECTION

1. Think about and name the differences between normal anxiety and anxiety disorder. At what point would you refer a student-athlete to a mental health professional for evaluation and possible treatment?
2. What are all of the stressors that your student-athletes are experiencing?
3. Do you know to whom you would refer a student-athlete with anxiety disorder for evaluation and possible treatment?



Scott Goldman is the director of clinical and sport psychology for the University of Arizona’s athletics department. Goldman provides direct patient care to the student-athletes as well as consulting services for the coaches and staff. His clinical experience includes working in university counseling centers, rehabilitation centers, private and government-funded psychiatric children’s hospitals, school counseling centers, and outpatient therapy institutes. Goldman serves on the advisory board for STEP UP!, a bystander intervention program that has been adopted by more than 100 universities and colleges. He earned his bachelor’s degree in psychology from Tulane University and a master’s degree and Ph.D. in clinical and school psychology from Hofstra University.

Mood Disorders and Depression

BY CHRIS BADER

Mental health and mental health disorders are a growing topic of conversation for athletics departments. Like the campuses with which they are affiliated, athletics departments have seen a rise in the number and severity of individuals with mental health concerns. One of the more common mental health concerns is depression. While there are a number of different clinical disorders that involve a depressed mood (see “What is new in depression?” below), for the purposes of this article, the focus will be on what most people refer to as “depression,” which is clinically considered major depressive disorder.

While most people can feel down or blue from time to time, individuals who are depressed experience prolonged times of sadness that interfere with their ability to function in daily life. When someone is depressed, the feeling of sadness is pervasive, and it is difficult for the individual suffering to imagine not feeling depressed.

According to the National Institute of Mental Health (NIMH) with data from the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 6.7 percent of U.S. adults experience major depressive disorder in a given year. That 12-month prevalence is actually higher among college-aged individuals (8.9 percent in 18- to 25-year-olds). Women are at increased risk, as are non-Hispanic whites (when compared with non-Hispanic blacks).

What is new in depression?

With the recent release of the newest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), there are some changes with regard to disorders that include depression. These disorders are now classified as “depressive disorders,” and they include:

- Disruptive mood dysregulation disorder
- Major depressive disorder
- Persistent depressive disorder (dysthymia)
- Premenstrual dysphoric disorder
- Substance/medication-induced depressive disorder
- Depressive disorder due to another medical condition
- Other specified depressive disorder
- Unspecified depressive disorder

The DSM-5 explains that the common feature of all of these is “sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual’s capacity to function.” The differentiating features of these disorders include duration, timing and presumed cause.

It is important to understand and recognize the breadth

of depressive disorders in order to properly identify, diagnose and treat the disorder most closely corresponding to the symptoms of the individual.

What are the signs/symptoms of depression?

For a proper diagnosis of depression, most of the following symptoms must be present. Some of the individual symptoms could appear to be other conditions of concern (for example, ADHD, a sleep disorder, etc.)

- Depressed mood
- Loss of interest or pleasure
- Significant weight loss or gain
- Insomnia or hypersomnia
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feelings of worthlessness or excessive or inappropriate guilt
- Diminished ability to think, concentrate or make decisions
- Recurrent thoughts of death, recurrent suicidal ideation, suicide attempt or plan

These symptoms need to be present for more days than not over a period of at least two weeks. We all display some of these symptoms sometimes, but the key to proper diagnosis (and thus effective treatment) is the symptom picture, the time frame and the level of disturbance in daily functioning.

SIGNS AND SYMPTOMS

- Low or sad moods; for some people this may involve crying episodes
- Irritability or anger
- Feeling worthless, helpless and hopeless
- Eating and sleeping disturbance (reflected in an increase or decrease)
- Decrease in energy and activity levels with feelings of fatigue or tiredness
- Decrease in concentration, interest and motivation
- Social withdrawal or avoidance
- Negative thinking
- Thoughts of death or suicide
- In severe cases, intent to commit suicide with a specific plan, followed by one or more suicide attempts

What causes depression?

The cause of almost any mental health disorder general-

ly consists of a number of interrelated factors, including (1) biology – the genetic, biological and physiological makeup of the individual; (2) psychology – the mindset and mental state of being; and (3) social factors – stressors, changes in environment and related factors.

Taken together, this suggests that we need to consider the biopsychosocial factors in the individual's development and current state to determine his or her individual cause. The root causes of depression have been linked to the levels of various chemicals in the brain. A combination of genetics and brain chemistry lay the groundwork for developing depression, and the individual's day-to-day functioning and state of mind about life can lead to the expression of that genetic predisposition.

For example, someone may have a parent who suffers from depression, but may perceive himself to be a positive agent for change in his own life and has set up a very supportive social network. This individual may not ever have a depressive episode despite his genetic predisposition for depression.

RISK FACTORS IN THE SPORT ENVIRONMENT

Although most depression probably occurs for reasons unrelated to sport-participation, for some student-athletes there can be risk factors associated with their participation in sport. These can include:

- Psychological response to injury
- Psychological response to end of athletics career
- Overtraining

How is depression treated?

Individuals choose a number of ways (some healthy and some less so) to address depression. Some individuals do not seek treatment – sometimes that is related to not wanting to ask for help or not feeling worthy of someone else's time. Other individuals choose to treat depression on their own – anything from self-help readings (healthy) to substance use/abuse (unhealthy).

WHAT ELSE CAN AFFECT AND CAN BE AFFECTED BY DEPRESSION?

- **HEALTH/PERFORMANCE.** When we feel depressed (or suffer from diagnosed depressive disorder), our health and general performance in life can suffer. This can become a downward spiral into a deeper depression if not noticed and addressed. And, our physical health can begin to suffer as our depressed mental state is prolonged.
- **INJURY RISK.** In dealing with student-athletes, depression can be both a precursor to and a result of injury. A gymnast may not be feeling quite right and may be displaying some of the symptoms of depression. Because of that, his or her concentration is lacking and he or she lands a skill awkwardly, leading to a serious injury. On the other hand, student-athletes performing at their best who are injured in an unpredictable situation may begin to display symptoms of depression once their athletics status is threatened or taken away completely.
- **SUICIDAL RISK.** Suicide risk has been linked to feelings of hopelessness and talk of death or suicide (both symptoms of depression). Recent genetic findings suggest a strong genetic link to suicidal behavior and action. So again, we see the interaction of a number of factors. The main takeaway is to consider any talk of or threat of suicide seriously and to understand the aforementioned factors that can increase suicidal risk. Just because someone is depressed does not mean that he or she is suicidal, but we should be aware of the connection of these two serious clinical situations. (See David Lester's article on suicidal tendencies later in this chapter.)
- **SPORT PARTICIPATION.** Participation in sports can help or hurt, depending upon the individual suffering the depressive episode. Student-athletes often have a high athletics identity, and if that identity is threatened because their position is taken away because of depression, that can serve to further the depression. At the same time, forcing student-athletes with depression to perform while they are in a depressive state can be detrimental to their ability to perform and to manage their depression. Given this paradox, it is important to talk with the student-athlete and all individuals involved in their care in order to determine the best course of action.

It is now a widely accepted practice to suggest counseling and consideration of medication management for an individual suffering from depression. Research has suggested that a combination of psychological intervention (counseling), with medication management as warranted, has shown the most promise for positive outcomes associated with the treatment of depression. While many people do not seek treatment, it is important to try to guide individuals suffering from depression toward effective resources that may be beneficial.

Additional resources

CASE PRESENTATION. Consider this hypothetical situation: A student-athlete is benched for the first competition of the season. She is new to the university and is expected to contribute significantly to the success of her team. Recently, however this student-athlete hasn't been feeling "right." At times, things seem fun and manageable; but, increasingly, things seem boring and hopeless. These symptoms began soon after the student-athlete arrived on campus and have gone on for about six weeks. In the past two weeks, the student-athlete has missed class more than usual and has stopped hanging out with friends. Additionally, this student-athlete's grades have dropped and she has avoided the academic center and dining hall where most of the student-athletes gather. This student-athlete's teammates have approached the coach about some concerns they have about this person's behavior.

This presentation is more common than one might think. This student-athlete is displaying a number of symptoms of the depressive disorders, and the timing and duration seem to be in line with major depressive disorder. In this case, this student-athlete would likely benefit from someone reaching out to her in a non-evaluative manner and expressing concern while also helping her find psychological and medical resources.

DIFFICULTIES IN IDENTIFICATION. At times, identifying a depressive disorder (especially major depressive disorder) can be difficult given the nature of the life of student-athletes. Because they are busy and because they interact with a number of areas of campus, consolidating the identifying symptoms can be tough. For example, if someone in academics sees some of the symptoms mentioned earlier, they may not know if that student-athlete is showing the same symptoms in his or her athletics and social pursuits.

It is also possible that student-athletes may try to hide their symptoms (through substance use, for instance) or may withdraw to the point that even their closest friends/teammates do not know what is going on.

WHAT CAN YOU DO?

- Coaches and athletic trainers should recognize the power and influence they have over student-athletes. This power and influence can be positive or negative. Coaches need to be particularly responsive and careful with depressed student-athletes, as they may interpret your words and actions more negatively than you intend.
- Depending on the cause, nature and severity of the mood disorder, it may or may not be beneficial to withhold a student-athlete from participation. For some, sports can provide a sense of identity, a source of self-esteem and a sense of accomplishment. For others, it may increase the student-athlete's symptoms. This is a decision that should be made with the student-athlete's health care team.
- Take all thoughts, behaviors and threats of suicide very seriously. Details on what to do are available in David Lester's article about suicidal tendencies.

QUESTIONS FOR REFLECTION

1. Do you feel comfortable understanding the difference between a student-athlete who is feeling sad and a student-athlete with depression who needs to be evaluated by a mental health professional?
2. Do you know to whom you would refer a student-athlete in need of evaluation and possible treatment for depression?
3. Is there anything you could be doing better to psychologically support student-athletes who are dealing with major injuries?

It is important to note here that there are other disorders or situations (for example, substance use/abuse) that lead to similar symptoms. Thus, talking with the student-athlete as well as others in the student-athlete's life can be important in identifying and possibly treating a depressive disorder. Most (if not all) college campuses now have someone who provides clinical psychological service to that campus; thus, consulting with that person can help properly identify symptoms and provide a proper diagnosis.

SUICIDE INTERVENTION. A number of national programs address the topic of suicide intervention. One of the most important factors in intervening with someone who may be considering suicide is simply to ask if he or she is

considering suicide. Secondary to that is to not be afraid of the answer given. The person may say, “Yes, I’ve considered it,” and your reaction at that point is very important. Communicating your support for that individual is very important and could save a life. Again, at this point, it is important to consult with a mental health provider or physician to get that person immediate help.

SUICIDE PREVENTION: HAVING A PLAN. One thing

to consider before needing hospitalization after a threat or attempt of suicide is a plan of action. For example, if your department works closely with a mental health practitioner, talk with that practitioner about the steps involved in crisis response given a suicidal threat or gesture. In most cases, a mental health practitioner will have an idea of what needs to take place to ensure the safety of the student-athlete, depending upon the situational factors involved.



Chris Bader has been the counseling and sport psychologist for the University of Colorado athletics department since August 2012. Bader provides clinical, assessment and individual and team consultation to the student-athletes and coaches and helps incoming student-athletes adjust to their new environment. From 2007 to 2012, Bader was on staff in the Psychological Resources for Student-Athletes office at the University of Oklahoma. He earned his bachelor’s degree in psychology at Louisiana State University in 1998, where he was a member and president of the Rugby Football Club. Bader earned his master’s degree in psychology with an emphasis in psych neuroendocrinology at the University of Louisiana at Lafayette.



Eric Bronson / University of Michigan photo

Former Michigan star recounts depression's effects

At 6 feet, 6 inches and 295 pounds, Will Heining cuts a formidable figure. Now working in the investment industry, Heining was a four-year letter-winner during his time on the University of Michigan's football team, where he graduated in the winter of 2011. In conversation he is cheery and outgoing, fitting the image of a successful student and football player.

It is less apparent that Heining was depressed for months during his time on campus.

Heining grew up in Ann Arbor and always dreamed of playing for the Wolverines one day. He was living that dream; everything was going smoothly. Then the symptoms of depression set in after the summer of his freshman year. Heining said a contributing factor to his depression was his adjustment to a new life at home after his parents' di-

orce, which occurred when he left for college. He kept himself busy, avoiding free moments that would fill with negative thoughts as he stared off into space and faced the dreadful specter of personal failure that others couldn't imagine in a Division I football player.

When he returned to Michigan as a sophomore, he carried his depression with him, although the return to the activity and normalcy of university life helped him stave it off more effectively than at home. Heining at first tried to combat his depression with the same single-minded determination that had brought him success both as a student and an athlete.

"That athletics mindset got me so far, so I tried to attack it that way. It just made it worse. I felt like I'd failed because I couldn't beat it myself," he said. "Sometimes I just sat on the couch and cried."

“It’s chemicals of the brain really; it’s not anything that’s a representation of you. But there’s so much misinformation out there. Most people don’t really understand depression. I didn’t either.”

Heininger decided to ditch the “carry-the-burden” approach that sport psychologists so often see and began to reach out for help. He confided to his mother first, a step he found worthwhile, but that alone was not enough to bring him out of his depression. It was not until he began to use the resources available at Michigan that he truly made progress on his path to recovery.

Heininger had previously been reluctant to confide in his teammates or coaches because he feared the stigma attached to mental illness.

“I had an irrational fear that I’d be weak in their eyes, that they’d see me as unstable, someone they couldn’t trust,” Heininger said.

He also worried about how it might affect his reputation outside the team.

“There’s some amount of celebrity, where students don’t understand that athletes are like them. Some people don’t think of athletes as human; they just see them for what they do and their success on the field,” Heininger said. “The more athletes define themselves by what they do, the more susceptible they are.”

But he did eventually open up to his coach, experiencing a self-described breakdown in his office.

“It wasn’t so much courage that finally made me come forward; I was just so sad I didn’t care,” Heininger said.

That is when he found out about the support services available to him and began to have therapy sessions with an athletics counselor. Once he started therapy, Heininger began to better understand depression. Rather than an indictment of himself, he began to recognize its true causes.

“It’s chemicals of the brain really; it’s not anything that’s a representation of you,” he said. “But there’s so much misinformation out there. Most people don’t really understand depression. I didn’t either.”

He also found that instead of being stigmatized, there was an outpouring of support among his friends, family and teammates. Heininger said that contrary to what he imagined, almost everybody was “super receptive” and helpful.

After his own experience as a student-athlete suffering from mental illness, Heininger decided to use the knowledge he gained to help other people experiencing mental illness.

Initially he applied his new understanding of the nature of depression and why people experience it to help his father, who had been experiencing some issues at the time.

Heininger also presented Michigan’s 2013 Mental Health Advocate Awards in February, which are given to graduate and postgraduate students across the country who advance de-stigmatization and improved awareness of mental health issues.

Heininger continues to advocate for better mental health himself, driven by a desire to help others who may be experiencing the same struggles he did.

“I believe in it – if you save one life, you’ve done well,” he said. “I want everyone in the world out there to know that mental illness is a disease, which means that there are professionals who can help you get better. In my ideal world, there is zero stigma associated with mental illness. None.”

“Everybody would go to therapy, and there would be nothing wrong with it.”

– *The preceding was excerpted from “Mindful Healing,” a feature story on student-athlete mental health issues written by Jassim Kunji and published in the Fall 2013 issue of NCAA Champion magazine.*

Depression and Anxiety Prevalence in Student-Athletes

BY ANN KEARNS DAVOREN AND SEUNGHYUN HWANG

In 2011, more than 41 million U.S. adults over the age of 18 (about 18 percent) had a mental disorder, and nearly 9 million U.S. adults (4 percent) had a mental illness that greatly affected day-to-day living or resulted in serious functional impairment. Almost three-fourths of those who have been diagnosed with a mental disorder, such as anxiety, mood disorders, etc., have their first onset by age 24.

College students – including student-athletes – are not immune to struggles with mental well-being. About 30 percent of the 195,000 respondents to a recent American College Health Association (ACHA) survey reported having felt depressed in the last 12 months, and 50 percent reported having felt overwhelming anxiety during the same period.

One of the primary concerns regarding the prevalence of mental illness among student-athletes is that it may affect not only their success in academics and athletics but also their general well-being. While depression and anxiety have been found to be significant predictors of a lower grade-point average and poor athletics performance, they're also highly correlated with other risky behaviors, including suicide.

While it's not clear whether the source of challenges to student-athlete mental well-being is the same as those non-athletes face, collegiate student-athletes are known to encounter unique stressors that the general population doesn't have to deal with, such as time demands, relationships with coaches, and missed scheduled classes.

To help determine the prevalence and effects of anxiety and depression in the student-athlete population, we studied data from eight National College Health Assessment surveys the ACHA administered from 2008 through 2012*. Those surveys cover issues including substance use, sexual behavior, physical health, weight, personal safety, violence, and mental health and well-being.

Varsity student-athletes were identified as those who answered “yes” to the question: “Within the last 12 months, have you participated in organized college athletics at any of the following levels...a) Varsity?” The others compose

the non-athlete comparison group. In total, 19,733 student-athletes and 171,601 non-athletes were included in the analyses.

Two independent logistic regression models were applied to investigate variables related to depression and anxiety. Both associated and demographic variables were included in the models. Demographic variables included sex, race, sexual orientation, transfer student status in the last 12 months and varsity athlete status in the last 12 months. The associated variables included perceptions of general health, perceptions of stress and substance use.

Additionally, a multipart item asking whether a series of events or situations had been traumatic or difficult for one to handle was included in the model. These included:

- Academics
- Career-related issue
- Death of a family member or friend
- Family problem
- Intimate relationship
- Finance
- Health problem of a family member or partner
- Personal appearance
- Personal health issue
- Sleep difficulty

After accounting for the demographics, nearly all of the associated variables were significant predictors for depression and anxiety. And, student-athlete status, our primary demographic variable of interest, also was found significant and was a negative predictor.

A few factors presented a comparatively strong relationship with depression and anxiety. Not surprisingly, the strongest was the perceived level of stress in the last 12 months. Stress can be associated with a number of the daily challenges college students face, including academics, interpersonal relationships, health concerns of a family member and financial concerns. Symptoms such as fatigue, hypertension, headaches, depression and anxiety can be attributed to stress.

The ACHA data show that sleep difficulties, and diffi-

PERCENT OF STUDENTS BY GENDER AND ATHLETE STATUS REPORTING DEPRESSION/ANXIETY IN LAST 12 MONTHS

	Male		Female	
	Student-athletes	Non-athletes	Student-athletes	Non-athletes
Felt depressed	21%	27%	28%	33%
Felt anxiety	31%	40%	48%	56%

culties with intimate relationships and other social relationships also are strongly related to depression and anxiety.

SLEEP DIFFICULTY was a self-reported measure asking if the respondent had experienced trouble sleeping in the last 12 months. Of those who reported yes, just 9 percent indicated that they had been diagnosed with insomnia in the last 12 months, and an additional 4 percent reported they had been diagnosed with another sleep disorder.

Fewer are being treated with medication for their diagnoses – just 7 percent in total. While few are reporting official diagnoses, a significantly greater percentage are reporting that difficulties with sleep are affecting them. Among those who said they are experiencing difficulty sleeping, 34 percent indicated that sleep difficulties resulted in a lower grade on an exam or test, and an additional 13 percent reported that it resulted in a lower grade in the course. (See Michael Grandner’s article later in this chapter for more on sleeping disorders.)

RELATIONSHIPS. The data also show that females and underclassmen were more likely to report difficulties with intimate relationships and other relationships. While reports of physical or sexual abuse in an intimate relationship are generally low (around 2 percent of all respondents), emotional abuse appears to be a greater concern, with 10 percent overall reporting having been in an emotionally abusive relationship. In all, 22 percent of those who claim having experienced difficulties in an intimate relationship report emotional abuse.

Loneliness is a common factor related to difficulties in relationships. Among those who reported relationship problems, 85 percent reported feeling very lonely in the last 12 months, compared with 50 percent of those who did not report

problems with relationships. The data indicate that loneliness also is highly correlated with both anxiety and depression

ANXIETY also was strongly related to difficulties with academics. An additional factor with a significant relationship to both depression and anxiety was a catch-all category of “other” traumatic events. This may potentially include characteristics of collegiate student-athletes that were not covered in the survey. For example, poor athletics performance or loss of an athletics scholarship may be traumatic for student-athletes who are highly motivated athletically.

SEEKING HELP Most student-athletes and non-athletes in the study indicated a willingness to seek help for mental health concerns in the future (63 percent of student-athletes, compared with 68 percent of their non-athlete peers). However, the data indicate that student-athletes are less likely to report having received psychological or mental health services from a variety of providers, including counselors and psychiatrists. This could be due either to a reduced need among the student-athlete population or because they are less likely to report and seek treatment for these concerns.

Overall, while college student-athletes do struggle with depression and anxiety, the data indicate they are less likely than their non-athlete peers to report issues with either. Stress, interpersonal relationships and difficulty sleeping are strongly associated with depression and anxiety. Moreover, academic difficulties also are related to higher anxiety. Given the reluctance of student-athletes to report challenges with mental well-being, coaches, team physicians and athletic trainers are a good potential line of defense in encouraging their athletes to seek help when needed.



Ann Kearns Davoren joined the NCAA staff in 2004 and has focused primarily on student-athlete survey research, and academic, governance and health and safety research across all three membership divisions. Before joining the NCAA, Davoren was the assistant staff director at the Advisory Committee on Student Financial Assistance, a federal committee that advises Congress and the U.S. Department of Education on issues affecting student financial aid policy. Davoren received her B.A. in speech communication from Saint Mary’s College in Notre Dame, Indiana, and her MPA with a focus on policy analysis and comparative international affairs from Indiana University, Bloomington. She currently is pursuing her Ph.D. in research methodology at Loyola University, Chicago



Seunghyun Hwang is a researcher at the Korea Institute of Sport Science. He holds a dual Ph.D. from the College of Education at Michigan State University, where he specialized in the psychosocial aspects of sport and physical activity. He also has conducted research on student-athletes with respect to their academics and psychological well-being. He recently completed a Postdoctoral Research Fellowship in the Sport Science Institute at the NCAA national office in Indianapolis.

*American College Health Association. American College Health Association-National College Health Assessment, Fall 2008, Spring 2009, Fall 2009, Spring 2010, Fall 2010, Spring 2011, Fall 2011, Fall 2012 ACHA-NCHA II, ACHA-NCHA IIb). Hanover, MD: American College Health Association; (2013-10-31).

Substance Use and Abuse

BY BRIAN HAINLINE, LYDIA BELL AND MARY WILFERT

The prevalence of mood-altering substances on campus – alcohol, marijuana, narcotics, stimulants, depressants, hallucinogens – has been tracked by campus prevention professionals for decades, evoking varying degrees of effort and success to reduce use and negative consequences.

More recently, a keen understanding of the interplay between substance use and mental health brings two distinct fields – prevention specialists and treatment specialists – together to define more comprehensive and evidence-informed approaches to address these issues, including population-based environmental management, large screening events, and personalized assessment, feedback and intervention.

College students, including student-athletes, are susceptible to the college effect, in which heavy and frequent alcohol use increases when students arrive on campus, buying into the cultural myth that campus life is about alcohol abuse and drug use. Such beliefs result in an increase in negative impact on academic success, increased risk of sexual assault and other interpersonal violence, and other negative consequences.

Student-athletes, compared with other students on campus, report higher rates of heavy episodic drinking, sometimes referred to as “binge drinking” (defined as four or more drinks for women and five or more for men). Even more disturbing is that one in five male student-athletes who use alcohol report drinking 10 or more drinks in an outing when they drink.

For marijuana, the good news is that fewer NCAA

student-athletes report using marijuana than other students on campus. But the percentage of student-athletes who use marijuana has remained relatively flat over the last 10 years.

And though alcohol and marijuana are the two most reported recreational drugs student-athletes use, the new illicit drug-use concern is the abuse of prescription stimulants and narcotics.

Substance abuse and mental health

There is no doubt that for many, substance abuse co-occurs with mental health issues. A 2004 Harvard University study described patterns of depression and alcohol abuse among young adults in college, and confirmed that “a substantial fraction of college youth are experiencing poor mental health – at any given time approximately 5 percent – and that these youth are at high risk for alcohol abuse, with depressed young women at highest risk.”

The Harvard study noted the age of traditional students, 18-24, coincides with peak years for onset of common mental health problems among youth related to alcohol, tobacco and other drug use, depression and anxiety disorders and suicide.

The 2012 National Survey on Drug Use and Health of the Substance Abuse and Mental Health Services Administration identifies that 8.9 million adults have co-occurring mental and substance use disorders and recommends integrated treatment to improve outcomes.

FIGURE 3A

WHEN YOU DRINK ALCOHOL, TYPICALLY HOW MANY DRINKS DO YOU HAVE IN ONE SITTING?

Female Student-Athletes			
	Division I	Division II	Division III
More than 4 drinks	31.9%	32.6%	37.8%
10+ drinks	2.4%	3.2%	3.3%

Male Student-Athletes			
	Division I	Division II	Division III
More than 5 drinks	39.6%	39.6%	50.4%
10+ drinks	15.5%	16.8%	20.4%

Student-athlete substance use

Since 1985, the NCAA has conducted a quadrennial research study of substance use of college student-athletes, and collected survey data again in the spring of 2013 from more than 20,000 NCAA student-athletes from all three divisions and NCAA-sponsored championship sports.

ALCOHOL. Figures 3A and 3B present data about heavy episodic drinking and the negative consequences reported

as a result of alcohol use.

It is particularly alarming that 30 percent of these student-athletes report experiencing blackouts, which are red flags for developing an alcohol addiction. In addition, more than 30 percent have done something they later regretted and more than 25 percent have been criticized for their drinking.

These data also identify implications of use on both academic and athletics success, with more than 25 percent

FIGURE 3B

STUDENT-ATHLETE DRINKING BEHAVIOR – DURING LAST 12 MONTHS

	Never	Once	Twice	3-5 times	6-9 times	10+ times
Had a hangover	36.7%	14.3%	11.5%	14.8%	7.4%	15.3%
Performed poorly on a test or important project	83.3%	6.9%	4.3%	3.3%	1.1%	1.1%
Been in trouble with police or other college authorities	91.0%	6.7%	1.5%	.6%	.1%	.2%
Damaged property, pulled fire alarm, etc.	92.9%	3.2%	1.8%	1.2%	.3%	.5%
Gotten into an argument/fight	77.0%	9.6%	6.2%	4.5%	1.2%	1.5%
Gotten nauseated or vomited	48.5%	19.8%	13.0%	11.7%	3.7%	3.3%
Driven a car while under the influence	86.3%	5.5%	3.5%	2.4%	.8%	1.5%
Missed a class	73.9%	7.9%	6.7%	6.7%	2.0%	2.7%
Performed poorly in practice or game	84.0%	6.6%	4.3%	3.2%	.9%	1.0%
Have showed up late or missed practice or game	94.3%	3.0%	1.4%	.8%	.2%	.3%
Been criticized by someone you know	74.6%	9.8%	6.6%	5.1%	1.5%	2.4%
Thought you might have a drinking or drug problem	94.4%	2.5%	1.2%	.8%	.4%	.7%
Had a memory loss	70.0%	10.4%	7.0%	6.4%	2.9%	3.3%
Done something you later regretted	68.0%	12.0%	8.0%	6.6%	2.3%	3.1%
Been arrested for DWI/DUI	99.0%	.7%	.1%	.1%	.0%	.1%
Tried unsuccessfully to stop using	96.7%	1.6%	.7%	.5%	.2%	.3%
Had feelings of depression, feeling sad for two weeks or longer	92.9%	3.7%	1.6%	.9%	.3%	.6%
Been hurt or injured	87.7%	6.0%	3.5%	1.9%	.3%	.5%

FIGURE 3C

STUDENT-ATHLETE MARIJUANA USE AND GRADES

	Never used	Used in last 30 days	Used in last 12 months	Used, but not in last 12 months
A (3.84 - 4.00)	10.5%	5.2%	5.8%	6.7%
A- (3.50 - 3.83)	19.8%	14.6%	16.1%	17.0%
B+ (3.17 - 3.49)	23.3%	20.7%	24.9%	23.0%
B (2.84 - 3.16)	21.4%	23.9%	23.2%	25.2%
B- (2.50 - 2.83)	13.5%	16.9%	15.3%	14.7%
C+ (2.17 - 2.49)	7.7%	11.8%	10.1%	9.1%
C (1.84 - 2.16)	2.9%	4.4%	3.6%	3.1%
C- (1.50 - 1.83)	.6%	1.5%	.8%	.9%
D or below (< 1.50)	.3%	1.0%	.2%	.3%

missing class and 16 percent performing poorly on a test or in practice due to use.

MARIJUANA. Another substance concern is the use of marijuana, which has remained fairly constant in this population over the past 10 years as noted in this table:

MARIJUANA USE WITHIN THE LAST 12 MONTHS

2005	2009	2013
21.2%	22.6%	21.9%

The college literature on marijuana use demonstrates strong links between use, especially chronic use, and cognitive deficits. Even for those who do not use regularly, marijuana use can impede concentration and attention, and interfere with student-athlete academic and athletics success.

Depression and anxiety are the most commonly reported psychological issues reported by traditional-aged students, including student-athletes, and the peak age of onset for schizophrenia is in the teenage years and 20s.

Marijuana use is implicated in exacerbating symptoms of anxiety, depression and schizophrenia, and those at risk of developing schizophrenia will have worsening symptoms if they use marijuana.

The NCAA study looked at marijuana use and grades, and found in the table above that those who have used in the last 30 days reported failing grades at three times the rate of those who don't use. The table also notes that for those student-athletes who have never used, more than 30 percent report A grades compared with 20 percent of those who have used, either in the last 30 days or ever. (See Figure 3C)

PRESCRIPTION DRUG USE. The following table notes that under 5 percent of NCAA student-athletes report prescribed ADHD stimulant medication use, similar to the estimates of ADHD in this population, but

PRESCRIPTION DRUG USE WITHIN THE LAST 12 MONTHS

	Year	With a prescription	Without a prescription
ADHD Medication: Adderall OR Ritalin	2009	4.8%	5.5%
	2013	4.0%	5.4%
Pain Medication: Vicodin, Oxycontin, Percocet	2009	13.6%	5.2%
	2013	12.9%	4.3%

more than 5 percent report use without a prescription. The percentage of student-athletes prescribed narcotics for pain medication is higher than the general student body, which is understandable with injury and pain a part of competitive athletics, but use without prescription is of great concern given the potential for addiction to these medications. Whether this nonprescribed use is self-medication for inadequate response to sports injury is an area for further research.

Prevention is a science!

The substance abuse prevention field has matured quickly since the 2002 publication of the National Institutes of Alcohol Abuse and Alcoholism. This report provided evidence of alcohol education and policy strategies that demonstrated an effect on use, strategies that held promise, and those that did not deliver.

Over the convening decade, prevention science has provided us greater insights into the kinds of campus efforts that support healthy choices, those that are ineffective, and even those that contribute to abuse.

The CDC's social-ecological model provides the framework for targeting our efforts, noting that individual behaviors are influenced by the individual's peer group, broader community and society. For the campus athletics culture, this translates into team, department and campus as a whole.

Understanding the process of behavior change, the role perception plays in use, the power of setting expectations, and the influence of environment and policy on individual choices is critical to effective alcohol abuse prevention. "Just say no" is not a method. Research has redirected our efforts toward more effective approaches to reduce substance abuse and its negative consequences, providing us evidence-informed strategies that affect behavior change, such as brief motivational interventions, correcting norms, engaging peers in intervention, and clear and consistent policy enforcement. As with any culture, educational efforts need to address student-athletes' motives, beliefs and expectations.

Athletics administrators will experience greater success in reducing substance abuse among their student-athletes when they partner with campus prevention specialists who have background and expertise in substance abuse prevention and mental health promotion.

The NCAA Division III and NASPA (Student Affairs Professionals in Higher Education) have entered into

SIGNS AND SYMPTOMS

Not all student-athletes with substance use problems consume alcohol or drugs in settings where the signs are easily visible; some may choose to consume these substances alone so as to avoid drawing attention to these signs.

Alcohol

- Being irresponsible regarding commitments or responsibilities to school, sport and relationships
- Consuming alcohol in situations that are dangerous to themselves and others

Stimulant-type substances (Amphetamines, cocaine, ephedrine and medication for ADHD)

- Shakiness
- Rapid speech or movements, difficulty sitting still
- Difficulty concentrating
- Lack of appetite
- Sleep disturbance
- Irritability

Marijuana

- Red eyes
- Lethargy
- Apathy

ATHLETICS CONSEQUENCES

Alcohol

- Alcohol is a central nervous system depressant. It can decrease concentration, coordination, reaction time, strength, power and endurance. It can also inhibit the body's absorption of nutrients. The effects of heavy alcohol consumption can last for days.

Stimulant-type substances (Amphetamines, cocaine, ephedrine and medication for ADHD)

- The individual may become nervous or jittery, which can negatively affect any skill requiring fine motor coordination and concentration. Performance can also be negatively affected by increased heart rate, blood pressure, heat production and body temperature.

Marijuana

- The effects of marijuana on sport performance are much like those of alcohol. It can slow reaction time, impair both motor and eye-hand coordination, and affect time perception.

a collaborative project that intends to bring the best of prevention science to their constituents, administered in partnership between athletics and student affairs administrators, in a project called 360Proof. This effort combines personalized feedback process with campus support and intervention, relying on the very evidence-based strategies defined by these recent efforts.

The NCAA provides resources to help its membership address substance abuse prevention and promote mental health. The NCAA-sponsored APPLE Conferences (Promoting Student-Athlete Wellness and Substance Abuse Prevention) bring campus “prevention teams” composed of four to six members, including at least two student-athletes, through a strategic planning weekend that provides a framework to identify gaps in the institution’s substance abuse efforts and walks them through the development of their institutional-specific plan to address those gaps.

The University of Virginia’s Gordie Center for Substance Abuse Prevention (www.virginia.edu/gordiecenter/apple) administers the program and houses the emerging support for “Coaches Assist,” which recognizes the critical role coaches play in addressing student-athlete substance abuse.

The NCAA 2012 Student-Athlete Social Environment Study found that of the 21,000 student-athletes surveyed across all divisions and sports:

- 42 percent of men and 39 percent of women said they would turn to their parents first when seeking help/advice/support for substance use.
- 89 percent of student-athletes report coaches or others in the athletics department have talked to them about expectations regarding drinking and substance use, yet a quarter of men and a third of women would like them to talk more about it with their team.
- 85 percent of men and 93 percent of women would be likely or extremely likely to accompany a teammate home if he/she had a lot to drink.
- 79 percent of men and 93 percent of women would be likely or extremely likely to stop a teammate from driving if drinking.

The Step UP! Bystander Intervention Program (www.stepupprogram.org) provides administrators with training materials to help student-athletes exercise leadership and to “step up” when a teammate or friend is engaged in potentially harmful or dangerous situations. Step UP!

WHAT CAN YOU DO?

Approaching a student-athlete with a suspected substance-abuse problem is somewhat different from approaching a student-athlete regarding symptoms of depression or anxiety. Student-athletes with depression and/or anxiety may be more receptive and motivated for assistance. Student-athletes with substance-related difficulties may be less receptive to assistance for the following reasons:

- They may be using the substance in order to not feel bad
- They may be dependent on their substance
- They may be in denial that they have a substance-use problem
- They may fear punishment for illegal activities
- They may fear stigma associated with admitting a substance-use problem

Given these issues, approaching a student-athlete with a substance-use problem can be difficult. They may deny the problem and resist your efforts to assist them. It is probably best not to argue with them or try to convince them. Simply tell them that you are concerned, and that the only way to know for sure if there is a problem is for them to be evaluated by a professional with expertise in this area. Make the referral and follow up to make sure the referral was accepted and completed.

QUESTIONS FOR REFLECTION

1. How do you model or discuss alcohol use with student-athletes?
2. At what point would you consider substance use a problem in need of treatment?
3. How would you distinguish between casual substance use and problematic substance use?

was developed from research that recognizes the desire of students to help a friend in distress but feel ill-equipped to do so safely and effectively. Step UP! training overcomes the bystander effect that sustains inertia, and takes students through the five-step process to recognize a problem and to take personal responsibility to help.

In the meantime, above all, athletics administrators must

demonstrate leadership in recognizing the relationship of substance use, mental health and academic success by:

- Viewing substance use prevention as critical to student success.
- Establishing an environment that is supportive

of student success and deters excessive drinking/ drug use.

- Working with campus and community constituents and experts to implement a comprehensive program of evidence-based strategies.



Brian Hainline began his tenure as the NCAA's chief medical officer in January 2013. As the first person to hold that position in the organization, Hainline oversees the newly created NCAA Sport Science Institute, a national center to promote and develop safety, excellence, and wellness in college student-athletes, and to foster lifelong physical and mental development. The NCAA Sport Science Institute works collaboratively with member institutions and centers of excellence across the United States. A graduate of Notre Dame and Chicago's Pritzker School of Medicine, Hainline completed his neurology residency at The New York Hospital-Cornell. He was chief medical officer of the US Open Tennis Championships for 16 years, and then served as chief medical officer of the United States Tennis Association before moving to the NCAA.



Mary Wilfert is an associate director in the NCAA Sport Science Institute. Since 1999, she has administered the NCAA drug-education and drug-testing programs and worked to promote policies and develop resources for student-athlete healthy life choices. She serves as primary liaison to the NCAA Committee on Competitive Safeguards and Medical Aspects of Sports, the governing body charged with providing leadership on health and safety recommendations to the NCAA membership. Wilfert has worked in the health education field for more than 30 years to empower individuals to make informed choices for lifelong health and success.



Lydia Bell is the associate director of research for academic performance at the NCAA. In this role, Bell assists in all aspects of development and analysis of research on current and former student-athlete academic performance and well-being. Before joining the NCAA, she was an assistant professor of practice and director of Project SOAR in the Center for the Study of Higher Education at the University of Arizona. She received her Ph.D. in language, reading and culture and M.A. in higher education from Arizona, and an A.B. in government and legal studies and sociology from Bowdoin College.

Gambling Among Student-Athletes: Cause for Concern

BY JEFFREY L. DEREVENSKY AND TOM PASKUS

Gambling remains one of the fastest-growing industries in the world, with multinational corporations investing billions of dollars to attract customers. While age restrictions exist in most jurisdictions (the age often is dependent upon the type of gambling), it is an activity in which many colleges students participate.

Most individuals gamble legally, occasionally and in a generally responsible manner (that is, setting and maintaining time and money limits). However, for a small but identifiable subset of youth, gambling can quickly escalate out of control and affect both psychological and physical well-being.

Excessive, problematic or pathological gambling has been repeatedly shown to result in consequences that can include deviant anti-social behaviors, decreased academic performance, impaired athletics performance, and criminal and legal problems.

Generally, the social and problem gambling experiences of college student-athletes are similar to those of other youth gamblers. Results of a 2012 study that the NCAA commissioned found that 57 percent of male student-athletes and 39 percent of female student-athletes reported gambling in some form during the past year, with those student-athletes in Division I reporting the lowest incidence of gambling (50 percent for males; 30 percent for females).

While pathological gambling is a problem that affects relatively few student-athletes, it is nonetheless a persistent health concern for some individuals: 1.9 percent of males and 0.2 percent of female student-athletes are exhibiting some clinical signs of problem gambling, placing them at extremely high risk for mental health issues.

One notable difference between student-athletes and their peers is that student-athletes tend to be drawn to sports wagering at higher rates. This is not surprising, given their background and interest in sports. However, for student-athletes, wagering on sports can have negative consequences even if the behavior is not classified as excessive or pathological.

To protect the integrity of college athletics contests, NCAA regulations prohibit student-athletes from betting money on any sporting event (college, professional or otherwise) in which the NCAA conducts collegiate championships. Violations of this regulation can result in a student-athlete losing his or her athletics eligibility, which has clear negative repercussions for the individual and his or her team.

Despite NCAA regulations prohibiting sports wagering for money, 26 percent of male student-athletes report doing just that, with 8 percent gambling on sports at least

monthly. Of particular concern is the culture surrounding golf, where on-course wagering is considered a normative aspect of the experience. Males who participate in NCAA golf are approximately three times more likely to wager on sports (or engage in other gambling behaviors) than other student-athletes.

While most student-athlete sports wagering occurs solely among friends and teammates, many are now placing bets with online sites or using bookmakers they can access easily via their smartphone. Technology is also allowing outside gamblers seeking “inside” betting information easier access to college student-athletes (for example, through social media). Nearly 1 in 20 Division I men’s basketball student-athletes in the 2012 study reported having been contacted for such inside information.

Unlike other more publicized addictive behaviors (for example, alcohol, drug abuse, tobacco consumption), gambling problems often go undetected. It is important that student-athletes and athletics personnel understand that a gambling problem parallels other addictive behav-

While most student-athlete sports wagering occurs solely among friends and teammates, many are now placing bets with online sites or using bookmakers they can access easily via their smartphone.

iors. Helping student-athletes with a gambling disorder requires education, early assessment, an acknowledgment of a potential problem and effective referrals into the mental health care system.

The ability to identify the college-age problem gambler may be more difficult today because more of it is occurring online. But two-thirds of student-athletes believe that teammates are aware when a member of the team is gambling. They also report that the coach has a strong influence on tolerance for gambling behaviors and for empowering members of the team to intervene when a teammate needs help. Athletics departmental personnel, including athletic trainers and coaches, are in a unique position to observe and interact with student-athletes on a daily basis and help refer student-athletes for the appropriate assistance should such a need arise.

GAMBLING BEHAVIORS AMONG MALE STUDENT-ATHLETES

	2004 Study		2008 Study		2012 Study	
	Past Year	1/month +	Past Year	1/month +	Past Year	1/month +
Played cards for money	46.8%	20.6%	45.9%	14.3%	27.4%	6.1%
Bet horses, dogs	9.8%	2.0%	8.5%	1.4%	6.5%	1.5%
Games of personal skill	39.7%	16.3%	33.1%	13.0%	25.4%	9.9%
Dice, craps	13.4%	4.3%	11.7%	3.9%	7.8%	2.5%
Slots	19.8%	3.6%	15.1%	2.0%	11.9%	1.8%
Lottery tickets	36.2%	11.1%	31.4%	9.1%	35.2%	11.1%
Played stock market	10.2%	4.7%	9.2%	4.5%	7.4%	3.6%
Commercial bingo	6.5%	0.9%	6.9%	1.1%	5.3%	1.2%
Gambled in casino	–	–	22.9%	3.8%	18.7%	3.3%
Bet on sports	23.5%	9.6%	29.5%	9.6%	25.7%	8.3%
Casino games on Internet for money	6.8%	2.8%	12.3%	4.7%	7.5%	1.9%

Percentages displayed are cumulative rather than independent. A student-athlete reporting having wagered “once/month or more” is also included in the “past year” figure.

GAMBLING BEHAVIORS AMONG FEMALE STUDENT-ATHLETES

	2004 Study		2008 Study		2012 Study	
	Past Year	1/month +	Past Year	1/month +	Past Year	1/month +
Played cards for money	19.0%	4.4%	10.7%	1.3%	5.3%	0.6%
Bet horses, dogs	4.8%	0.4%	3.2%	0.1%	2.8%	0.2%
Games of personal skill	14.1%	3.2%	7.2%	1.2%	4.0%	0.7%
Dice, craps	3.5%	0.7%	2.2%	0.3%	2.0%	0.3%
Slots	14.3%	1.3%	9.9%	0.5%	8.4%	0.6%
Lottery tickets	29.7%	5.4%	24.0%	3.5%	30.5%	5.1%
Played stock market	3.5%	1.3%	2.1%	0.6%	1.1%	0.4%
Commercial bingo	7.3%	0.8%	6.8%	0.8%	6.2%	0.8%
Gambled in casino	--	--	11.0%	0.6%	9.4%	0.6%
Bet on sports	6.7%	1.5%	6.6%	0.8%	5.2%	0.6%
Casino games on Internet for money	2.1%	0.8%	1.9%	0.2%	1.8%	0.3%

Percentages displayed are cumulative rather than independent. A student-athlete reporting having wagered “once/month or more” is also included in the “past year” figure.

Q&A WITH JEFF DEREVENSKY

When it comes to understanding the effects of gambling behavior on student-athletes (or the population in general), few people are more knowledgeable than Jeff Derevensky, the director of the International Center for Youth Gambling Problems and High-Risk Behaviors at McGill University in Montreal.

Following is a Q&A that probes Derevensky’s insights on gambling behaviors.

QUESTION: What are the most alarming trends you’ve seen to date?

JEFF DEREVENSKY: There are several. Perhaps the one from which all others emerge is the global normalization of the behavior. The gambling industry has done a terrific job in that regard – they don’t even call themselves gambling anymore. Now it’s “gaming.” They’re selling entertainment. They’ve gotten away from the sin-and-vice image that had been associated with gambling to where it’s now a normal socially acceptable behavior. TV also has done a remarkable job advertising gambling, not just through sports but through poker tournaments. ESPN has been able to develop inexpensive programming along those lines that has attracted millions of people. The electronic forms of gambling have made it accessible to the average person 24 hours a day, seven days a week. Even the government is in on the act, supporting lotteries as an easy kind of “voluntary taxation.”

SELF-REPORTED PERSONAL BELIEFS OF STUDENT-ATHLETES ABOUT SPORTS WAGERING

(all divisions; among student-athletes who reported wagering on sports in the last year)

2012 study	Males	Females
Most athletes in college violate NCAA sports-wagering rules	59%	48%
Wagering is acceptable as long as you don’t wager on your own sport	57%	41%
Coaches see wagering as acceptable as long as you don’t bet on your own games	41%	26%
Athletes and coaches take NCAA sports-wagering rules seriously	62%	68%
I think sports wagering is a harmless pastime	68%	58%
People can consistently make a lot of money gambling	59%	49%

Q: What about other trends and concerns?

JD: The landscape has changed dramatically. There are more states with casinos than ever before. When the NCAA initiated its first gambling task force in 2003, only Nevada and New Jersey had casinos. Now there are plenty of casinos in Florida, Oklahoma, Pennsylvania, Maryland, Virginia, Louisiana and many other states. Also, electronic forms of gambling are becoming increasingly popular. In 2003, very few people even thought of gambling online. Now you can wager virtually on anything online. There were odds on what Prince William and Kate Middleton were going to name their baby. You can gamble on who’s going to be the next pope, or the next president. There were odds on where Angelina Jolie would adopt her next child from. In that vein, there is now live in-game betting – odds generated in real time for participants to bet on various aspects of a game as it unfolds. About 10 percent of male student-athletes in the 2012 study who wager on sports have engaged in live in-game betting. “Spot fixing” is another one. Spot fixing is just a single midgame event or portion of a contest needing to be fixed for a bet to pay off. It’s generally seen as easier to do and harder to detect than manipulating a final outcome.

Q: What about the technology? Has gambling through social media become pervasive?

JD: Simulated forms of gambling – often referred to as “practice sites” – that’s the new phenomenon. We currently don’t know if there’s a causal relationship between simulated forms of gambling (for virtual currency) and actual gambling. We do know, however, that as simulated gambling goes up, so does actual gambling and gambling-related problems.

PERCENTAGE OF STUDENT-ATHLETES REPORTING THAT THEY PLAYED SIMULATED GAMBLING ACTIVITIES IN THE PAST YEAR

	Males	Females
Played activity via videogame console	18.2%	4.8%
Played activity via social media website	12.0%	4.2%
Played activity via Internet gambling site	10.3%	2.4%
Played activity on a cell phone	14.5%	5.4%
Played a free sports-betting or bracket game online	11.7%	2.2%

Q: What do you mean by simulated forms of gambling?

JD: If you play a simulated form of gambling online, such as virtual slots or fantasy sports or filling out brackets for “virtual money,” it hasn’t been proven that it will prompt you to gamble for real money. But the link is rather intuitive, isn’t it? Playing for “fun” or the “social media-type” games often have greater payouts than the real-money games do. So if you’re playing these games and you’re winning all this virtual money, the natural thought is that, gee, if I had only been playing for real money, look how much I would have made. One of the most frightening findings we’ve recently found in terms of motivation for gambling is that children, teens and even young adults are gambling either for virtual or real money to relieve boredom. It’s just a click away.

Q: How do audiences accept you when you’re presenting around the world?

JD: These days, the most receptive crowd is the industry itself. Years ago, I gave a talk to the Internet gambling industry and they regarded me as a pariah. Somebody in the audience emailed me afterward in fact and said that while it was an interesting presentation, why was I walking back and forth across the stage so much? I answered, “It’s harder to hit a moving target.” Now, the industry is looking at “responsible gaming.” They are concerned about keeping players safe; making sure that people don’t lose their homes, drop out of school, get involved in illegal behaviors or commit suicide because they’re overwhelmed by their gambling problems. Nobody wants that.

Q: What about the reception from colleges and universities?

JD: It’s a little more under the radar at the collegiate level. Most people are more familiar with drug and alcohol issues and violence on campus. But gambling is just like alcohol. While it’s a normalized behavior – for example, with drinking, the message is “as long as you’re old enough and you drink responsibly, then you’re OK.” But you can’t become an alcoholic if you don’t start drinking. And you can’t become a problem gambler if you don’t start gambling. At the youth level, authorities talk with young people about drinking, but not about gambling. We do need more prevention, education, awareness and treatment programs for our youth and their parents.

Q: What’s your advice for colleges and universities now?

JD: First of all, don’t ignore it. Does it affect, or is it harmful to, the majority of your student population? Probably not. But is it negatively affecting at least some of your students? Absolutely. I was with a university president once whose school had collected research on gambling behaviors on campus, but he said he wasn’t going to release the results. I asked him why, and he said he couldn’t trust “gambling researchers” because they would make a big deal of three people out of 5,000 having a problem. I said I understood, but I added that by not releasing the findings, people think you’ve got something to hide. That convinced him to be more transparent. Just like most campuses have policies on drugs and alcohol, they need a policy on gambling.

Q: What is a good way to spot problem gambling behavior?

JD: It’s difficult to do, because not many problem gamblers are open about their situation. But if you notice someone who maybe talks a lot about gambling or is pretty secretive about where he’s going, then that’s a clue. Also, problem gamblers become consumed with the behavior, and everything else tends to slide. If someone who had been doing well in class begins to let his or her grades slip, or if a usually outgoing person becomes reclusive, and of course if that person starts having financial trouble, then problematic gambling might be at the root of those behaviors.

Q: Are there approaches on campus that are known to work?

JD: Student-athletes report that coaches and teammates are their primary influences, so programs targeting those people – particularly coaches – are helpful. I like the idea of involving student services groups as well. The more campus-wide involvement, the better. This is a more general student issue, and not one that affects only student-athletes. It’s important to understand that what starts off as a fun, harmless activity can lead to other serious problems. One or two out of 100 college students having a problem isn’t likely to set the world on fire, but if you approach the gambling issue as being among a number of things that can negatively impact student health and well-being, then your odds of resonating, so to speak, are much greater. It’s important to remember that every problem gambler tends to seriously impact a dozen other people: boyfriends, girlfriends, peers, teammates, coaches, parents and employers. And for student-athletes, it can jeopardize their eligibility.

**MOST EFFECTIVE WAYS TO INFLUENCE STUDENT-ATHLETES
NOT TO WAGER ON SPORTS**

(as reported by student-athletes who have wagered on sports in the past year)

Rank	Males	Females
1	Coach	Teammates
2	Teammates	NCAA penalties
3	NCAA penalties	Coach
4	Pro athlete presentation	Pro athlete presentation
5	Parents	Law enforcement presentation
6	Athletics department info	Athletics department info



Jeff Derevensky is the director of the International Center for Youth Gambling Problems and High-Risk Behaviors at McGill University in Montreal. The National Center for Responsible Gaming recently honored Derevensky with its coveted Scientific Achievement Award, one of dozens of accolades he has earned from his research over time. He and NCAA Principal Scientist Tom Paskus co-authored the 2008 and 2012 NCAA studies on student-athlete wagering behaviors.



Tom Paskus is the principal research scientist for the NCAA. In this role, he directs the NCAA’s national portfolio of studies on the academic trajectories of college student-athletes and oversees the NCAA’s data collections and research initiatives pertaining to the academic, athletic, social, and personal well-being of current and former student-athletes. Before joining the NCAA, Paskus was a faculty member in the quantitative research methods program in the College of Education at the University of Denver. He received his Ph.D. and M.A. in quantitative psychology from the University of Virginia, and an A.B. in psychology from Dartmouth College.

Sleeping Disorders

BY MICHAEL GRANDNER

There's a reason most people spend about one-third of their lives asleep. Sleep is not a passive state of rest, but an active state of rebuilding, repair, reorganization and regeneration.

During waking hours, we engage with the environment, taking in information, interacting with others and forming new memories and experiences. During sleep, the body performs many other vital functions for which it needs to be disconnected from the environment. For example, sleep plays an important role in memory consolidation, emotional regulation, growth and cell repair.

Despite the importance of sleep, difficulties are common. Most adults need seven to eight hours of sleep to maintain optimum functioning, and younger adults need more (eight to 10 hours). However, many people – including student-athletes – do not get the amount of sleep they need, often due to insomnia, sleep apnea or another sleep disorder.

Lack or loss of sleep can also be due to the many competing demands for time, which is a prominent concern in the student-athlete population. Either way, understanding and dealing with sleep problems may have a profound effect on mental clarity and health.

Understanding and dealing with sleep problems may have a profound effect on mental clarity and health.

Inside the sleep process

Sleep is made up of two distinct states – REM (rapid eye movement) sleep, and non-REM (NREM) sleep. Most of the night is spent in NREM sleep, which is made up of:

- Stage 1 (very light, transitional sleep)
- Stage 2 (moderate sleep)
- Stage 3 (deep sleep)
- Stage 4 (very deep sleep)

REM sleep makes up about 20 percent of the night and is associated with (as the name implies) rapid eye movements. It is also characterized by a high degree of brain activity (similar to light sleep or waking). Dreams are common in REM sleep, and people would act out their dreams if it were not for signals from the midbrain that actively prevent skeletal muscle activity. Therefore, REM sleep is accompanied by lack of muscle tone (similar to paralysis).

Stages 3 and 4 of NREM sleep are crucial for growth, and cell rebuilding and repair. Stage 2, which accounts for more than 50 percent of the night, is important for many cognitive and bodily functions. For example, sleep is critically important for regulating many hormones that control stress, hunger and appetite, growth and healing, and biological rhythms. As such, sleep disruption is likely to disrupt any combination of these systems.

Almost 40 percent of American adults (about 80 million people) get six hours of sleep or less. The average American adult reports about two nights of insufficient sleep per week.

INSOMNIA, defined as a persistent difficulty falling or staying asleep, accompanied by daytime impairment, is common. Approximately one in three U.S. adults suffer from symptoms of insomnia, and about one in three of those meet criteria for an insomnia disorder (which is associated with increased risk of depression, substance use and medical problems).

SLEEP APNEA is also common. It is a condition in which an individual has difficulty breathing during sleep, usually because of a blocked airway, in which case it is referred to as “obstructive sleep apnea.”

It is estimated that among adults age 30 and older, rates for sleep apnea are 10-15 percent and 3-9 percent among men and women, respectively. This is significant, since sleep apnea is associated with obesity, cardiovascular disease, diabetes and neurological problems. Diagnosing and treating sleep apnea is a critical issue, since most people with the disorder do not know they have it,

RISK FACTORS IN THE SPORT ENVIRONMENT

- Timing of practices, travel and competition can interfere with regular sleep patterns.
- Athletics and academic time demands can decrease sleep opportunity.

POSSIBLE ATHLETICS CONSEQUENCES

- Sleep deprivation can result in decreased physical and mental functioning, both of which may adversely affect athletics performance.

and untreated sleep apnea is a major health risk factor.

Since body type (such as obesity and thick neck) can play a role in developing sleep apnea, certain student-athletes may be at high risk for the disorder, especially football linemen.

How student-athletes are affected

There hasn't been much research on student-athlete sleep patterns and problems, but given the timing of practices, travel and competition, student-athletes are likely at high risk of sleep difficulties. In addition, extra time demands, including balancing athletics with academics, can reduce sleep opportunity.

An American College Health Association survey found that on average, most student-athletes report four nights of insufficient sleep per week. However, insomnia diagnosis was very low, at 3 percent in athletes versus 2 percent in non-athletes.

An NCAA study showed that one-third of student-athletes get fewer than seven hours of sleep per night, with greater values among women.

Other studies have shown that improving sleep can lead to better performance. As such, it would benefit athletics departments to monitor their student-athletes' sleeping patterns to ensure proper behaviors.

As to the causes for sleep deprivation in the student-athlete population, the balancing act they must perform in being both a student and an athlete (and having a well-rounded college experience) can frequently impinge on sleep time. Making sleep an important priority and a part of more general work-life balance may help student-athletes better manage their time, their stress – and their sleep.

Athletics departments also should pay closer attention to student-athletes who travel frequently for competition. Travel across time zones can result in jet lag, which can take a physiologic toll on the body and also impair physical and cognitive performance. In addition, travel (even within a time zone) can involve uncomfortable sleeping arrangements, disrupted schedules, and other changes that can impair physical and mental health in the short and long term.

What athletics departments can do

It would behoove athletics departments to have a comprehensive sleep disorders screening and treatment program available for their student-athletes. And before

WHAT CAN YOU DO?

- Pay close attention to how athletics demands, including travel, influence sleep patterns and sleep opportunity, and consider revising team schedules as appropriate.
- Screen student-athletes for insufficient sleep.
- Communicate to student-athletes about the importance of adequate sleep for optimal athletics performance.

QUESTIONS FOR REFLECTION

1. Do you schedule obligations for student-athletes at times that interfere with their ability to get a full night's sleep?
2. Do you communicate with student-athletes about the importance of sleep for physical and mental functioning?

you say your school doesn't have the resources to create or maintain such a program, assessing sleep problems doesn't have to be costly or cumbersome.

Polysomnography ("sleep study" in the laboratory) is the most intensive approach to sleep assessment. It measures brain activity, muscle activity on the chin and legs, heart rhythm, and breathing effort in the chest and abdomen, among other things. Polysomnography is usually performed at a sleep center accredited by the American Academy of Sleep Medicine.

These types of studies are most useful for the detection of sleep apnea and sleep-related movement disorders, especially complex cases. For the detection of routine sleep apnea, home-based sleep recording, using portable devices that measure respiratory flow and effort and oxygen saturation, have been shown to be a useful, lower-cost option.

Insomnia and other problems with habitual sleep schedules are usually assessed with a daily sleep diary or wrist actigraphy (a device that records movement, providing an objective estimate of sleep and wake time).

Several brief screening questionnaires that can detect problem sleep are also available, including the Pittsburgh Sleep Quality Index, the Insomnia Severity Index, the STOP questionnaire and the Berlin Questionnaire.

In assessing general problems, getting information about weekday and weekend time into bed, the time it

takes to fall asleep (sleep latency), the number of awakenings, the duration of awakenings (wake after sleep onset), the final awakening time and final time out of bed can discern sleep timing, duration and overall quality of sleep, thus revealing the nature of many sleep problems.

Athletics departments can develop partnerships with local or regional sleep centers (accredited by the American

Academy of Sleep Medicine: <http://www.aasmnet.org>) to develop and implement long-term solutions for the problems that sleep disorders pose.

Taken together, raising awareness about sleep, getting students (and staff) appropriately screened, monitoring patterns and delivering helpful treatments are critical for maintaining student-athletes' long-term mental health.



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Suicidal Tendencies

BY DAVID LESTER

While there's no "good" news when it comes to suicide, the silver lining at least is that it is not especially common in undergraduate college and university students. Some studies report suicide rates that are lower than young people of the same age who are not in college, and some studies report similar suicide rates for the two groups.

As a result, when we turn to college student-athletes, there are very few cases of completed suicide. However, we do know what kinds of factors and stressors might lead to an attempted suicide, and we do know that participation in sports can actually protect against some of those stressors.

At the present time, student-athletes appear to be less likely to have suicidal ideation and to make suicide attempts than other college students, but the protective impact of sports varies with the type of sport, sex and ethnicity. The protective effect is most evident in white male student-athletes playing in traditionally "male" sports.

For amateur athletes, researchers have focused on suicidal ideation and attempted suicide, and most of the research has been conducted on high school athletes. The Centers for Disease Control and Prevention have conducted a Youth Risk Behavior Surveillance of high school students every two years from 1991 to 2011.

Of those studies, eight showed a protective effect for boys while three showed no effect. For girls, six studies showed a protective effect, one a detrimental effect, and four no effect. The protective impact of sports on suicidal ideation and attempts was, therefore, more evident for boys than for girls.

There also seemed to be an impact of ethnicity, with the protective effects more evident for white boys than for boys of other ethnicities.

We can only speculate about the reason why participation in sports generally finds a protective impact for suicidal behavior in most studies. First, participation in sports involves physical activity, and exercise may reduce depression. Second, participation in sports has many positive side effects, including the social bonding from being in a team and the increase in self-esteem from achieving success in the sport.

On the other hand, participation in some sports may increase the likelihood of hazing (especially of rookies), alcohol abuse, risky sexual behavior and violence. Since the limited research indicates a protective impact from sports participation, it would appear that the positive ef-

fects outweigh the negative ones.

A recent study reported that the protective impact of sports was found for some team sports, but that participation in a sports activity not generally engaged in by those of one's own sex is detrimental. For example, boys who were cheerleaders and girls who were wrestlers more of-

.....
Participation in sports involves physical activity, and exercise may reduce depression. Secondly, participation in sports has many positive side effects, including social bonding and increase in self-esteem.
.....

WARNING SIGNS

- Extreme depression, withdrawal
- Sleeplessness, lowered grades, poor work performance
- Giving away personal possessions
- Putting affairs in order (goodbye letters, wills)
- Suicide threats (verbal, written, nonverbal)
- Previous suicide attempts
- Acquiring the means to commit suicide (pills, rope, guns, knives, etc.)
- A sudden lift in spirits after extreme depression (this can mean a person is relieved that problems will "soon be ended")
- Having a plan

MYTHS ABOUT SUICIDE

- People who talk about suicide do not commit suicide.
- Mentioning the word "suicide" may give a person the idea.
- All suicidal people are mentally ill.
- A suicide threat is just a bid for attention and should not be taken seriously.
- Suicide happens without warning.
- If a person attempts suicide and survives, he/she will never attempt again.
- Once a person is suicidal, he/she is suicidal forever.

ten reported suicidal ideation. The study also found that the protective effects of sports participation were not as clear in African-American, Hispanic-American and Asian-American students.

Some studies have been conducted recently that explore suicide in professional athletes and the risk factors that predict these suicides. Many of these factors may apply to the student-athlete population as well.

ANABOLIC-ANDROGENIC STEROIDS. Professional athletes' anabolic-androgenic steroid use has been clearly documented in recent years, and research has found that it increases the risk of both suicide and outwardly directed violence such as assault and murder. One study of power lifters in Finland found that 38 percent of the deaths of power lifters who used steroids were from suicide as compared with only 3 percent of the deaths of Finnish men in general.

CONCUSSIONS. Concern about the role that concussions (mild traumatic brain injury) in sports play in athletes has increased, especially with the revelation that some former professional football players have developed chronic traumatic encephalopathy (CTE). Although depression is more common in professional football players who have suffered with multiple concussions, there is no clear relationship that has been described in collegiate football players. Suicide has occurred in professional football players who developed CTE, but the causal relationship between CTE and concussion is unknown, and the relationship – if any – of suicide and CTE is also unknown.

DRUG ABUSE AND ALCOHOLISM. Both are common in professional athletes, and college student-athletes, as noted in the prior article “Substance Use and Abuse,” are also at risk for these issues. Substance abuse of any kind is a risk factor for suicide.

PSYCHIATRIC PROBLEMS. Many professional and collegiate athletes have psychiatric symptoms, some of which predate their involvement in athletics and some of which are exacerbated by their sports careers. Psychiatric problems are another major risk factor for suicide.

BULLYING AND SEXUAL ABUSE. Some studies indicate that up to 10 percent of Olympic athletes endured bullying and sexual abuse as children and adolescents, often as part of their sports involvement. In recent years, several coaches have been found guilty of sexually abusing players, and hazing and bullying, especially of rookies, are part of the culture of sports. Again, these experi-

WHAT CAN YOU DO?

- When dealing with a student-athlete who has expressed, indicated an intent or plan, or attempted suicide, do not attempt to determine the seriousness of the thought, gesture or attempt. Such thoughts, behavior or threats are serious and potentially dangerous. Do not assume the person is engaging in suicidal thoughts or actions merely for attention.
- Make an immediate referral to a mental health professional who can immediately evaluate the student-athlete. Most college campuses have a counseling center staff member who can offer guidance or referral. Many counseling centers will offer “walk-in” or “emergency” services. For emergency situations after normal office hours, the counseling center staff can recommend other options, such as going to the nearest hospital emergency room.
- Your quick response lets a student-athlete know that you take his or her health difficulties and life seriously; it is better to err on the side of responding immediately and in a supportive manner.
- Have the names and phone numbers of referral sources available. Determine your options now before you need them.
- Make sure a suicidal student-athlete is not left alone. The student-athlete should have someone with him or her until a mental health evaluation is completed.

ences are important risk factors for suicide.

RETIREMENT. Retirement is perhaps the most important risk factor for suicide in professional athletes. Studies of baseball players and cricket players who died by suicide found that very few professional athletes died by suicide during their careers. Most killed themselves after their careers were ended either by injury, being fired or retiring. Many professional athletes have made no plans for their lives after their careers are over and when they are no longer in the spotlight. They may have pain and physical impairment from the injuries that they received during their careers, and they may face serious financial problems once their income ends, especially if they have incurred expensive long-term costs (such as alimony and child support) and if they spent their wealth unwisely during their professional careers.

Given all of these risk factors, how common is suicide in professional athletes? A 2013 study found that, after

controlling for age and sex, those currently listing their occupation as athletes did not have a higher risk of suicide, although they did have a higher risk of death from all violent causes (suicide, accidents and murder). In baseball, 1 percent of deceased players are documented to have died from suicide, less than expected for men in the United States. And for cricket in Great Britain, a 2001 study found that 1.5 percent of deaths were from suicide, again not especially high. Most of these suicides occurred in players no longer active in the sport.

Clearly, much more research is needed on this import-

ant topic to identify the reliable associations regarding suicide and suicidal ideation, and the causal mechanisms underlying these associations.

QUESTIONS FOR REFLECTION

1. Do you have the names and phone number of referral sources easily available?
2. Have you discussed the “myths” regarding suicide with your mental health team?



David Lester is a distinguished professor of psychology at the Richard Stockton College of New Jersey. He is a former president of the International Association for Suicide Prevention. Lester has published extensively on suicide, including “Understanding and Preventing College Student Suicide” (Charles C. Thomas, 2011) and “Suicide in Professional and Amateur Athletes” (Charles C. Thomas 2012).

Education-Impacting Disabilities and the NCAA Waiver Process

BY MARCIA RIDPATH

The population of students with disabilities is growing in the postsecondary setting. One of the reports provided by the U.S. Government Accountability Office (GAO) indicates that students with disabilities represented nearly 11 percent of all postsecondary students in 2008. This upward trend is reflected in the world of athletics as well.

In the NCAA waiver process, we have seen a steady increase in the number of student-athletes with disabilities, particularly those with diagnosed or suspected mental health disorders.

Athletic trainers often have a unique perspective because they work closely with student-athletes and can be one of the first to identify signs of a potential mental health impairment. When a student-athlete arrives on campus, he or she may not have a formally identified mental health concern; however, we often see difficulties develop as the student-athlete transitions to the collegiate environment.

Many student-athletes struggle both in and out of the classroom and find themselves in need of an academic waiver to establish or repair their athletics eligibility. Athletic trainers and other athletics department staff can often provide insightful documentation when an institution chooses to file a waiver on behalf of a student-athlete.

*For academic eligibility purposes,
the NCAA defines a disability as
a current impairment that has a
substantial educational impact on
a student's academic performance
and requires accommodation.*

It is important that colleges and universities are aware of the NCAA's definition of disability. We use the term "education-impacting disability" (EID) in Divisions I, II and III, in all types of waivers, and in related policy/procedures tied to disability. The definition is as follows:

"For academic eligibility purposes, the NCAA defines a disability as a current impairment that has a substantial educational impact on a student's academic performance and requires accommodation."

Following is a list of the various types of disabilities

that typically surface in the waiver process. Learning disabilities/disorders, attention-deficit hyperactivity disorders and mental health disorders are the most prevalent impairments. Documentation often indicates that students present with more than one identified disorder.

- Learning disabilities/disorders (LD)
- Attention-deficit hyperactivity disorder (ADHD)
- Mental health disorders
- Medical conditions
- Hearing impairment
- Autism spectrum disorders (ASD)

Athletics department personnel are in a key position to observe the challenges and behaviors present in the lives of student-athletes, often on a daily basis. This is particularly true for those student-athletes with suspected or formally diagnosed mental health disorders. Because "mental health disorder" is such a broad category, it helps to see a list of the most frequent impairments cited under this umbrella in the waiver process. Common disorders include:

- Major depressive disorder
- Generalized anxiety disorder
- Social anxiety disorder/social phobia
- Adjustment disorder
- Obsessive/compulsive disorder
- Oppositional defiant disorder
- Addictions
- Post-traumatic stress disorder
- Panic disorder
- Bipolar disorder

It is also important to note that not every individual with a diagnosed condition (including mental health disorders) is considered "disabled" under the Americans with Disabilities Act (as amended). The ADA is a civil rights law with the goal "to provide a clear and comprehensive national mandate for the elimination of discrimination of individuals with disabilities."

The ADA provides the following definition to help identify individuals who are protected by this law:

"The term 'disability' means, with respect to an individual, a physical or mental impairment that substantially limits one or more major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment. Major life activities include caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking,

communicating and working. Major life activities also include the operation of a major bodily function, including functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.”

When an NCAA member institution submits a waiver under the EID category, we review the documentation to see if the individual has self-identified as someone with an impairment under the ADA. This usually occurs when the student voluntarily chooses to disclose his or her documentation to the disability office on campus.

The disability office verifies the impairment and determines reasonable accommodations or academic adjustments specific to that student in order to “level the playing field and remove barriers.”

It is important to note that a diagnosis does not automatically result in certain accommodations and services. It is the role of the disability office on campus to work individually with each student to “identify the limits caused by the disability and determine ... which accommodation(s) will be appropriate and reasonable.”

The EID waiver process also includes an in-depth review of the documentation to note the date of initial onset of the disorder(s), the duration and severity of the disorder(s) and the potential educational impact (including identifying the major life activities that are substantially limited). In addition, most waivers require a written statement from the student-athlete that addresses the disability(s) and the impact he or she has encountered in the academic setting.

Whether the student chooses to disclose his or her impairment is often a key component to examine in the EID waiver process. The decision and responsibility to disclose belongs to the individual with a disability. Because concern about discrimination is so prevalent, some students decide not to disclose, even though they often forfeit needed services and accommodations.

The October 2009 GAO report makes the following comment about students and disclosure in the postsecondary environment:

“A related challenge for schools is providing services to students with disabilities who did not initially disclose their need for accommodations. Some students choose not to disclose their disability, even when they are aware of available services, according to school officials and disability experts. While a student is not obligated to inform a school that he or she has a disability, in or-

It is the role of the disability office on campus to work individually with each student to “identify the limits caused by the disability and determine ... which accommodation(s) will be appropriate and reasonable.”

der for the school to provide an academic adjustment or another disability-related service, the student must identify himself or herself as having a disability. Any initial nondisclosure may become problematic for schools when students disclose and request accommodations after they fall behind academically. For example, a school may find it difficult to provide timely accommodations to a student who disclosed a visual or learning disability in the middle of a semester because of the time required to convert textbooks into electronic format. School and disability group officials told us that some students choose not to register with the disability services office and request accommodations for a variety of reasons. For example, they said some students, especially those with ‘hidden’ disabilities, such as learning disabilities, are reluctant to disclose because they want a fresh start in higher education without the label of having a disability.”

Disclosure is a critical but voluntary component in the EID waiver process. Many student-athletes find themselves in need of a waiver because they haven’t accessed the services available through the disability office. This scenario can be true for many types of waivers, such as student-athlete reinstatement, progress-toward-degree, legislative relief, and 2-4 transfers.

For students with mental health disorders, fear of disclosure can be especially inhibiting and it is often an assertion in the waiver process. There are stigmas and perceptions related to mental illness that affect both the individual with the impairment and those around that individual. This is certainly true if the student has a first-time experience with a mental health issue after enrolling in a postsecondary institution.

The combination of unsettling symptoms and transi-

tion to the collegiate environment can result in isolating behaviors and diminished participation; student-athletes pull away from people who can provide much-needed support. In these circumstances, the athletic trainers or other athletics department staff who have regular contact with the student may have firsthand knowledge with important insight into the student-athlete's difficulties and how his or her collegiate journey has been impacted.

Looking ahead poses a unique opportunity for athletics department staff. Departments have the important responsibility of educating their staff and developing best practices to address the specific needs of student-athletes with education-impacting disabilities. This is timely and critical because the complexity and combinations of disabilities (and specifically mental health disorders) has increased over the past several years. Many EID waivers

provide documentation for students with significant personal, emotional and medical issues that impact academic progress.

Athletics department personnel are in a unique position to encourage their student-athletes with disabilities to seek all of the support and services available at the institution. Self-advocacy is a crucial skill for all students but it is especially important for student-athletes with EIDs.

Many student-athletes need assistance in developing the ability to explain their disability and its educational impact and access their approved services and accommodations to maximize academic success. Athletic trainers and department staff can play an important role in the lives of student-athletes as they learn how to navigate the intersection between their disability and the world of college and athletics.



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CHAPTER 4
THE BIG INJURY (AND SMALL ONES, TOO)

[How Being Injured Affects Mental Health](#)

By Margot Putukian

[Post-Concussion Syndrome](#)

By David Coppel

[Supporting Student-Athletes in Transition](#)

By Penny Semaia

How Being Injured Affects Mental Health

BY MARGOT PUTUKIAN

Injuries, while hopefully infrequent, are often an unavoidable part of sport participation. While most injuries can be managed with little to no disruption in sport participation and other activities of daily living, some impose a substantial physical and mental burden. For some student-athletes, the psychological response to injury can trigger or unmask serious mental health issues such as depression, anxiety, disordered eating, and substance use or abuse.

When a student-athlete is injured, there is a normal emotional reaction that includes processing the medical information about the injury provided by the medical team, as well as coping emotionally with the injury.

Those emotional responses include:

- Sadness
- Isolation
- Irritation
- Lack of motivation
- Anger
- Frustration
- Changes in appetite
- Sleep disturbance
- Disengagement

How student-athletes respond to injury may differ, and there is no predictable sequence or reaction. The response to injury extends from the time immediately after injury through to the post-injury phase and then rehabilitation and ultimately with return to activity. For most injuries, the student-athlete is able to return to pre-injury levels of activity. In more serious cases, however, a student-athlete's playing career may be at stake, and the health care provider should be prepared to address these issues. The team physician is ultimately responsible for the return-to-play decision, and addressing psychological issues is a significant component of this decision.

It's important for athletic trainers and team physicians, as well as student-athletes, coaches and administrators, to understand that emotional reactions to injury are normal. However, problematic reactions are those that either do not resolve or worsen over time, or where the severity of symptoms seem excessive. Examples of problematic emotional reactions are in the accompanying table.

One problematic reaction is when injured student-athletes restrict their caloric intake because they feel that since they are injured, they "don't deserve" to eat. Such a reaction can be a trigger for disordered eating. When a student-athlete is already at risk for disordered eating, this problematic reaction only heightens the likelihood these unhealthy behaviors will worsen.

PROBLEMATIC EMOTIONAL REACTIONS

Persistent symptoms

- Alterations of appetite
- Sleep disturbance
- Irritability

Worsening symptoms

- Alterations of appetite leading to disordered eating
- Sadness leading to depression
- Lack of motivation leading to apathy
- Disengagement leading to alienation

Excessive symptoms

- Verbal and nonverbal behaviors that indicate the individual is experiencing high levels of pain
- Excessive anger or rage
- Frequent crying or emotional outbursts
- Substance abuse

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It's important for athletic trainers and team physicians, as well as student-athletes, coaches and administrators, to understand that emotional reactions to injury are normal.
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Another problematic response to injury is depression, which magnifies other responses and can also impact recovery. Depression in some student-athletes may also be related to performance failure. When student-athletes sustain significant injuries, such as knee injuries associated with time loss from sport, they can suffer both physically as well as emotionally with a decrease in their quality of life. When Olympic skier Picabo Street sustained significant leg and knee injuries in March 1998, she battled significant depression during her recovery. She stated: "I went all the way to rock bottom. I never thought I would ever experience anything like that in my life. It was a combination of the atrophying of my legs, the new scars, and feeling like a caged animal." Street ultimately received treatment and returned to skiing before retiring.

Kenny McKinley, a wide receiver for the Denver Bron-

cos, was found dead of a self-inflicted gunshot wound in September 2010 after growing despondent following a knee injury. He had undergone surgery and was expected to be sidelined for the entire season. He had apparently made statements about being unsure what he'd do without football and began sharing thoughts of suicide.

These case examples demonstrate how injury can trigger significant depression and suicidal ideation.

Concussion is another injury that can be very challenging for student-athletes to handle emotionally. An injury like an

What makes concussion particularly difficult is that unlike most injuries, the timeline for recovery and return to play is unknown.

ACL – while it poses a serious setback to the student-athlete – at least comes with a somewhat predictable timeline for rehabilitation and recovery. What makes concussion particularly difficult is that unlike most injuries, the timeline for recovery and return to play is unknown. With concussion, the initial period of treatment includes both cognitive and physical rest, which counters the rigorous exercise routine many student-athletes often depend on to handle stressors. Given the emotional and cognitive symptoms associated with concussion, student-athletes often struggle with their academic demands. In addition, compared with some injuries where a student-athlete is on crutches, in a sling, or obviously disabled in some way, with the concussed student-athlete, he or she “looks normal,” making it even more challenging to feel validated in being out of practice or play.

For the student-athlete with concussion, it is especially important – and difficult – to watch for problematic psychological responses to the injury. Some student-athletes experience emotional symptoms as a direct result of the brain trauma that can include feeling sad or irritable. If these symptoms don't seem to be going away it is important to explore whether they might be related to a mental health issue such as depression and not directly to the injury itself. In some cases, the psychological reaction to the concussion – rather than the concussion itself – can be the trigger for the depression. When this is the case, simply waiting for the brain to recover

isn't enough: the depression also needs to be treated.

It is also important to be aware that with increasing media attention being paid to neurodegenerative diseases such as chronic traumatic encephalopathy (CTE) among professional athletes, some student-athletes might fear that even the mildest concussive injury will make them susceptible to these highly distressing outcomes. Though there is very little known about what causes CTE or what the true incidence of CTE is, the concern for possibly developing permanent neurodegenerative disease can be paralyzing. Athletic trainers and team physicians can help educate injured student-athletes about the known risks associated with concussions and can help them focus on managing the injury in the present. They should also be aware that student-athletes who are expressing a high level of anxiety could be experiencing a mental health condition that requires treatment by a mental health professional.

Seeking treatment

Injured student-athletes who are having a problematic psychological response to injury may be reticent to seek treatment. They may be afraid to reveal their symptoms, may see seeking counseling as a sign of weakness, may be accustomed to working through pain, may have a sense of entitlement and never had to struggle, and may not have developed healthy coping mechanisms to deal with failure. In addition, many student-athletes have not developed their identity outside of that as an athlete. Thus, if this role is threatened by injury or illness, they may experience a significant “loss.” Getting a student-athlete to consider treatment can be challenging (and it is complicated by privacy issues), so coaches, athletic trainers and team physicians as the support network for the student-athlete should work together to provide quality care.

As an athletic trainer or team physician, it's important to be aware of common signs and symptoms for various mental health issues and understand the resources available to treat them. Those personnel also must do everything possible to “demystify” mental health issues and allow student-athletes to understand that symptoms of mental health issues are as important to recognize and treat as symptoms for other medical issues and musculoskeletal issues. Underscoring the availability of sports medicine staffs to provide for early referral and management of mental health issues is essential.

It's also important for coaches, athletic trainers and team physicians to support injured student-athletes and do what they can to keep athletes involved and part of

SUGGESTIONS FOR COACHES

1. Understand both common psychological responses to injury as well as problematic responses.
2. Communicate with athletic trainers and team physicians regarding injured student-athletes, and work to include the injured student-athlete in team functions and practice/competitions when possible.
3. Understand the mental health resources available to student-athletes as well as the role of athletic trainers and team physicians in expediting referrals. Be supportive of seeking care for mental health issues.

the team. This might include keeping student-athletes engaged, and at the same time encouraging them to seek help and not try to “tough their way through” situations that include mental health factors.

For coaches, one of the most powerful actions is to “give the student-athlete permission” to seek treatment (see Mark Potter’s article in Chapter 1 emphasizing this notion). This is often incredibly helpful in encouraging

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As an athletic trainer or team physician, it’s important to be aware of common signs and symptoms for various mental health issues and understand the resources available to treat them.
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student-athletes to seek care. Having programs available to educate student-athletes as well as sports medicine and administrative staffs regarding the resources available and the importance of collaborative programming helps provide appropriate care.

It is important to understand the mental health resources available on each campus and consider both early referral as well as establishing multidisciplinary teams that include athletic trainers, team physicians, psychologists, psychiatrists and other health care providers to provide care for mental health issues in student-athletes. If this can be incorporated into the overall goal of optimizing performance, along with nutrition and strength and conditioning, it may be better received by student-athletes and coaches, thereby

SUGGESTIONS FOR ATHLETIC TRAINERS AND TEAM PHYSICIANS

1. Understand the common psychological responses to injuries as well as the need for monitoring for problematic responses that can be triggered by injury.
2. Screen for underlying mental health issues, such as depression, anxiety, eating disorders, substance use and gambling issues during the pre-participation physical as well as during the season.
3. Look for problematic psychological responses (those that do not resolve, worsen over time, or where the severity of symptoms seem excessive) in athletes during all aspects of injury (immediately after injury, post-injury, rehabilitation, return to play progression).
4. Understand the unique challenges of the psychological response to concussive injury given the individualized and often unclear timeline for recovery, the overlap of common post-concussive symptoms with mental health symptoms, and the increasing concern for the possibility of complications such as neurodegenerative disease and persistent post-concussive symptoms.
5. Understand the resources available and the importance of referral to a team physician and mental health care provider, using a team approach and “demystifying” the stigma often attached to seeking help for mental health issues.
6. Provide an environment of listening and empathy for athletes that may be experiencing mental health issues and provide referrals in a supportive manner.
7. Communicate with coaches regarding any problematic responses to injury that may occur and provide suggestions to keep injured athletes involved in team functions and practice/play activities.
8. Provide early referral to mental health providers for evaluation and management, and include mental health providers in management of injured athletes. Develop multidisciplinary teams that include athletic trainers, team physicians, psychologists and psychiatrists to collaborate and address mental health issues in athletes.

increasing the compliance with management and treatment.

Given all that is known about mental health issues in athletes – and the role of injury and the barriers to treatment – the bar is raised in terms of what athletic trainers and team physicians can do in the future. Having a comprehensive plan in place to screen for, detect and manage student-athletes with problematic response to injury is an important first step.



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Post-Concussion Syndrome

BY DAVID COPPEL

Over the last decade, sport-related concussions have become an important focus within the general sports injury and sports medicine field. Clinical and research studies regarding this form/context of mild traumatic brain injury have increased geometrically as its position as a public health concern elevated and the Centers for Disease Control and Prevention (CDC) became involved.

The CDC has compiled guidelines and resources for health care providers, coaches, parents and athletes regarding concussions. Great progress has been made in understanding and managing sport-related concussions, especially in terms of:

- Incidence and prevalence of sport-related concussion at all levels of sports participation,
- Delineating acute symptoms and sideline management,
- Describing the general course of recovery for most athletes, and
- Identifying risk factors or modifiers associated with prolonged recovery and/or persistent symptoms.

Expert reviews of available scientific evidence have resulted in a series of consensus or position statements that have guided concussion definitions, evaluation, management and return-to-play guidelines.

The current definition of concussion is a brain injury involving a “complex pathophysiological process affecting the brain, induced by mechanical forces.” Concussion has a number of described features:

- Concussion may be caused by either a direct blow to the head, face, neck or elsewhere on the body with impulsive force transmitted to the head.
- Concussion typically results in the rapid onset of short-lived impairment of neurological function that resolves spontaneously or may evolve over minutes or hours.
- Concussion may result in neuropathological changes, but the acute clinical changes largely reflect a functional disturbance rather than structural injury.
- Concussion results in a graded set of clinical symptoms that may or may not involve a loss of consciousness, and resolution of clinical and cognitive symptoms typically follows a sequential course, with some cases having prolonged symptoms.

Diagnosing concussion may be complicated in some instances, as most do not involve a loss of consciousness or overt neurological signs, and impact on functioning can be quite mild and temporary. No consistent biomark-

SIGNS AND SYMPTOMS

According to the Diagnostic and Statistical Manual of Mental Disorders – 4th edition (DSM-4) – an individual with post-concussion disorder experiences objective declines in attention, concentration, learning or memory. The individual also reports three or more subjective symptoms, present for at least three months:

- Becoming fatigued easily
- Disordered sleep
- Headache
- Vertigo
- Irritability or aggression on little or no provocation
- Anxiety, depression, or affective lability
- Changes in personality
- Apathy or lack of spontaneity

The symptoms result in a significant impairment in functioning, which can include impairment in social and occupational functioning.

ATHLETICS CONSEQUENCES

- Student-athletes who experience post-concussion syndrome will likely miss games and practices over a prolonged period. Those who return to play while symptomatic and sustain an additional injury are at risk of magnified neurologic consequences. To minimize the net amount of time that a student-athlete is held out of practice and competition, early detection and removal from play, and ensuring that the student-athlete does not return to play before it is medically indicated, are critical risk-reducing behaviors.

ers or neuroradiological findings have been delineated, although the research continues in these areas.

The neuro-pathophysiology of sport-related concussion has been described in terms of changes in brain metabolism and evidence of temporary metabolic-based vulnerability to secondary injury. Typically, concussion events produce physical, cognitive and emotional/neuro-behavioral symptoms that are generally most severe in the acute post-injury time frame (one to two days) and then reduce/resolve over subsequent days and weeks.

Recent consensus guidelines indicate that 80-90 percent of concussions resolve in seven to 10 days, sometimes longer for children and adolescents. The diagnostic

WHAT CAN COACHES DO?

- Make sure student-athletes who sustain a concussion are immediately removed from play and that they do not feel pressure from the coaching staff to return to play before fully recovered. Communicating with team members before the season about concussion safety, and verbally reinforcing the importance of concussion safety throughout the season are important ways to encourage student-athletes to feel comfortable reporting concussion symptoms to medical personnel.
- Student-athletes who are experiencing post-concussion syndrome may feel isolated from their team and from their normal social roles. These changes can manifest in mental health issues, such as depression, that are not a direct consequence of the initial injury. Be in touch with your student-athletes during their recovery period, communicate that they remain valued team members, and encourage help-seeking from relevant medical professionals, including mental health professionals as appropriate.

complexity emerges when symptoms are delayed or prolonged, or when symptoms are not specific to concussion, but instead are temporally related to the concussive event or experienced/perceived as having been brain-injury related. Due to the range of symptoms (physical, cognitive, emotional) and the individual factors influencing recovery, a multidisciplinary management approach is often indicated. Physicians, athletic trainers, neuropsychologists, academic advisers, physical therapists and clinical/sport psychologists all play roles in clarifying symptoms and providing support.

The strong desire and motivation of some athletes to return to play provides the opportunity for these motivational factors to be manifest in symptom reporting. Since tracking self-reported post-concussion symptoms over time (typically with checklists) is the main aspect of management, some athletes will minimize or report resolved symptoms in order to be seen as “symptom-free” and begin the return-to-play protocol or be cleared. Knowing the athlete and his or her baseline or pre-injury functioning can be crucial in evaluating post-injury symptom reports and presentations.

Acute sport-related concussion signs may include loss of consciousness, headache, dizziness and alteration of mental status (confusion or foginess). Headache, nausea,

fatigue, irritability, sleep disturbance and sensitivity to light and noise may continue over the next few days. Other symptoms seen on post-concussion symptom checklists include attention and concentration difficulties, slowed processing, distractibility, memory problems, slowed visual tracking or vision problems, balance disturbance, and anxiety or depressed mood. Typically, depressed mood or

WHAT CAN ATHLETIC TRAINERS DO?

- Make sure coaches are appropriately educated about concussion safety and post-concussion syndrome. Talk to them explicitly about the role they can play in creating a team culture that encourages symptom reporting and early detection of concussions. For some coaches, it may be useful to emphasize the negative athletics performance consequences of continued play while symptomatic, and the long-term athletics consequences if a student-athlete sustains an additional impact while still symptomatic.
- Be aware that student-athletes who are experiencing post-concussion syndrome may experience other related mental health issues as an indirect consequence of this injury. Screen and refer student-athletes to mental health professionals as appropriate.
- Ensure that your athletics department has a protocol for helping student-athletes experiencing post-concussion syndrome manage their academic demands during the recovery process. If your school has a policy for academic accommodations and support during the concussion recovery process, make sure that your student-athlete is aware of this policy and that all relevant stakeholders in its implementation are engaged in supporting the student-athlete. If your school does not have such a policy, work with other stakeholders at your institution to develop and implement one. Additional information about recommendations for managing academic demands during the concussion recovery process is available in Marcia Ridpath’s article in Chapter 3.

anxiety levels improve as the physical symptoms resolve, but it is important to assess and intervene if these emotional issues persist.

While most sport-related concussions (concussion symptoms) resolve over days and weeks (most within three weeks), a subset of sport-related concussion patients

may not resolve in this expected time frame and have persistent post-concussion symptoms, or be seen as developing post-concussion syndrome/disorder. Diagnostically, according to the International Classification of Diseases, post-concussion syndrome occurs after a head trauma (which may include a loss of consciousness), and includes at least three of the following symptoms:

- Headache
- Dizziness
- Fatigue
- Irritability
- Difficulty in concentration and performing mental tasks
- Memory impairment
- Insomnia
- Reduced tolerance to stress, emotional excitement and alcohol.

Symptoms of depression or anxiety resulting from loss of self-esteem or fear of permanent brain damage are seen as adding to the original symptoms.

Treatment/management of sport-related concussion is often based on self-reported symptoms, and these symptoms may reflect other conditions and/or factors not related to concussion, but more with post-traumatic stress disorder. Thus, based on the nonspecificity of symptoms, there is some controversy about the validity of a “post-concussion syndrome.” In general, when athletes continue to be significantly symptomatic (or worsen) beyond the three- to four-week recovery period, the symptoms could be more influenced by psychological factors than the original physiological factors associated with the acute injury.

Following a sport-related concussion, athletes are told initially to observe relative physical and cognitive rest. Reducing physical activity for an active student-athlete can be a difficult and stressful adjustment. A prescribed reduction in cognitive demands often involves reduced class time or assignments and is described by some as “cognitive or brain rest.” These restrictions and reductions appear appropriate in the initial week of recovery, but may become harmful later in recovery, as other stressors may emerge with falling behind in school (making up and keeping up demands upon return) and concern over training/conditioning effects.

As student-athletes recover and are cleared, they begin a return-to-play protocol that incrementally increases the physical exertion level, and ultimately the risk of re-injury over days, leading to a return to full

QUESTIONS FOR REFLECTION

1. How do you communicate with student-athletes about concussion safety? How do you think your actions influence the likelihood that student-athletes report their concussion symptoms immediately after injury?
2. Do you know to whom you should refer student-athletes who are experiencing symptoms that are directly or indirectly related to post-concussion syndrome?

practice and participation. Student-athletes must complete each stage without emergence of symptoms. Similar “return to learn” approaches have been proposed for academic re-entry.

Strong somatic focus, hyper-vigilance to symptoms, sleep disturbance (often due to mental activation or worry), general stress/rumination behaviors, or a pattern of maladaptive coping styles may also be factors associated with prolonged or persistent symptoms. Family or social network/support problems, which include negative/nonsupportive responses or reactions from teammates, coaches or other primary relationships can result in more emotionally based symptoms.

During sport-related concussion recovery, if significant mood swings, depressed mood, or increasing anxiety or panic symptoms arise, they are indicators for referral to clinical or counseling psychologist/sport psychologist or other health care providers with expertise in these management areas.

Most concussed student-athletes recover symptomatically relatively quickly and return to their sport and academic activities. However, some have persistent symptoms, or delayed symptom resolution, which often impacts their athletics, academic, social and emotional functioning.

In addition to the basic approach of monitoring symptoms over time, interventions aimed at sport-related concussion education, management of recovery expectancies, symptom attributions and addressing emotional issues have been positive factors in recovery from sport-related concussions.

Ideally, management and treatment of sport-related concussions should include opportunities to evaluate and address the psychological impact and emotional responses that can be activated in student-athletes in varying degrees. When student-athletes are unable to practice or

train, or when they feel significant physical, cognitive or emotional vulnerability, they often perceive/feel challenges to their identity – particularly their athletics identity, self-esteem, and in some cases, their future plans or goals.

Discussion of sport-related concussion as an injury with varying degrees of concurrent neurophysiological *and* psychological components appears to be the most ef-

fective approach with student-athletes. It helps avoid concussion being seen with the false dichotomy of the athlete having physical *or* mental issues. Referrals to licensed health care providers or counseling centers can help the student-athlete deal with those challenges, as well as the fear of re-injury, and address potential concerns over long-term consequences of concussions.



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Supporting Student-Athletes in Transition

BY PENNY SEMAIA

It's been 10 years since I last strapped on a helmet and played the game that has done so much for me. Yet, I still have this bond with football that seems to never go away. It's almost like a sixth sense that pops up when someone mentions the game. When I'm watching a Pitt game at Heinz Field, it's as if each play is in slow motion. I see every block. I can predict certain movements. Sometimes, I catch myself lifting my arm up as if I was the one shedding a block. I laugh when I think about it. I laugh even harder when I see my old teammates do the same thing. It's a reflection of our past and what we were – student-athletes.

Today, I work in student-athlete development at the University of Pittsburgh, where I earned my degree and played football. Although it's been a long time since I played, I've transitioned out of my sport in my own way, yet am still connected to it through work and play.

However, not everyone is as fortunate as I am, in the sense that I'm still connected to my sport and alma mater on a daily basis. For much of the 10 years that I've been out of uniform, I've witnessed many of my student-athletes go through their own transition of taking off their jersey for the last time. For some, it was seamless; they were able to move on to the next phase of their life and not look back. For others, it was the day they wanted to avoid the most; the day they realized they are no longer

It was the day they wanted to avoid the most; the day they realized they are no longer athletes.

athletes. Their commitment to their sport had been their identity for as long as they remembered. Now, their identity is a question mark.

As professionals working in student-athlete development, it is our duty to help our student-athletes gain the knowledge and skills to prepare for life after sport. In the area of identity and life transitions, this is one of the most difficult and time-sensitive topics. There is a fine balance to helping student-athletes understand the importance of focusing on their current situation while also preparing them for the next stage. I believe that one of the most important steps in helping student-athletes successfully navigate this transition starts with establishing a strong baseline relationship with them. Programs and resources are

important, but in my experience, they are most effective when delivered with what I like to call a *human touch*.

For example, a student-athlete walked into my office, sat down and stared at me. She said, "Penny, I can't believe this is it. It's over. I'm done with track."

Knowing this student-athlete, I knew she had a great job lined up and was prepared. Yet, she was so caught up in her athletics career ending. My immediate response was, "How do you feel?" She answered, "Well, I don't know. I'm just ... I don't know."

I'm sure this sounds familiar. It's the end of the academic year. We get the trickling-in of seniors who just want to chat, and the conversation somehow always flows into the end of their athletics career. I always anticipate going into this topic with seniors. We've been talking about it since day one.

This is where the *human touch* is most important. The key is taking all of the programs and services that we deliver and narrowing them down to the individual level. It's also about understanding our student-athletes as individuals and knowing that they are all unique.

For example, just because two student-athletes may compete in the same sport and are from the same region, or even the same family, we cannot assume that we will serve them in a similar way as individuals. The groundwork to all of our programs and services relies on the *human touch* approach.

The initial phase of this happens by developing:

POSITIVE AND TRUSTING RELATIONSHIPS. When student-athletes trust us, they will approach us for anything – especially when they need help facing the end of their athletics careers. One thing that has helped me gain trust is taking the time to really listen – that has allowed me to get to know student-athletes as individuals. The information gained through listening, no matter the topic, is often vital for future conversations. I always take notes after my meetings with student-athletes, no matter how insignificant it seems at the time (such as noting a pet's name). I know that this information can be useful when I need to communicate with them in the future. The more our student-athletes know that we are interested in them, the more they will begin to trust us.

Once this is established, we can have real conversations about their future long before the end of their athletics career is imminent. To quote Theodore Roosevelt, "People don't care how much you know until they know how much you care." It's when our student-athletes know

that we care enough about them that they will open up.

Instances in which our student-athletes will need support are career-ending injuries, end of eligibility, and stressors in play (not playing at the same level or up to their or their coaches' expectations). The relationships we build when our student-athletes are under the least amount of stress can help us identify the times when their behaviors are out of character. This is where our gauge of our student-athletes is both a benefit and vital to helping provide the necessary care for them.

EXERCISE PATIENCE. We need to know and understand that athletics is a *big deal* for our student-athletes. They wouldn't be participating if it wasn't! This came up for me early in my career while I was trying to help a young football player.

This young man did not play at all before his senior year. Following his senior season, during which he got in a few times, he still wanted to focus on working out and postpone finding a career. I was trying to help him focus on moving on. In my mind, he was a long shot and he didn't even see that. I wanted him to know and understand this, so I took the "keeping it real" approach of providing statistics of student-athletes who play professionally, horror stories and anything else that revealed the odds that this was not a viable path for him. The more I tried to talk to him, the more he didn't want to hear me.

This was very frustrating for me. Everything led to a standstill in our progression. It wasn't until I heard someone say, "Who are we to shatter a kid's dream?" that I re-evaluated my train of thought. They were right. Who was I to tell this young man he shouldn't pursue his dreams? That really stuck with me.

Since that experience, I've shifted my approach and have focused on the idea of *Life Beyond Sport*. Instead of saying, "move on," my approach is "prepare for when the day comes." Helping our student-athletes learn how to balance their preparation is tough, especially when they've been told to focus on their athletics for so long. We have to help them realign their objectives and dig deeper into understanding what they want most out of life and how they will get there.

MAINTAIN THE EDUCATOR ROLE. One last bit of advice I'd have for anyone working in our field is to maintain the educator role. Being in a position where we are on the front lines – working directly with student-athletes daily, I've learned that I can't be the answer for everything. Instead, when student-athletes approach me, I want to en-

SUMMARY OF RECOMMENDATIONS

- Take the time to really listen to student-athletes and get to know them as individuals.
- It is not your role to tell student-athletes which dreams they should or should not pursue.
- Talk about life beyond sport before a student-athlete gets to be a senior, no matter what his/her post-college goals are.
- Don't be an enabler. Support and educate student-athletes about exploring career options and searching for a job. Focusing on the process and helping them learn new skills is more useful in the long term than handing them a solution, even though that may be easier in the short term.

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they will approach us for anything –
especially when they need help facing
the end of their athletics careers.*
.....

gauge them in the learning process as much as possible instead of just spoon-feeding them the answers. Our focus should be on helping them learn how to figure things out, helping them identify the necessary resources, or just simply pointing them in the right direction.

Far too often we are looked at as the "go-to office" that solves all of the issues. As nice as that is, it can stir up misinterpretations of what our mission is and what we do. For example, if a sophomore gymnast enters our office and is looking for a summer job and then we provide the individual with a person's name and phone number to call for a job, are we truly helping that gymnast? By the time their senior year comes around, they will have the same expectations of our services and think that we will just hand them a career. For that office staff, the pressure is often to help serve this student-athlete as quickly as possible.

Instead, our approach should be focused on the *process*. We should help point them to the resources (such as career services) that can help them develop skills to search for a job and learn about the types of careers that they may want to pursue after graduation. We can support them in

this process, but they must be active participants for it to be effective. We cannot be the answer to everything, but we can be a great resource to help point our student-athletes in the right direction. For some student-athletes, this will include referral to a mental health professional.

FOSTER TRUST. For us to effectively help our student-athletes transition to life beyond sports, a foundation of trust must be laid. We cannot simply rely on programs and lectures to have the type of impact necessary. The stronger the relationship, the more likely our student-athletes will understand and accept the services we are providing and the recommendations we are making.

This is where our role becomes a key factor for our athletics departments. I understand that not everyone has one role. Many of us share coaching, academic, or athletic training responsibilities – some have all three

We have to help them realign their objectives and dig deeper into understanding what they want most out of life and how they will get there.

roles. No matter what hat we wear, when it comes to the health and well-being of our student-athletes, this should always be the top priority.

By implementing services with a *human touch* and keeping a focus on *life beyond sport* – no matter what the student-athlete’s athletics goals – our student-athletes will have the right type of support in their journey.



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CHAPTER 5
SOCIAL AND ENVIRONMENTAL RISK FACTORS

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Risk Factors in the Sport Environment

BY EMILY KROSHUS

Many mental health disorders are at least partially rooted in genetic biological predispositions (genetic vulnerability). However, genetic vulnerability is not destiny – environmental stressors and resources play a critical role in whether individual vulnerabilities turn into burdensome health conditions. By environment, we mean all of the factors outside the individual, ranging from their interactions with people close to them, to institutional policies and programs, to the broader culture within which they live, learn and play.

Collegiate student-athletes face many of the same mental health risk factors as their non-athlete peers, but their roles as student-athletes both expose them to additional environmental risk factors and offer protective resources to help mitigate those factors.

The environmental risks can take the form of direct stressors (for example, time demands, performance pressures, coaching style); interactions with others in their environment that encourage risk behaviors and discourage individuals from seeking help; harassment and discrimination related to personal characteristics such as race/ethnicity or sexual orientation; and exposure to interpersonal or sexual violence.

The protective factors can include prevention and screening programs, and interactions with others that encourage individuals to seek help.

These risk and protective factors are introduced briefly below, and then discussed in greater detail later in the chapter in essays from leading clinicians.

Sport-related stressors

Stress is not inherently bad. In fact, in many cases it is a healthy part of growth. However, if it is chronic or inadequately managed, it can result in negative health outcomes either directly or through unhealthy coping behaviors (such as substance abuse).

Interactions, resources, policies, programs and cultural attitudes in the sport environment have the potential to reduce the presence of stressors and to help student-athletes deal effectively with them.

Time demands are a frequent source of stress for student-athletes. Many student-athletes spend more than 30 hours per week on their sport, with extensive in-season travel and early morning practices that limit sleep. Managing both sport and academic demands often results in elevated stress, inadequate sleep, and an inability to participate in other extracurricular or leisure activities that

help promote overall well-being. Because of the physical demands on their sport, many student-athletes need more sleep than the average college student. Individuals with adequate sleep also respond more effectively to stressors as they arise. Research has indicated that sleep is critical for mental acuity, sport performance and injury prevention.

Another frequent source of stress is pressure to perform athletically. Some of this pressure is self-imposed. When sport is central to identity, so is sport performance. Pressure often comes from outside sources, most critically from coaches. Coaching style plays a role. When coaches use an ego/performance-centered motivational climate (as compared with a skills-mastery motivational climate), student-athletes tend to experience greater anxiety and distress, and are at elevated risk of negative outcomes, including burnout and disordered eating.

Institutional policies matter, too. Athletics scholar-

Stress is not inherently bad. In fact, in many cases it is a healthy part of growth. However, if it is chronic or inadequately managed, it can result in negative health outcomes either directly or through unhealthy coping behaviors (such as substance abuse).

ships put a dollar value on athletics performance, and policies related to scholarship reductions heighten performance-related pressure for student-athletes, particularly those with financial need. Interactions with parents, peers and fans can put a premium on athletics performance and a microscope on failure to perform athletically. The growing use of social media allows alumni and other fans to interact with student-athletes directly, and can have the result of exacerbating this pressure.

Normative behaviors

Interactions with teammates can be a source of risk – or protection. Adolescents and young adults often place a high value on peer approval and in looking and acting like

their peers. For student-athletes, this often means teammates. The stronger the group's identity and cohesion, the more important individuals tend to find conforming to the group's norms.

Sports teams often have extremely high group identity and cohesion. When some teammates model unhealthy behaviors, such as disordered eating or substance use, other teammates are at elevated risk of adopting those behaviors. Whether exposure to or experimentation with these types of unhealthy behaviors results in an individual progressing to a clinically diagnosable mental health

Coaches, clinicians and others who interact with student-athletes need to be aware that individuals of minority status may be shouldering a heavy load from their experience functioning outside the sport environment. In some cases, it may be appropriate to engage resources to help athletes cope with these external sources of stress, or at the very least to function in a supportive and understanding role.

disorder depends in part on his or her underlying genetic vulnerability. However, environment matters a great deal.

Another way in which teammates and others in the sport environment can influence mental well-being is in the extent to which mental health issues and help-seeking are stigmatized or encouraged. If teammates and coaches stigmatize mental health conditions or encourage a culture of toughness and not admitting weakness, symptomatic or at-risk individuals will be less likely to disclose their mental health conditions or seek help. Conversely, teammates who don't stigmatize disclosure of mental health conditions and who encourage help-seeking can be powerful positive forces. Coaches can play a critical role

in serving as a resource for student-athletes who want to discuss mental health issues, and in encouraging or discouraging help-seeking for these issues.

Harassment and discrimination

Minority populations, including racial/ethnic minorities and sexual minorities, often experience negative mental health outcomes connected to their experiences with harassment and discrimination. While some sport environments may be fully inclusive of all minority groups, others are not. Additionally, while the sport environment is a critical one for student-athletes, it is not the only environment in which they function. Even when a sport environment is fully inclusive, student-athletes from minority populations who are stigmatized or who experience more overt forms of harm such as verbal harassment and violence in nonsport environments can experience negative health consequences. For example, sexual minority college students tend to experience more anxiety and mood disorders, engage in more frequent suicidal ideation, and make more suicide attempts than their heterosexual peers.

The Minority Stress Model has helped explain this difference. Acute and chronic stressors – including violence and harassment and the fear of violence and harassment occurring – as well as internalized stigma lead to physiologic responses, such as elevated cortisol levels. These physiologic processes can have direct bodily harm. They can also increase the risk of maladaptive coping behaviors such as substance abuse.

In addition to ensuring that sport environments are free of harassment and discrimination of minority populations, coaches, clinicians and others who interact with student-athletes need to be aware that individuals of minority status may be shouldering a heavy load from their experience functioning outside the sport environment. In some cases, it may be appropriate to engage resources to help athletes cope with these external sources of stress, or at the very least to function in a supportive and understanding role.

Interpersonal violence

Experiencing interpersonal violence, particularly sexual violence, can have lasting mental health consequences. Recent evidence from the National Collegiate Health Association indicates that nearly 10 percent of female college students have been sexually touched without their

consent during the past 12 months, with no significant differences between athletes and non-athletes.

Sexual minority students – both male and female, athlete and non-athlete – experienced significantly higher rates of sexual assault within the past 12 months than those who did not identify as lesbian, gay, bisexual or transgender. Individuals who self-reported experiences of sexual assault were significantly more likely to struggle academically, find it hard to handle intimate relationships, and experience hopelessness, mental exhaustion, sleep issues, depression and suicidal thoughts.

Interpersonal violence, including hazing and bullying, may be elevated in certain sport environments. While being a student-athlete does not increase risk of experiencing sexual violence, student-athletes who experience sexual violence or other forms of interpersonal violence in any settings bring these experiences and the resultant mental health consequences back with them to the sport environment. Consequently, individuals in the sport environment need to be aware of the resources available to student-athletes so that they can manage the mental health consequences that often result from experiencing these forms of violence. Individuals in the sport environment can also play an important role in encouraging victims of violence to report their experience and in supporting them emotionally in this process.

* * * *

The sport environment matters for both risk and prevention of mental health disorders. Unique stressors often accompany the experience of being a student-athlete. Resources in the sport environment can potentially mitigate stressors and encourage help-seeking for individuals who

are experiencing mental health disorders or who are at risk of these disorders.

Student-athletes benefit from being part of the sport family – with teammates and coaches who see them on a daily basis. Whereas many students transitioning to college run the risk of being isolated and not finding a supportive community, college student-athletes often have a built-in community from the moment they step foot on campus.

Student-athletes are often used to working with a team of multidisciplinary health care professionals to facilitate optimal health and sport performance. Coaches, athletic trainers and teammates can reinforce to symptomatic individuals that mental health professionals are just one more piece of this equation.

Student-athletes are also used to adhering to routines and dealing with aversive conditions rehabilitating injuries – and receiving support from teammates and coaches during this process. The process of recovery from mental health disorders can in some cases be similarly onerous – and social support matters a great deal here, too.

Drawing on the experience of recovering from other health- and performance-impacting injuries in the sport environment can help more positively frame mental health-related treatment-seeking and adherence for the symptomatic individual.

While the sport environment presents numerous risk factors for student-athlete mental health, it can also play an important role in prevention and wellness. Reducing unnecessary sources of stress and stigma in the sport environment, increasing access to resources to help mitigate stress, and encouraging help-seeking for mental health disorders are all critical ways in which the sport environment can function to improve mental well-being among student-athletes.



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Harassment and Discrimination – Ethnic Minorities

BY TERRIE WILLIAMS

While previous sections of this publication talked at length about common stressors on student-athlete mental health because of the unique position these students are in as athletes, cultural factors exist that complicate those stressors even further for under-represented student-athlete populations.

As a woman of color and someone who has experienced her own clinical depression, I am acutely aware of the challenges and stigma facing blacks when trying to address mental health issues. And as a trained licensed clinical social worker, I've had the great opportunity to engage with the National Alliance on Mental Illness, the Substance Abuse and Mental Health Services Administration, and other mental health organizations that have allowed me to create mental health advocacy campaigns for the black community.

The following comments focus on the work my colleague, Yolanda Brooks, and I have done over the past decade with black male athletes. To be sure, there are some commonalities in the experiences of black male athletes and the experiences of men and women from other racial

It is critical that athletics administrators and others working with minority and socioeconomically disadvantaged student-athletes gain an appreciation for their unique experiences and backgrounds.

and ethnic minority groups – and in the experiences of student-athletes from socioeconomically disadvantaged backgrounds, across all races and ethnicities. In my work with black male athletes, I have seen many struggle with socioeconomic barriers and remnants of a racist system that continues to plague many in this community. It is critical that athletics administrators and others working with minority and socioeconomically disadvantaged student-athletes gain an appreciation for their unique experiences and backgrounds.

To be a black man in our society often means to experience

overt violence and subtle forms of racism. It may mean being stopped and frisked, racially profiled and made to feel insecure about the complexion of one's skin. It may mean feeling pressure to not appear threatening to others for fear of being further harassed by police. Even in the absence of overt discrimination and racial violence, black men are too often aware that discrimination and violence are possible. Having to be constantly on guard has real physiologic consequences.

The young, developing black male may have experienced family violence and an absentee father. In some families, as a coping mechanism, black men are taught to cut off their feelings and normalize horrific events that happen to them personally or to people they know. What happens to the child and/or adult who watches a relative – or anyone – be killed in front of him and then has to go about his normal routine?

Another cultural factor that can negatively affect a young, developing black male is an adherence to hip-hop culture, which is heavily influenced by street culture and may define “ownership” of women and money as a means to feel valuable in place of authentic self-esteem. Within these settings, a maturing black male may learn or interpret that in order to be considered a man, one never discusses his feelings. It becomes safer to lash out in anger than to let on to the hurt within. The bruised ego, pride and self-loathing eventually manifest into a stoic demeanor that sabotages any chance of meaningful and intimate relationships.

In a number of instances, as young black student-athletes were developing, parents altered the family lifestyle (changed/left jobs, moved to another city, etc.) so that the most talented child would have the best opportunity to succeed in his/her sport. This could mean playing for the best elite team (which is expensive) or getting the coveted college athletics scholarship.

But if the student-athlete is underperforming, loses passion for the sport or wants to develop a more balanced lifestyle (engaging in social behaviors of a typical adolescent athlete versus the insulated, isolated, intense, laser-focused, all-consuming lifestyle of elite sports), there may be strong pushback from the support network – especially those who've sacrificed or have made a strong investment in the student-athlete. They aren't allowed to quit even if they wanted to, as there has been too much invested in that student-athlete – too much is at stake.

When they arrive at college, many black student-ath-

Student-athletes – particularly those in high-profile sports – are not new to high-pressure situations. However, if stretched beyond their capacity to manage, they may find themselves struggling to adjust to the demands of their life situation regardless of talent, potential or sport.

letes experience an additional set of stressors. These can include a feeling of isolation from the majority and from dominant social-cultural aspects of college life, the absence of supportive social networks outside of sports, academic struggles (and in some instances, barriers) created by socioeconomic challenges.

In environments where there are sociocultural differences, some black student-athletes may struggle to transition and fit in. This may overwhelm an already stressed indi-

vidual. Student-athletes – particularly those in high-profile sports – are not new to high-pressure situations. However, if stretched beyond their capacity to manage, they may find themselves struggling to adjust to the demands of their life situation regardless of talent, potential or sport.

These stressors can leave the student-athlete overwhelmed and vulnerable to developing stress-related symptoms, mental disorders such as clinical depression and anxiety, or even at higher risk to incur a career-threatening injury. As a group, blacks tend not to seek help for psychological problems – and student-athletes are even less likely to do so in fear of appearing weak and vulnerable.

Managing all of these stressors and pressures can challenge the strongest adult; however, for a college student-athlete (who is still growing and developing mentally and physically), such demands can quickly overwhelm and lead to serious mental and behavioral problems. Reactionary high-risk behaviors (substance abuse, sexual promiscuity, illegal activity, etc.) may emerge along with avoidance and detachment from support networks.

To effectively address this issue, there need to be outreach strategies embedded systemically in collaborative athletics and health programs in order to identify, enhance and encourage these student-athletes to access support – and if warranted, intervention – before sliding down the slippery slope of stressed to distressed to depressed.



Terrie Williams, a licensed psychotherapist, is CEO of the Terrie Williams Agency, a public relations and communications firm, and the author of several books, including “Stay Strong: Simple Life Lessons for Teens,” and “Black Pain: It Just Looks Like We’re Not Hurting,” which recounts her personal struggles with depression and the impact the stigma of mental illnesses has, particularly on the African-American community. Williams’ creation of a mental health advocacy campaign for the African-American community in 2007 under her Stay Strong Foundation entitled, “Healing Starts With Us,” led to a 2010 collaboration with The Ad Council and the Substance Abuse and Mental Health Services Administration that generated 11 million media impressions and \$3 million in donated advertising space. Williams has a B.A. (cum laude) in psychology and sociology from Brandeis University and an M.S. in social work from Columbia University.

Harassment and Discrimination – LGBTQ Student-Athletes

BY SUSAN RANKIN AND GENEVIEVE WEBER

Perhaps nowhere is the expression “the only constant is change” more evident than in higher education. The experiences of college students, including student-athletes, are ever changing, which means that faculty, staff, coaches and administrators have to recognize and act on these changes or they will quickly find themselves left behind.

Those of us who work with students who identify within the queer-spectrum (bisexual, gay, lesbian, queer, pansexual, same-gender loving, etc.) or the trans-spectrum (androgynous, gender-nonconforming, gender-queer, transfeminine, transmasculine, transgender, etc.) can attest to the extensive changes that members of these groups have experienced just in the last decade.

The settings of college campuses have improved for queer-spectrum and trans-spectrum students over the years; yet, when research examines the experiences of queer-spectrum and trans-spectrum students, one group – student-athletes – is routinely absent from studies.

One of the biggest changes has been the age at which students disclose their sexual identity. From the 1970s through 1990s, it was commonplace for queer-spectrum individuals who were planning on attending college, especially if the college was away from home, to wait until they were on campus and had developed new friends before they disclosed their identity. This disclosure is colloquially known as “coming out.”

In some cases, the students were not delaying disclosure, but simply did not recognize themselves as lesbian, gay, bisexual and queer (LGBQ) until they met others like themselves and were in a more supportive environment. Today, with a growing number of gay-straight alliances in middle and high schools, the availability of online resources and (for student-athletes) the rising number of professional athletes who are “coming out,” students more readily understand themselves to be attracted to others of the same sex/gender and often come out in high school and, increasingly, in middle school.

Although there has been an increased focus in the professional literature on the experiences and perceptions of queer-spectrum and trans-spectrum college students, there is limited research examining sexual identity and transgender identity in intercollegiate athletics.

In this section, we offer a review of the influence of campus climate on the well-being of queer-spectrum and trans-spectrum college students, including those who identify as student-athletes. We summarize a large amount of empirical and conceptual research related to the colle-

giate experiences and perceptions of queer-spectrum and trans-spectrum non-athletes in the absence of student-athlete-focused research. This is based on the assumption that the unique stress related to sexual and gender identity development influences both queer-spectrum and trans-spectrum student-athletes and non-athletes alike.

Campus climate within athletics

Historically, athletics programs on college or university campuses might be sources of specific concerns for queer-spectrum and trans-spectrum students. Studies have shown that despite the diversity of ethnicity, socioeconomic status, geographic background and even sexual orientation, coaches, administrators and student-athletes nonetheless often exhibit heterosexist and homophobic attitudes.

One study of five Division I campuses in fact explored how athletics teams respond to diversity, including race, gender, socioeconomic level, geographic region and sexual orientation. The authors noted that “questions about sexual orientation brought about the most highly charged

Studies have shown that despite the diversity of ethnicity, socioeconomic status, geographic background and even sexual orientation, coaches, administrators and student-athletes nonetheless often exhibit heterosexist and homophobic attitudes.

responses.” Many also denied that LGBT individuals were members of their teams or expressed negative reactions to the idea of having LGBT team members. The overall message from the findings was that hostility toward gay men and lesbians exists on nearly all teams and at all the case study sites.

In one of the first studies to comprehensively explore the perceptions and experiences of student-athletes with regard to campus climate, we developed and tested the Student-Athlete Climate Conceptual Frame, which suggests that individual and institutional characteristics directly influence both how student-athletes experience climate and a

variety of educational outcomes unique to student-athletes. At the same time, student-athletes' experiences of climate can also influence these educational outcomes.

The findings offered that climate significantly affects lesbian, gay, bisexual, transgender and queer (LGBTQ) student-athletes' academic and athletics outcomes. LGBTQ student-athletes generally experience and perceive a more negative climate than their heterosexual

Athletics departments have the power to improve the collegiate experiences of all student-athletes through cooperation with athletics personnel, student-athletes and faculty members at their institutions.

peers. These negative experiences with climate adversely influence their athletics identities and reports of academic success. Although sexual identity is not a direct predictor of academic success or athletics identity, the way LGBTQ student-athletes experience the climate significantly influences both.

Thirty years of research underscore the disproportionately higher rates of depressive symptoms, substance use/abuse, suicidal ideation and suicide attempts among queer-spectrum and trans-spectrum youth.

Experiences with harassment place queer-spectrum and trans-spectrum individuals at high risk for alcohol and drug use/abuse, and previous studies have noted that binge drinking is more prevalent among LGB college students than their heterosexual counterparts and that there is a relationship between psychological distress and alcohol use for LGB college students.

Other studies found that sexual-minority college students were more likely to experience and witness incivility (disrespectful behaviors) and hostility (overt violence), and personal incivility and witnessing hostility were associated with greater odds of problematic drinking. These studies and others generally conclude that experiences with minority stress place LGB individuals at high risk for adverse mental health outcomes, including alcohol and drug use/abuse.

The social stigma and discrimination associated with

LGBTQ identities are contributing factors to the elevated rates of depression and suicide as well. Discrimination at the individual level (hostility, harassment, bullying and physical violence) and institutional level (laws and public policies) have been identified as risk factors for depression, social isolation and hopelessness, which in turn place LGBTQ people at risk for contemplating suicide.

Among college students, extant studies also indicate that sexual minorities are at increased risk for poorer mental health, including suicide attempts. LGB students have been found to be more depressed, lonely, and had fewer reasons for living compared with heterosexual students.

How athletics departments can help

While many of the experiences of LGBTQ student-athletes are similar to the general population, there are several ways in which their lives are very different from their heterosexual peers. Overall, "in-house" harassment, or harassment experienced at practice or similar athletics-related events, whether intentional or not, is the most prevalent kind experienced by our respondents. It follows, therefore, that athletics departments have the power to improve the collegiate experiences of all student-athletes through cooperation with athletics personnel, student-athletes and faculty members at their institutions.

However, to effectively address the experiences of LGBTQ student-athletes in particular, it behooves athletics personnel to look beyond the obvious and attend to the myriad ways in which LGBTQ student-athletes encounter discrimination and harassment as they strive to achieve both academic and athletics success as well as overall well-being in college.

We propose the following best practices for creating positive campus climates for queer-spectrum and trans-spectrum student-athletes.

THE POWER OF LANGUAGE. First, we encourage the use of language that extends beyond the binaries in all of the following recommended potential best practices. Many individuals do not fit the socially constructed definitions of gender identity, sexual identity and gender expression. Language instills and reinforces cultural values, thereby helping to maintain social hierarchies. While definitions facilitate discussion and the sharing of information, terminology remains subject to both cultural contexts and individual interpretation. As a result, the terminology that people use to describe themselves and their communities is often not universally accepted by everyone within these communities.

Therefore, it is recommended that we value the voices of those within our campus communities and use language that reflects their unique experiences. It is important for athletics personnel to familiarize themselves with the language offered in the beginning of this article with respect to LGBTQ communities. Using inclusive language provides a sense of safety for LGBTQ student-athletes.

Finally, the frequent use of derogatory language such as “faggot,” “that’s so *gay*,” or “dyke” are common sources of harassment experienced by LGBTQ student-athletes. Language is powerful and has a significant impact on LGBTQ student-athlete success. To create a more inclusive environment, we encourage athletics personnel to respond quickly to end the use of derogatory language aimed at LGBTQ student-athletes.

OFFER A VISIBLE AND SUPPORTIVE PRESENCE.

There are multiple venues where intercollegiate athletics can offer a visible and supportive presence. This serves two goals: (1) It lets the LGBTQ community know that intercollegiate athletics at your institution is knowledgeable of the issues/concerns facing the LGBTQ community and stands as an ally in the fight against anti-LGBTQ bias, and (2) It provides an environment for LGBTQ student-athletes and athletics personnel to feel safe and supported in acknowledging their sexual and/or gender identities.

- Create an athletics department or individual team videos (PSAs) that show your support of LGBTQ people and student-athletes. New York University (<http://www.youtube/MriTHFvYZVc>) and the University of North Carolina, Chapel Hill, (<http://www.youtube/e4TJqZXk12A>) have developed videos to give you an example.
- Support LGBTQ events on your campus (for example, National Coming Out Day; Day of Silence, LGBTQ Pride Week) by encouraging student-athletes and athletics personnel to attend the events. Just standing in solidarity alongside LGBTQ students and allies will speak volumes with regard to your support and may encourage them to attend more athletics events. If your institution has an LGBT Resource Center, they can provide a calendar of events. For a list of LGBTQ Resource Centers or other support services available on your campus, go to the Consortium of Higher Education Lesbian Gay Bisexual Transgender Resource Professionals home page at www.lgbtcampus.org.

DEVELOP INCLUSIVE POLICIES. Policies that explicitly welcome LGBTQ student-athletes, coaches and athletics personnel powerfully express the commitment of an athletics department and, based on the results of this project, will add to team success (winning!). Individuals will be more likely to be open about their sexual identity or gender identity when they know that the institution is supportive. When individuals do not have to expend energy hiding aspects of their identity, they are able to focus on team and individual goals.

Our recommendations include:

- Develop/enforce inclusive policies. If your institution does not have a nondiscrimination policy inclusive of actual or perceived sexual identity, gender identity, and gender expression, you can work with senior administrators to adopt one.
- Develop fair and consistent enforcement (consequences) for incidents related to the inclusive nondiscrimination policies.
- Prohibit homophobic, transphobic, and heterosexist behavior and language by fans at athletics events.
- Include sexual identity and gender identity in the athletics department’s student-athlete handbook.
- Include sexual identity and gender identity in the Student-Athlete Advisory Committee (SAAC) publications.
- Extend health insurance coverage to athletics personnel’s same-gender partners/spouses.
 - ◇ If the institution does offer health insurance coverage, “gross up” wages for employees who enroll for these benefits to cover the added tax burden from the imputed value of the benefit that appears as income for the employee.
 - ◇ If the institution cannot offer health insurance coverage to employees’ same-gender partners/spouses, offer cash compensation to employees to purchase their own health insurance for same-gender partners/spouses.
- Include sexual identity and gender identity issues and concerns or representations of people with various sexual identities and gender identities in the following:
 - ◇ Application for student-athlete financial aid/athletics grants-in-aid
 - ◇ Student-athlete health intake forms
 - ◇ Alumni materials/publications
- Offer students who identify outside the gender

binary the ability to self-identify their gender identity/gender expression, if they choose, on standard forms. For example:

- ◇ Application for admission
- ◇ Application for housing
- ◇ Student health intake form
- Provide appropriate health care for transgender student-athletes.

INCREASE AWARENESS OF LGBTQ ISSUES AND CONCERNS. Since LGBTQ and non-LGBTQ individuals are socialized into a homophobic and heterosexist society, athletics community members need the space to question and examine unfounded attitudes and beliefs.

Acknowledging the contributions of LGBTQ former athletes/coaches in the sports arena is important to fully integrate LGBTQ concerns and experiences into the athletics community. The omission of such topics from athletics “de-historicizes” LGBTQ experiences and paints a false picture of the world in which we live. We offer the following potential best practices for consideration:

- Provide the 2013 Champions of Respect: Inclusion of LGBTQ Student-Athletes and Staff in NCAA Programs to all athletics personnel. A copy of the publication is available at www.NCAA.org.
- Integrate LGBTQ issues and concerns into the Challenging Athletes’ Minds for Personal Success (CHAMPS)/Life Skills Program for student-athletes.
- Integrate LGBTQ issues into existing courses for student-athletes. For example:
 - ◇ First-year student-athlete class (first-year seminar)
 - ◇ Student-athlete leadership development courses
 - ◇ Athletic Directors Leadership Institutes
- Integrate LGBTQ issues and concerns into existing professional development programs. For example:
 - ◇ National Association of Collegiate Directors of Athletics (NACDA) Management/Leadership Institute
 - ◇ NACDA Sports Management Institute
 - ◇ NCAA Women Coaches Academy (WCA)
 - ◇ NCAA Achieving Coaches Excellence Program (ACE)
 - ◇ NCAA Career in Sports Forum (Forum)
 - ◇ NCAA Diversity Education Workshops
 - ◇ NCAA Emerging Leaders Seminar
- Include programs that incorporate topics regarding sexual identity and gender identity in all new

athletics personnel orientations.

- Promote the use of inclusive language in all athletics venues (playing fields, locker rooms, training rooms, etc.).
- Create a pamphlet with examples of heterosexist assumptions and language with suggested alternatives.
- Provide course credit to LGBTQ student-athletes for participating in peer education initiatives (Straight Talks, Speakers Bureaus, etc.).
- Offer programming to discuss multiple identities of LGBTQ people (LGBTQ Latinos/Latinas, international LGBTQ people, LGBTQ people with disabilities, LGBTQ Muslims, etc.).
- Offer resources about LGBTQ people and the intersections of their sexual identity and gender identity with their religious and/or spiritual needs (Unity Fellowship for Students, Gays for Christ, etc.).
- Acknowledge the different ways that LGBTQ student-athletes experience harassment. Take steps to improve their perceptions of climate (for example, athletics department responses to acts of anti-LGBTQ bias incidents).

RESPOND APPROPRIATELY TO ANTI-LGBTQ INCIDENTS/BIAS. As long as anti-LGBTQ bias persists in athletics, LGBTQ student-athletes and athletics personnel will need to feel safe and supported by their departments when acts of anti-LGBTQ intolerance occur. LGBTQ student-athletes and athletics personnel should be able to speak and act without fear of homophobic reprisal.

- Offer a clear and visible procedure for reporting LGBTQ-related bias incidents.
- Develop a bias incident and hate crime reporting system for LGBTQ concerns that includes the following:
 - ◇ Bias incident team
 - ◇ Methods for supporting the victim
 - ◇ Outreach for prevention of future incidents
 - ◇ Protocol for reporting hate crimes and bias incidents

OFFER COMPREHENSIVE COUNSELING AND HEALTH CARE. The literature suggests that LGBTQ people who experienced both ambient and personal heterosexist harassment had the lowest overall well-being as compared with respondents who experienced only ambient heterosexist harassment and those who did not experience any heterosexist harassment.

Given that our results indicate many LGBTQ student-athletes experience heterosexist climates, the need for counseling support is evident. Further, more students are “coming out” as transgender in intercollegiate athletics. Although this growing population has unique needs related to physical and mental health care, most colleges and universities offer little or no support for this population.

We recommend the following best practices for addressing the counseling and health care needs of LGBTQ student-athletes:

- Offer support for student-athletes in the process of acknowledging and disclosing their sexual identity and for other concerns with one’s sexual identity.
- Offer counseling services that support LGBTQ people, with a staff that knows and understands LGBTQ student-athletes’ needs and experiences.
- Provide training for team physicians, athletic trainers and other medical staff to increase their awareness of and sensitivity to LGBTQ people’s health care needs.
- Actively distribute condoms and LGBTQ-inclusive information on HIV/STD services and resources.
- Offer a student health insurance policy that covers ongoing counseling services for transgender students who need such counseling, as consistent with the World Professional Association for Transgender Health’s (WPATH) Standards of Care.
- Offer a student health insurance policy that covers the initiation and maintenance of hormone replacement therapy for transgender students who need such therapy, as consistent with the World Professional Association for Transgender Health’s (WPATH) Standards of Care.
- Offer a student health insurance policy that covers gender confirmation (“sex reassignment”) surgeries, including mastectomy and chest reconstruction, breast augmentation, complete hysterectomy, genital reconstruction and related procedures, for transgender students who need such surgeries, as consistent with the World Professional Association for Transgender Health’s (WPATH) Standards of Care.

INCREASE AWARENESS OF TRANSGENDER ISSUES AND CONCERNS. In 2010, the NCAA reported that its national office received 30 inquiries in the previous two years about how colleges should “deal with trans-

gender athletes.” Those numbers, NCAA officials offered, could increase, given that more people than in the past are identifying themselves as transgender, more are doing so at younger ages than in the past, and a growing number of colleges have anti-bias policies that cover gender identity.

A report titled, “On the Team: Equal Opportunity for Transgender Student-Athletes,” argued that in this environment, the lack of a national standard is unfair both to transgender students and to all student-athletes. The report divides its recommendations for colleges into two categories of transgender students: those who are undergoing hormone treatments and those who are not, and the report notes that many people who identify as transgender do not take medical steps.

For those undergoing hormone treatments, the report recommends that a male-to-female transgender student-athlete should be able to participate on a men’s team but should complete one year of hormone treatments before competing on a women’s team.

The report recommends that a female-to-male transgender student-athlete who is taking prescribed testosterone should be allowed to compete on a men’s team but must seek an exemption to NCAA rules barring the use of testosterone.

For those not undergoing hormone treatments, the report recommends that transgender students should have the option of competing on the teams consistent with sex assigned at birth, female-to-male students be allowed to participate on either the men’s or women’s team, but that male-to-female transgender students not be permitted to compete on women’s teams.

In 2011, the NCAA clarified its policies on transgender student-athletes. The new policy, which embraced the suggestions in the 2010 report from the National Center on Lesbian Rights and the Women’s Sports Foundation, ensures that student-athletes are allowed to participate on male or female teams, so long as they adhere to two key rules. The policy required no new legislation but rather clarified two pieces of existing legislation regarding banned substances – namely, testosterone – and a team’s official “status,” determined by the gender of its players.

- Provide the publication “On the Team: Equal Opportunity for Transgender Student-Athletes” for all athletics personnel. A copy of the publication is available at <http://www.nclrights.org/wp-content/uploads/2013/07/TransgenderStudentAthleteReport.pdf>
- Provide the 2011 NCAA Policy on Transgender

Inclusion to all athletics personnel. The policy is aimed at allowing student-athletes to participate in competition in accordance with their gender identity while maintaining the relative balance of competitive equity among sports teams. The policy will allow transgender student-athletes to participate in sex-separated sports activities so long as the student-athletes' use of hormone therapy is consistent with the NCAA policies and current medical standards, which state:

- ◇ A trans-male (female to male) student-athlete who has received a medical exception for treatment with testosterone for gender transition may compete on a men's team but is no longer eligible to compete on a women's team without changing the team status to a mixed team. A mixed team is eligible only for men's championships.
- ◇ A trans-female (male to female) student-athlete being treated with testosterone suppression medication for gender transition may continue to compete on a men's team but may not compete on a women's team without changing it to a mixed-team status until completing one calendar year of documented testosterone-suppression treatment.
- Provide the resources offered by the NCAA to all

athletics personnel that includes:

- ◇ Inclusion of Transgender Student-Athletes resource book.
- ◇ A CD that contains the resource book and a slide presentation to educate administrators and student-athletes.
- ◇ A 30-minute video that discusses transgender issues.
- Increase the awareness of student-athletes regarding transgender student-athletes and policies in the NCAA.

Further recommendations for future research and promising best practices are offered in recent studies by Beemyn and Rankin (2011), Marine (2011) and Rankin et al. (2010).

Other recommended resources include the Campus Pride Friendly Campus Index (<http://www.campusprideindex.org/>), Promising Practices for Inclusion of Gender Identity/Gender Expression in Higher Education (<http://www.campuspride.org/tools/promising-practices-for-inclusion-of-gender-identitygender-expression-in-higher-education/>), and the Consortium for LGBT Professionals in Higher Education Architect (<http://www.lgbtcampus.org/architect>).



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The Haunting Legacy of Abuse

BY CINDY MILLER ARON

As previous chapters have pointed out, student-athletes may be an at-risk population for developing psychiatric symptoms. But individuals with abuse histories can be at even higher risk, given the likelihood of greater emotional vulnerability.

The highly functional exterior of athletes often belies psychological fragility. Individuals with histories of abuse can lack the emotional resilience to cope with the ordinary acclimation to college life, let alone the extraordinary demands made upon student-athletes.

The legacy of abuse operates on a preconscious level. There is an individual's obvious response to an athletics experience, and then there is what lies underneath. It is the preconscious, underlying areas of loss/sadness that compounds the intensity of what occurred.

The individual experiences his or her frustrations or disappointments as greater than the reality of what transpired. The student-athlete loses his or her ability to distinguish how he or she feels from what actually happened. Battling the persistence of these feelings results in an inefficient use of psychological energy. As a result, depletion can occur rapidly. Soon the student-athlete is emotionally running on empty. This is when psychiatric symptoms present.

Individuals with a history of sexual/physical/emotional abuse can suffer from post-traumatic stress disorder, which is a psychological reaction to experiencing a highly stressful event or series of events, outside the normal range of human experience. The disorder is characterized by depression, anxiety, flashbacks, intrusive thoughts and nightmares, among others. The demands of college athletics create an area ripe with "triggers" for the affected student-athletes.

Individuals with abuse histories have an extraordinary sensitivity to boundary violations or perceived boundary violations. A seemingly benign exchange can provoke a flood of effect with debilitating results. These responses can be confusing to the individual as well as teammates and other athletics department personnel. The student-athlete can begin to be labeled as "hot-headed," "overly emotional," "an over-reactor," "too sensitive" and so on. These kinds of dismissive responses trivialize what is a deeper-seated struggle for an individual that bears attention.

Less than benign exchanges, in the form of harsh coaching behavior, create a different set of challenges for those with abuse histories. The familiarity of mistreat-

ment may allow a greater degree of tolerance than for individuals with no abuse history. However, this is not without emotional cost.

The individual can quickly experience a shrinking sense of self and self-worth, which over time compromises the individual's ability to manage these exchanges. The student-athlete likely begins to experience increased frustration, distortion in thinking, unrealistic performance expectations and self-deprecating statements.

Coaching feedback can intensify arousal, causing further emotional distress in the individual. The person begins to feel worthless, and helpless about having any impact on the circumstance, which then can lapse into

It is common for individuals with abuse histories to experience inappropriate guilt, meaning the assumption of greater responsibility for what transpired than is reasonable.

hopelessness. Images of failure loom large, compounded by feelings of embarrassment, self-loathing and the potent affect of shame.

It is common for individuals with abuse histories to experience inappropriate guilt, meaning the assumption of greater responsibility for what transpired than is reasonable. This is the result of the masterful way in which abusers can project responsibility for their actions onto the victim. The abused individual experiences a mistake or disappointment as a crime of sorts for which they need to be punished.

Errors/mistakes are inherent in performance-based endeavors. An athlete can experience a relentless feeling of responsibility for such a metaphoric crime, triggered by a game error or dismal performance. This burden of failure, which "demands punishment," deploys more assaults on the individual's self-esteem and sense of his or her own character, further eroding the individual's effective stability.

Somatic complaints, without medical explanation, are a psychiatric symptom that is split off from the origin in

internal distress. These are often manifestations of depression. These can present as pregame nausea, chronic aches/pains, headache and so on.

Depression/anxiety can come in many disguises, such as psychomotor agitation, balking, hitting a hurdle, cramping and tight muscles. Additional disguises involve psychomotor retardation, inability to pass a fitness test, missing balls/shots and fumbling, to name a few. Somatic complaints bear further exploration. The preconscious conflicts of those with abuse histories can be a primary driver of such concerns.

Student-athletes are especially vulnerable to losses in physical functioning through injury, which removes them from the athletics activity. Considerable research – described in some detail in Chapter 4 of this publication – has been done on this issue outlining predictable post-injury adjustment/depression. For student-athletes, an injury can become a significant life stressor. It not only prevents participation in their sport and with their team, it affects self-image and status on the team. The inability to participate in practice creates increased social isolation, all of which exacerbates their emotional response to injury.

Individuals with abuse histories can suffer more acute psychiatric symptoms in response to injury as a result of an already compromised sense of self, tolerance for stress, frustration and emotional distress.

Individuals with histories of abuse are also at a higher risk for developing eating disorders. It is estimated that

30 percent of individuals who develop eating disorders have abuse histories. Once again, student-athletes are already an at-risk population for developing eating disorders (see Ron Thompson's article in Chapter 3). Combine this with an abuse history, and the preponderance of this psychiatric condition comes as no surprise.

An injury or incident can derail a student-athlete, causing a psychological free fall. Some of the warning signs are reckless behavior, such as careless sexual encounters, smoking pot, drinking and irritability, which can translate into fighting. Reckless behaviors are efforts to manage intolerable feelings, and are but temporary solutions that inevitably exacerbate the circumstance at best and can land individuals in considerable trouble at the worst.

The free fall can result in destructive thoughts, such as suicidal ideation, suicide attempts and other forms of self-harm. Student-athletes lose their capacity to manage unacceptable and intolerable feelings, trapping themselves in a black hole of despair.

Student-athletes competing at the collegiate level are at a confluence of circumstances, with limited preparation for the magnitude of the pressures they will encounter. Student-athletes with histories of abuse are subjected to an unusual combination of internal and external pressures that place them at risk for emotional compromise and struggle.

This can be mitigated with keen recognition of the signs of psychiatric distress, combined with early intervention and treatment.



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Interpersonal Violence and the Student-Athlete Population

BY LYDIA BELL AND MARY WILFERT

Sexual assault, harassment, bullying and hazing – these serious interpersonal injuries to an individual’s sense of safety and well-being find their way into athletics departments from the culture at large, tainting the experience of student-athletes.

When an event unfolds on campus, it can cast a shadow on a university’s reputation as a safe place for emerging adults to explore who they will become and how they will contribute to society. As educators, we have an understanding of some of the underlying factors that may increase the risk of interpersonal violence for students-athletes and students at large.

The challenge before us is to examine components of the athletics culture, including issues around masculinity, encouraging aggression, group-think, bystander effect, homophobia and gender discrimination, that may contribute to violence, and to identify ways to mitigate the impacts of these factors on behavior.

As we consider education and prevention, it’s important to note that many aspects of the student-athlete experience provide opportunities to reinforce positive behaviors and outcomes, including the influence of coach as mentor, the support found in being part of a team, and leadership roles and skill development integrated in competitive play.

We do not have the data to indicate whether student-athletes experience more violence than their non-athlete peers, nor if the athletics culture by nature increases the risk of interpersonal violence. However, violence precursors, such as aggression and control, are part of the athletics culture, and “group-think,” which is embedded in team play, may allow some behaviors to go unchallenged.

Though most men on campus and on athletics teams are not involved in perpetrating violence, most interpersonal violence is perpetrated by men, and occurs more often within the context of group behaviors, and these can include fraternities and athletics teams. It is imperative that we take a critical look at these precursors and assess in what manner and to what extent they need to be tempered to reduce the potential they may exacerbate the behaviors of those with a predisposition to become violent.

Our data sources include the 2012 NCAA Social Environments Study and the 2008-12 iterations of the National College Health Assessment. The Social Environments Study features a representative sample of more than 20,000 male and female student-athletes across Divisions I, II and III. The survey included items assessing campus environment, entitlement and aggression, social relationships and help-seeking behaviors, and character

education and intervention.

The National College Health Assessment, a comprehensive survey covering issues including substance use, sexual behavior, physical health, weight, personal safety, violence, and mental health and well-being, is offered through the American College Health Association and administered in either the spring or fall term. Varsity student-athletes were identified upon indicating that they had participated in organized, varsity, college athletics within the last 12 months. All other participants constituted the non-athlete comparison group.

Aggression in athletics

In his 2010 book “Anger Management in Sport,” sport psychologist Mitch Abrams identified two forms of aggression, which he termed as instrumental and reactive. Instrumental aggression is behavior defined by actively, forcefully pursuing one’s goal, where harm to others may be a potential result of the action, but would never be a primary goal.

Reactive aggression or hostile aggression is related to anger, and is behavior that has harming another as a primary goal. Abrams also notes that anger, in and of itself, if not necessarily negative, is an emotion like any other, and does not have to lead to violence.

In some cases, anger may enhance athletics performance as it prompts a physiological response of increased muscle strength. However, slower cognitive processing, and decreased fine motor skills are also part of that physiological response, which could hamper athletes, depending on the sport.

It is important to keep these differences in mind when viewing the data regarding aggression both on and off the field for student-athletes, as not all aggressive behavior is linked to interpersonal violence.

The 2012 NCAA Social Environments Study examined both athletics aggression and general aggression. Responses indicated that more than a third of males and a quarter of females have been trained to be aggressive in competition and believe that aggression is key to being a good athlete (see the table at the top of the following page).

Additionally, 45 percent of men and 29 percent of women are willing to do whatever it takes to win, and more than a fifth of men indicate that winning is more important than good sportsmanship. It is important to note that these numbers are nearly identical across divisions, with the exception that Division I males agree that they would do whatever it takes to win at slightly higher rates than those in Divisions II and III.

ATHLETICS AGGRESSION AMONG NCAA STUDENT-ATHLETES

% Agree/Strongly Agree that...	Men	Women
I've been trained to compete with aggression.	42%	25%
Being fiercely aggressive during competition is a key to being a good athlete.	40%	23%
During a competition I would do whatever it takes to win.	45%	29%
Winning is more important to me than good sportsmanship.	21%	5%
I perform better in competition if angry.	26%	14%
If an athlete is fouled hard, he/she is justified in retaliating physically.	15%	5%

The data also reveal that being athletically aggressive may be entwined with unethical decision-making. In determining whether an athlete is justified in retaliating physically when fouled hard, we find that when a student-athlete indicates that he or she has been trained to compete with aggression, he or she is three to four times more likely to agree that the retaliation is justified.

For example, only 2 percent of women not trained to be athletically aggressive agreed that retaliation was acceptable, as compared with 11 percent of the women who were trained to be aggressive. Among men, 7 percent of those not trained to be athletically aggressive agreed that retaliation was acceptable, as compared with a quarter of the men trained to be aggressive.

In examining aggressive behavior *off the field*, males indicated higher levels of physical aggression than females, which is consistent with existing research on aggression. In most cases, men agreed to these items at twice the rate of

women, with the exception of the question asking if they exhibited irritation when frustrated, with nearly one in five men and women agreeing to the item. Additionally, some of these items specifically ask about violent behavior resulting from anger, indicative of reactive aggression.

While these data do not allow us to determine whether general aggression predicts aggression on the field, a relationship between the two scales is clear. Males prone to general aggressive behavior were far more likely to agree that winning was more important than good sportsmanship (64 percent vs. 20 percent), and aggressive females were six times more likely to agree (30 percent vs. 5 percent) that winning was more important than good sportsmanship.

Additionally, as we do not have a nationally representative sample of non-athletes responding to these questions, we do not know if the rates of off-field aggression for student-athletes is any higher or lower than their non-athlete peers.

AGGRESSION MEASURES FOR NCAA STUDENT-ATHLETES

% Agree/Strongly Agree that...	Men	Women
I have trouble controlling my temper.	13%	7%
Some of my friends think I get angry easily.	13%	7%
When frustrated, I let my irritation show.	17%	18%
Given enough provocation, I may hit another person.	19%	6%
I have become so mad that I have broken things.	19%	8%

The influence of alcohol

The role alcohol plays as a factor in violence and sexual assault has been well documented. At least 50 percent of college student sexual assaults are associated with alcohol use.

The NCHA survey data provided insight on negative behaviors attributed to alcohol consumption, which include engaging in regrettable actions, memory loss, police encounters, unprotected sex, physical injury to self or others, and suicidal thoughts. (See Figure 5A)

As the table indicates, male and female student-athletes report higher rates of alcohol-related regrettable actions and memory loss than their non-athlete peers. The high-profile nature of the student-athlete role, coupled with the pressure to serve as role models, may in part explain this higher rate of regrettable actions.

However, the higher rates of memory loss may indicate higher rates of excessive drinking among the student-athlete population.

The other statistic that bears further consideration is that more than one in 10 students overall reported engaging in unprotected sex related to alcohol consumption, and that this number jumped to nearly one in five among male student-athletes.

Additionally, student-athletes and non-athletes attributed alcohol consumption to incidences of physical violence and sex without consent, reinforcing the role alcohol can play in interpersonal violence.

Sexual violence

The NCHA survey also gathered data about experiences of sexual violence within the past year. The accompanying table contrasts rates of sexual violence by sex and compares student-athletes with non-athlete populations. (See Figure 5B)

As indicated in the table, the percent of student-athletes and non-athletes in self-reported sexually abusive relationships was not significantly different. However, male

FIGURE 5A

BEHAVIORS AS A CONSEQUENCE OF ALCOHOL CONSUMPTION

As a consequence of drinking, have you...	Males		Females	
	Athlete	Non-athlete	Athlete	Non-athlete
Done something you later regretted	33%	27%	33%	28%
Forgot where you were/what you did	32%	27%	30%	24%
Got in trouble with the police	6%	5%	3%	3%
Had sex without giving consent	2%	1%	2%	2%
Had sex without getting consent	1%	1%	0%	0%
Had unprotected sex	19%	13%	14%	12%
Physically injured self	16%	15%	14%	13%
Physically injured another person	5%	3%	2%	1%
Seriously considered suicide	1%	2%	1%	1%

Percentages represent the percent of respondents in each group that answered “yes” to each survey item. The other choices were “No” and “N/A, I don’t drink.” Approximately 20 percent of male and female student-athletes reported not drinking, so if one was to compare only the behaviors of those who drink, the respondents who say “yes” to experiencing these consequences are higher in number. For example, of the nearly 5,500 male student-athletes who reported that they consume alcohol, 24 percent reported that they had had unprotected sex as a consequence of drinking.

FIGURE 5B

EXPERIENCES OF SEXUAL VIOLENCE

Within the past 12 months...	Males		Females	
	Athlete	Non-athlete	Athlete	Non-athlete
Sexually touched without consent	4.6%*	3.5%	9.1%	8.5%
Sexual penetration attempted without consent	1.2%*	0.9%	4.0%	3.6%
Sexually penetrated without consent	0.9%*	0.6%	2.1%	2.1%
Sexually abusive relationship	1.0%	0.9%	2.0%	2.1%

*p<.01

student-athletes experienced some form of sexual assault at rates significantly (p<.01) higher than their non-athlete peers, and female students overall experienced sexual violence at rates twice that of men, across all categories.

The data also revealed that lesbian, gay, bisexual and transgender (LGBT) students, independent of sex or athlete status, experienced significantly higher rates of sexual assault within the past 12 months than those who did not identify as LGBT. Such data serve as a reminder that sexual assault prevention training is applicable to both male and female student-athletes, and bring our attention to the need for additional focus on this topic among those athletes who identify as LGBT.

Mental health implications of sexual violence

NCHA survey participants were asked a series of questions about their mental health status within the past 30 days. To understand the mental health implications of sexual assault, the mental health responses of participants who indicated experiencing any sort of sexual assault (touched, attempted penetration, penetrated without consent) within the past 12 months were compared with those who had not experienced any of these conditions.

The data revealed that for both athletes and non-athletes, males and females who self-reported experiences of sexual assault were significantly more likely to experience hopelessness, mental exhaustion, depression or suicidal thoughts; struggle academically; find it hard to handle intimate relationships; and experience sleep issues.

However, student-athletes – both those who have experienced sexual assault and those who have not – appear

to experience each of these conditions, with the exception of academic struggles, at lower rates than non-athletes. It is important to note that among both male and female student-athletes, those who indicated experiences of sexual assault within the past 12 months were three times more likely to have had recent suicidal thoughts than those who did not (13 percent vs. 4 percent for women, and 12 percent vs. 4 percent for men). (See Figures 5C and 5D)

Hazing and bullying

Hazing has been a topic of discussion for many years, and research has shown that the student-athlete population may be particularly vulnerable when first joining their teams.

The 1999 Alfred University hazing study of college athletics shed light on this topic when it revealed that upon joining their team, more than two-thirds of college student-athletes had experienced humiliating hazing, and half were required to participate in alcohol-related hazing.

The prevalence of hazing in sport – despite harsher penalties and intensive prevention efforts – has been attributed in part to group-think and masculinity in sport. Athletics teams are like a family and become extremely close, allowing for forgiveness or ignorance of negative situations.

Student-athletes are especially vulnerable to group-think when they are isolated from outside opinions, when they are in homogenous groups, when they are expected to be obedient to “superiors,” and when there are no clear rules for decision-making.

Masculinity can also play a role in hazing, as the definition of being a “real man” can encourage hazing as a practice to prove that one can be physically and emotionally tough.

FIGURE 5C

MALE RESPONSES TO MENTAL HEALTH ITEMS

	Male Non-athletes		Male Athletes	
	No sexual abuse	Sex abuse in past 12 mo.	No sexual abuse	Sex abuse in past 12 mo.
Felt hopeless within last 30 days	22%	33%*	17%	32%*
Felt exhausted (not from activity) within last 30 days	57%	66%*	47%	61%*
Felt so depressed it was hard to function within last 30 days	13%	24%*	10%	23%*
Seriously considered suicide within last 12 months	6%	14%*	4%	12%*
Diagnosed with depression within last 12 months	12%	20%*	8%	12%*
Difficult to handle academics within last 12 months	19%	32%*	35%	51%*
Hard to handle intimate relationships within last 12 months	28%	48%*	27%	48%*
Sleep issues within last 12 months	22%	35%*	18%	32%*

*p<.01

FIGURE 5D

FEMALE RESPONSES TO MENTAL HEALTH ITEMS

	Female Non-athletes		Female Athletes	
	No sexual abuse	Sex abuse in past 12 mo.	No sexual abuse	Sex abuse in past 12 mo.
Felt hopeless within last 30 days	27%	40%*	23%	36%*
Felt exhausted (not from activity) within last 30 days	71%	81%*	65%	74%*
Felt so depressed it was hard to function within last 30 days	16%	29%*	12%	22%*
Seriously considered suicide within last 12 months	6%	16%*	4%	13%*
Diagnosed with depression within last 12 months	18%	29%*	13%	19%*
Difficult to handle academics within last 12 months	48%	62%*	43%	59%*
Hard to handle intimate relationships within last 12 months	33%	59%*	31%	55%*
Sleep issues within last 12 months	25%	41%*	20%	34%*

*p<.01

Despite increased attention on this topic and stricter enforcement of anti-bullying codes of conduct, the University of Maine’s National Hazing Study (2008) found that more than 55 percent of college students involved in clubs, teams or Greek organizations have been subject to hazing, and more than 25 percent of club advisers or coaches were aware that this behavior was occurring.

Such discouraging data reinforce the need for continued anti-hazing programming for student-athletes, in addition to programming tailored specifically for coaches who may be able to prevent such actions at the outset.

The Maine Collaborative is currently conducting pilot programs on a number of NCAA campuses, engaging multi-departmental cross campus working groups, to test effective comprehensive prevention programs. As a supporter of this effort, the NCAA will receive and share findings to the membership on how best to decrease the risk of hazing.

Cyberbullying

An Indiana State University study in 2011 defined cyberbullying as using technology, such as social networking, text messaging or instant messaging, to harass others with harmful text or images or intentionally isolate another from a social group. The study found that almost 22 percent of college students reported being cyberbullied, 38 percent of students knew someone who had been cyberbullied, and almost 9 percent reported cyberbullying someone else.

The rise in cyberbullying is not limited to college students, and has received increased attention and in some cases local and state-level law adoption designed to mitigate this behavior among the K-12 population.

Among the student-athlete population, concerns about cyberbullying are not limited to peer-to-peer interactions. The 2012 NCAA Social Environments

Study revealed that coaches have begun to encourage student-athletes to interact with fans via social media. While many reported positive interactions, some also noted receiving negative or threatening messages. (See Figure 5E)

Of particular concern is black student-athletes who reported receiving negative or threatening messages at twice the rate of white student-athletes. Although approximately 80 percent of student-athletes noted that their coaches or others in athletics talk to them about responsible use of social media, departments may also want to consider how to help student-athletes address negative or threatening messages from fans.

Hazing and bullying, both in traditional forms and online, exist in the absence of strong leadership and direction, when groups are allowed to operate in secrecy and without supervision. These groups are more likely to deviate from social norms of conduct when coaches and administrators take a “hands-off” position, and when there are not clear policies or they are not consistently enforced.

The NCAA Hazing Prevention Handbook recommends actions that administrators, coaches, team captains and athletes can take to ensure an athletics environment that speaks clearly to discourage hazing and that provides positive opportunities to enhance team building and bonding.

The NCAA Social Environments Study revealed that when faced with concerns over hazing and bullying, nearly 30 percent of student-athletes turn first to their parents for advice, support or assistance. While many would turn to teammates or coaches, parents were the most consistent first choice across the sample.

This was particularly true for freshmen, as nearly 40 percent indicated a desire to turn to parents first. As such, athletics departments may consider sharing information about hazing and bullying prevention and campus

FIGURE 5E

PREVALENCE OF CYBERBULLYING

% Agree/Strongly Agree with the following	Men				Women			
	White	Black	Latino	Other	White	Black	Latina	Other
I sometimes receive negative or threatening messages from fans via social networking sites.	9	17	12	11	3	6	3	4

resources with parents so they can assist their children if approached about this topic.

Various efforts have recognized that effective hazing prevention requires collaboration across campus to assure clear and consistent hazing policies, and targeted educational programming to address the unique cultural elements for various student groups. The NCAA published the Hazing Prevention Handbook (www.NCAA.org/ssi), which provides examples of hazing prevention policy and education, and specific guidance for athletics administrators, coaches and student-athletes.

Athletics departments can join the broader campus effort to address hazing through www.HazingPrevention.org, which sponsors the annual Hazing Prevention Week (<http://www.hazingprevention.org/programs/national-hazing-prevention-week>) the third week of September, providing resources that support hazing prevention at the campus level.

Participation with campus colleagues working to decrease hazing in student groups will facilitate the athletics effort to assure team environments are free of hazing activities.

Additionally, best-practice models in effective hazing prevention are under development through the National Collaborative for Hazing Research and Prevention (<http://umaine.edu/hazingresearch>), a multiyear pilot project to build an evidence base to better understand how to change the campus culture in order to reduce the risk of hazing for any one student.

Intervention and character education

The 2012 NCAA Social Environments Study included items regarding participants' willingness to intervene in a range of situations that could lead to aggressive or violent

behavior. As the accompanying table reveals, the rates of intervention vary widely depending on the situation, and men and women appear willing to intervene at significantly different rates depending on context. (See Figure 5F)

Understanding the considerations students weigh when deciding whether to intervene is useful when designing future training or having relevant discussions about intervention behavior.

Participants' responses reveal that there is a range of incentives and drawbacks to intervention that come into play when deciding whether to act. Overall, a large majority of student-athletes felt that they had a duty, at least in some cases, to act in a way that kept others safe. Additionally, many, especially females, agreed that they liked to think of themselves as helpers.

When considering drawbacks, fears of physical harm, angering teammates, and being perceived as over-reacting, often play a role in deciding whether to step in. Perhaps most concerning is that for 37 percent of males and 29 percent of females, intervening is at times perceived as just too much trouble. (See Figure 5G)

Character education

The Social Environments Study also included items that asked both about the types of training and character education student-athletes were receiving from their coaches, and also in what areas they would like more discussion or information. (See Figure 5H)

More than any other topic, student-athletes want their coach or athletics department to talk about what to do when they see something around them that is not right. This is the No. 1 request across divisions, for both men

FIGURE 5F

LIKELIHOOD OF INTERVENTION

% Likely/Extremely Likely to do the following...	Men	Women
Step in to stop a fight if someone threatens a teammate	82%	74%
Walk away from a confrontation	58%	74%
Get in a fight if the situation calls for it	50%	19%
Confront a teammate if he/she is treating a partner inappropriately	59%	47%
Intervene in a situation if it could lead to inappropriate sexual behavior	63%	71%

and women. Student-athletes are seeking empowerment and want to build their skills in bystander intervention.

The second- and third-most requested topics were conducting one's self appropriately on campus and in the community, and drinking and substance use. Approximately one in three men and women request more information about personal conduct, while women seek information about drinking and substance use at higher rates (32 percent) than men (25 percent). (See Figure 5H)

Coach implications for intervention

In examining character education and intervention, it is important to note some very interesting analyses a colleague at the Harvard School of Public Health has been doing with these data.

Looking specifically at predicting male student-athletes' willingness to intervene in situations of partner mistreatment or inappropriate sexual behavior, it has been found that having a coach who talks to student-athletes about treating members of the opposite sex appropriately, relationship violence, and speaking up when things are not right, is both directly and indirectly significantly related to their willingness to intervene in both situations.

It is clear that a coach's messages matter and can play a role in these behaviors. These analyses will be published soon and made available to NCAA members through the NCAA.org/research website.

Future directions

Interpersonal violence in the forms of sexual assault, harassment, hazing and bullying are under intense scrutiny as higher education is held accountable to provide safe environments for student life and learning. Included in this federal oversight are recommendations for education, prevention and response, identifying environmental strategies and bystander intervention training as best practices.

A critical best practice for athletics administrators is to partner with higher education associations and experts in the field to advance our understanding of the causes and impact of interpersonal violence, and even more importantly to engage in effective prevention practices.

NASPA, the organization for Student Affairs Professionals in Higher Education, is working to identify campus practices that support healthy interpersonal relationships and that deter interpersonal violence. Athletics administrators and educators are encouraged to join in campus

FIGURE 5G

CONSIDERATIONS REGARDING INTERVENTION

% who Agree/Strongly Agree with the following statement about deciding whether to help someone in trouble.

Incentives	Men	Women
All community members play a role in keeping people safe	78%	85%
I like thinking of myself as a helper	58%	89%
Teammates will look up to me if I intervene	59%	47%
Drawbacks		
I could get physically hurt by intervening	45%	40%
Intervening might make my teammates angry with me	43%	41%
People might think I'm overreacting to the situation	40%	37%
Sometimes it's just too much trouble to intervene	37%	29%
I could get in trouble if I intervene	37%	32%

FIGURE 5H

CHARACTER EDUCATION PROVIDED TO AND SOUGHT BY STUDENT-ATHLETES

Coach/athletics department education topic:	Men		Women	
	Discussed	Want more	Discussed	Want more
Conducting self appropriately on campus and in community	90%	29% (#2)	94%	31% (#3)
Drinking/substance use	87%	25% (#3)	93%	32% (#2)
Diffusing/avoiding confrontations	83%	22%	79%	26%
Speaking up when you see things around you that aren't right	80%	35% (#1)	77%	47% (#1)
Appropriate treatment of members of the opposite sex	80%	16%	66%	19%
Hazing/bullying	78%	16%	74%	20%
Relationship violence	67%	13%	54%	18%

efforts, to meet their duties as members of the higher education community, and to address these issues in a true team effort. The NCAA is currently compiling a best-practice handbook on interpersonal violence prevention and response, to be published in the spring of 2014.

Athletics administrators and student-athletes alike are called upon to exert leadership and to model appropriate behavior, as they wear the mantle of high-profile representatives of the university community. Recent federal actions – namely the Dear Colleague Letter of Title IX, and the Campus Sexual Violence Elimination Act or SaVE Act administered under the Clery Act – have increased the duty to achieve compliance in prevention, education, and response to any violent incident. Athletics departments are equally responsible to ensure staff and students are provided resources to intervene and respond to acts of interpersonal violence.

Current data tell us that a large number of student-athletes have been trained to compete with aggression, and that some, particularly males, exhibit aggressive behaviors off the field as well. Additionally, both male and female student-athletes are victims of sexual assault or relationship violence while on campus. Sexual assault can pose serious threats to an individual's mental health. Those who have experienced sexual assault are significantly more likely to

experience hopelessness, mental exhaustion, depression or suicidal thoughts; to struggle academically; to find it hard to handle intimate relationships; and to experience sleep issues.

While these data shed light on some of the mental health outcomes related to sexual assault, we also want to bring attention to sexual assault and relationship violence prevention and bystander intervention.

The promise of bystander intervention training is an exciting and welcome strategy, engaging and empowering students to intervene safely and effectively when they see a friend or teammate in distress or at risk for experiencing interpersonal violence in the form of sexual assault/harassment and hazing/bullying.

The 2012 NCAA Social Environments Study revealed that a surprising number of student-athletes appear to be reluctant to intervene in instances of relationship violence or inappropriate sexual behavior. However, more than a third of male student-athletes and half of female student-athletes note that they would like to talk more about speaking up when they see things that aren't right.

Many student-athletes are seeking the means to be empowered to act, and understanding their rationale for deciding when to intervene may assist us in developing programming that can directly address the perceived drawbacks to intervention.

Sexual assault education of student-athletes and coaches is required in the U.S. Department of Education's Title IX Dear Colleague Letter (<http://www2.ed.gov/about/offices/list/ocr/letters/colleague-201104.pdf>). Bystander intervention training is a defined strategy and expectation offered in the 2013 Campus Sexual Violence Education or SaVE Act (<http://clerycenter.org/campus-sexual-violence-elimination-save-act>) administered through the Clery Act and enforced by the Department of Education, requiring campus compliance in education, prevention and response.

The Step UP! Bystander Intervention Program (www.stepupprogram.org), which the NCAA supports, provides facilitator-friendly training materials to conduct training with student-athletes and other student groups to help overcome the bystander effect, addressing attitudinal impediments to timely intervention and providing real skill building to safely and effectively intervene when a friend or teammate is at risk.

Athletics departments can expect to be scrutinized and expected to step up and join the campus effort to create safe and healthy learning environments for all students. Athletics administrators are in position to influence the lives of so many, and through this guidance provide a unique opportunity to assist student-athletes to experience what it truly means to be a teammate on and off the field.

Note: The NCAA issued to member schools a new handbook that illustrates the responsibility athletics departments have in collaborating with other campus leaders to fight sexual assault and interpersonal violence. Titled "Addressing Sexual Assault and Interpersonal Violence: Athletics' Role in Support of Healthy and Safe Campuses," the handbook was created to help athletics departments partner to change the culture surrounding this issue. The NCAA Executive Committee also issued a statement on sexual violence. To read the statement and to view more information on the issue, visit www.NCAA.org/ssi.



Lydia Bell is the associate director of research for academic performance at the NCAA. Bell assists in all aspects of development and analysis of research on current and former student-athlete academic performance and well-being. Prior to joining the NCAA, she was an assistant professor of practice and director of Project SOAR in the Center for the Study of Higher Education at the University of Arizona. She received her Ph.D. in language, reading and culture and M.A. in higher education from Arizona, and an A.B. in government and legal studies and sociology from Bowdoin College.



Mary Wilfert is an associate director in the NCAA Sport Science Institute. Since 1999, she has administered the NCAA drug-education and drug-testing programs and worked to promote policies and develop resources for student-athlete healthy life choices. She serves as primary liaison to the NCAA Committee on Competitive Safeguards and Medical Aspects of Sports, the governing body charged with providing leadership on health and safety recommendations to the NCAA membership. Wilfert has worked in the health education field for more than 30 years to empower individuals to make informed choices for lifelong health and success.

Potential Barriers to Accessing Mental Health Services

BY KEN CHEW AND RON THOMPSON

Over the past decade, research and reports from university counseling centers have suggested that students are generally using mental health services at a much higher rate. They are displaying higher levels of distress and psychopathology, and their overall coping and adaptive skills are not as well developed as in prior generations.

Research has repeatedly demonstrated that having access to mental health services has a number of positive benefits, which include reduced risk for behavioral problems and suicide and better overall academic outcomes, including better grades, higher retention rates, and reduced overall liability for the colleges and universities. Further, students who use counseling services generally have higher graduation rates than students who never seek counseling.

Historically, the perception has been that student-athletes are more well-adjusted than non-athletes and are therefore less likely to struggle with mental health concerns at the same level. Further, studies have shown that participation in sport at the high school level and before acts as a protective factor that leads to more pro-social behavior.

Nevertheless, as students-athletes move into the colle-

Students who use counseling services generally have higher graduation rates than students who never seek counseling.

giate environment, they become at increased risk for issues related to alcohol abuse, aggression, injury and other negative behaviors. More and more, mental health professionals and individuals who regularly work with college-level student-athletes are acknowledging that they may actually be at greater risk for mental health concerns because they have the same risk factors as non-athletes, while also dealing with the pressures related to sport participation. Despite these additional stressors, student-athletes continue to use mental health services at a much lower rate than non-athletes.

Because student-athletes are often perceived as being higher functioning and have a variety of resources available to them to be successful both academically and athletically, it can be difficult to recognize when these individu-

als are distressed versus just having a bad day. As a result, it's often not until performance drops or there are recognizable behavioral problems that there is even an awareness that the student-athlete may be struggling. However, that initial recognition and getting the student access to a mental health professional may be challenging because of a variety of barriers that limit or prevent access.

In an effort to improve student-athlete use of mental health services, it's important to briefly discuss some of the barriers that may make access challenging. These generally fall into three fairly broad categories:

- Student variables
- Barriers associated with service provision
- A general misunderstanding of the difference between mental health counseling and mental health performance

Student variables

The most common student-related factors that may affect entry into or follow-up in counseling include the stigma around counseling, a desire for a quick fix rather than wanting to go through the process of counseling, fear of change, resistance related to feeling as if they are being made to go versus choosing for themselves, embarrassment, limited time, uncertainty of why they're being referred, and confusion about what counseling is.

Of these, the most noteworthy is the stigma related to counseling, which is common to both student-athletes and non-athletes. In fact, stigma is often perceived as the most significant factor preventing people from seeking counseling or being referred.

This especially holds true for student-athletes who may be taught from an early age that they need to persevere and push through pain or discomfort to be successful. The concept of being "mentally tough" actually conflicts with the very concept of counseling, which may require opening up to another person about any perceived weaknesses or things that the individual may be struggling with.

Nevertheless, it's important to note that the stigma associated with counseling has been lessening over the past decade, and students in general are seeking services at much higher rates than in the past. In fact, approximately 1 in 4 young adults between 18 and 24 are dealing with some form of mental illness; and it's estimated that approximately one-third of students entering colleges and universities at this time are coming in with some prior

counseling experience or having been on medication for a diagnosed mental health condition.

Source of service provision and culture

Barriers related to service provision and culture are sometimes the most difficult to navigate because there are so many potential variables that may have an impact, many of which may have developed over time or may be related to institutional structure. Two of these potential barriers in particular are source of service provision, and historical/cultural barriers.

With regard to the source of service provision, there are currently three major ways that mental health services are provided to student-athletes: (1) counseling centers, (2) positions within athletics, whether dedicated or shared with counseling, and (3) outside consultants. All of these have benefits and barriers.

COUNSELING CENTERS. The most common source of mental health service provision to both student-athletes and non-athletes comes from university counseling centers. The benefits of counseling centers are that they typically offer a variety of specialties or service providers, an increased level of privacy, and independence from pressure from athletics administration. Also, counselors are able to easily consult with each other on difficult cases.

Despite these benefits, the biggest limit is the fact that most counseling centers don't have psychologists who are trained specifically to work with student-athletes or are aware of sport culture. Additionally, access to services may be slow or difficult during busy times of the year, and there may be pushback from centers that believe that student-athletes are given preferential treatment. Also, hours of availability are often limited, and communication issues between counseling centers and athletics may limit referral. Unfortunately, at many institutions, there has been a historical rift between counseling services and athletics that only has served to add to the challenge of getting student-athletes proper counseling.

POSITIONS WITHIN ATHLETICS. Over the past decade, more universities have been moving to a model in which athletics has a dedicated in-house psychologist or a shared position with a counseling center. These positions provide greater flexibility in terms of overall access, and having a person familiar to the department increases use as well as referral.

Additional benefits may include reduced concerns about higher-profile athletes being identified as being

It's important to note that the stigma associated with counseling has been lessening over the past decade, and students in general are seeking services at much higher rates than in the past.

in counseling, consistency of treatment with the sports medicine team, increased availability to consult with or provide training to coaches and athletics administration. Having an in-house person also allows for greater awareness of the culture around athletics at a particular institution, which may be useful in helping student-athletes adjust or work through related pressures.

Though the benefits may seem great, there are a number of challenges with these positions as well. These may include limited professional support, a high level of demands on a single clinician, limited resources, potential pressures from athletics administration or sports medicine, and professional resentment from other clinicians on campus who may not fully understand the position.

Also, there can be confusion over whether the student-athlete is being referred for psychological counseling, which centers on helping people who are struggling with personal or mental health concerns and helping them get back to a normal or healthier level of functioning, or *sport psychology/mental performance services*, which focus on developing optimal performance in relatively well-adjusted individuals.

OUTSIDE CONSULTANTS. The third method of service provision is the outside consultant who comes in on a part-time basis. The primary benefit of this kind of position is that the athletics department can hire a person with a dedicated specialty to work with their student-athletes on an identified issue or set of issues.

These arrangements can range from a set amount of contracted time within athletics to see multiple athletes and teams or be limited to seeing a select number of student-athletes for specialized treatment in a private practice setting. For many institutions, having an outside consultant can save on cost and allows for a greater control over access to services.

Nevertheless, these positions continue to pose as a barrier because access to services is only as available as what athletics contracts; services may be limited based on the specialty of the provider; there may be confusion as to whom the client is; these positions may be less stable over time; and there may be pressures for the consultant to focus more on higher-profile or revenue-producing sports.

With regard to historical and cultural barriers, these are generally more long-standing and persist because of a shared resistance by all involved entities to change. Further, these variables generally overlap with some of the previously mentioned barriers. These may include the prior history between athletics and mental health services, uncertainty about what the other does, general misperceptions from the mental health side about athletics and student-athletes, appropriateness of referral, and issues related to the control and exchange of information, which may include confidentiality and privacy.

When combined with the previously mentioned barriers associated with stigma, ease and speed of access, limited availability of qualified professional, and confusion about who the client is, it's not hard to see why working relationships between counseling and athletics may have a history of challenges.

Future directions

As noted earlier, access to psychological services has positive benefits for the individual as well as the institution. This holds true for athletics as well. Reducing barriers that may prevent student-athletes from receiving mental health services can actually strengthen athletics programs by:

- Reducing behavioral concerns that may impact team dynamics.
- Helping prevent or moderate significant drops in academic or athletics performance.
- Reducing risk and liability associated with mental health concerns.
- Serving as an additional support for students in need.
- Improving overall student wellness.
- Taking pressure off coaches, athletic trainers and other administrators in working with student-athletes who may be in distress.
- Helping students to enhance functioning in multiple areas of their lives, including athletics performance.

To reduce these barriers and to receive the previously mentioned benefits, we encourage the following

best-practice guidelines for athletics departments and university counseling services that can make a difference going forward.

- (1) Have a discussion between athletics and counseling services as to the source and structure of mental health services on campus. This should ideally include sports medicine or athletic training, as these individuals have regular contact with student-athletes and are more aware of their personal and mental health needs. The purpose of this meeting should not be to create a specialized service for student-athletes but rather to identify what is available and ways to make referral easier and more user-friendly on both sides.
- (2) Recognize that student-athletes are a specific population with an emphasis on bringing in li-

Mental health services should be presented to student-athletes as part of the overall sports medicine package and included in any resource guides directed to student-athletes.

censed psychologists with competence in sport or counseling of athletes. Having clinicians aware of the sport culture could ease the referral process, reduce stigma, and start the process of healing any cultural rifts between athletics and counseling.

- (3) Present mental health services to student-athletes as part of the overall sports medicine package and included in any resource guides directed to student-athletes. Being made aware of psychological services, increasing their visibility, and having them normalized early on will serve to reduce stigma and ease referral.
- (4) Make sure coaches and athletics administrators learn the difference between mental health counseling versus mental performance referral to cut down on any confusion with referral.
- (5) Identify a person within athletics or sports

medicine whose role includes overseeing the emotional well-being of student-athletes. This individual would help facilitate referral, establish a collaborative relationship with campus and

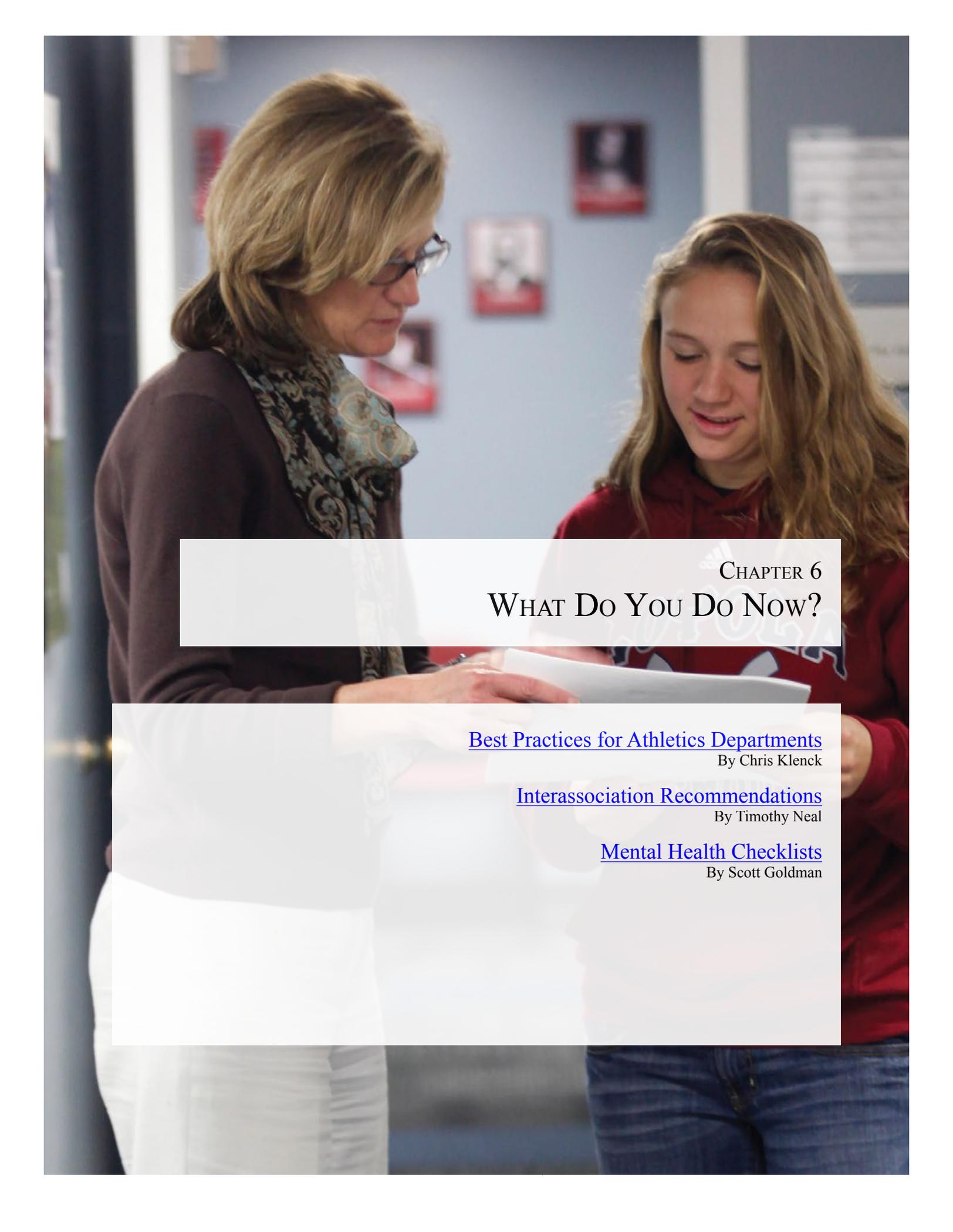
community resources, help create opportunities for counseling and athletics to cross-educate the other as to services and structure, and work with counseling to reduce any barriers that may arise.



Ken Chew has been the director of the Indiana State University Student Counseling Center since 2007. He also serves as director of training for the Counseling Center. Chew received his doctorate from the Virginia Consortium Program in Clinical Psychology in 2001 and completed his undergraduate work at Jamestown College, where he majored in psychology with a minor in fine art. His professional interests include the counseling of athletes, performance enhancement, drug and alcohol issues, multicultural counseling, facilitation of professional and personal development training, and outreach programming.



Ron Thompson is a consulting psychologist for the Indiana University, Bloomington, Department of Athletics and co-director of the Victory Program at McCallum Place, which offers a specialized eating disorder treatment staff to meet the unique needs of athletes. Thompson has served as a consultant on eating disorders to the NCAA and on the female athlete triad with the International Olympic Committee Medical Commission. He can be reached at rthomps2@sbcglobal.net.

A photograph of a woman with blonde hair, glasses, and a patterned scarf looking at a document held by a young woman with long blonde hair wearing a red hoodie. They are in a room with a blue wall and some framed pictures.

CHAPTER 6
WHAT DO YOU DO NOW?

[Best Practices for Athletics Departments](#)

By Chris Klenck

[Interassociation Recommendations](#)

By Timothy Neal

[Mental Health Checklists](#)

By Scott Goldman

Best Practices for Athletics Departments

BY CHRIS KLENCK

While the previous chapters in this publication have expertly documented the unique challenges student-athletes face regarding mental health, individuals charged with caring for student-athletes need help recognizing and managing these concerns.

The purpose of this article is to identify “best practices” for establishing mental health services at the collegiate level. While “best practices” are defined as “methods or techniques that have consistently shown results superior to those achieved with other means,” medical “best practices” often are considered to be no more than expert opinion.

In addition, individual athletics departments (and campuses overall) vary regarding the resources they have available to allocate toward mental health services. Thus, perhaps the best approach is to suggest key components believed to be consistent with “best practices” for establishing mental health services at the collegiate level, while allowing individual institutions to formulate their own consensus as to the best way to incorporate these components into the fulfillment of their unique needs.

The following eight components are suggested for constructing mental health services on college campuses:

IDENTIFYING MEMBERS OF THE MENTAL HEALTH SERVICES TEAM. While institutions will vary greatly with respect to human resources available to them, all collegiate athletics programs should have both an athletic trainer and designated team physician who will serve as core members of the mental health team. These individuals may not be mental health experts, but they can serve as a “point person” for referring student-athletes to the appropriate professional for evaluation and treatment.

Other ideal core members should include a psychiatrist, a clinical psychologist or a licensed clinical social worker with experience in mental health counseling. As these professionals may not be readily available to all athletics departments, it is critically important that the institution collaborate with on-campus services such as university counseling services or student health services, or off-campus services such as community mental health facilities or hospital clinic, private psychiatric, psychological, or other psychotherapy practices, and disordered eating clinics.

Establishing these relationships before a specific need is particularly important when timely referrals are essential. Additional team members may include sport psychologists, licensed drug and alcohol counselors, a team chaplain, academic counselors, sport dietitians, athletics

directors or sport administrators, and coaches. Finally, the confidentiality of the student-athlete should always be of utmost importance and taken into consideration when involving various members of the team.

RAISING AWARENESS OF THE MENTAL HEALTH SERVICES AVAILABLE. The goal is to ensure that every student-athlete or athletics department member is familiar with the services available and how to access them. Potential ways to accomplish this goal include: (1) presentations at team meetings; (2) presentations at coaches or staff meetings; (3) printed handouts or pamphlets with program information and contact numbers; (4) information posted on athletics department websites; and (5) use of social media (such as Facebook). Increased awareness will enhance the likelihood of self-referrals by student-athletes or referrals from teammates, coaches or other staff, and improving the timely evaluation of those student-athletes in need.

SCREENING, RECOGNITION AND APPROPRIATE REFERRAL. Screening student-athletes for psychological concerns such as depression and anxiety is extremely important for early recognition and intervention. Pre-participation physical examinations (PPE) afford an excellent opportunity to screen for and discuss issues such as depression, anxiety and disordered eating. Many PPE questionnaires specifically address these issues and can be a useful tool for screening. Other validated screening tools include the PHQ-9 Patient Depression Questionnaire.

It’s also important to ask about current and past prescription medications, recreational drug and alcohol use, and family history of mental health issues, as these are important indicators of possible psychological and psychiatric concerns.

In addition to screening, it is important that both student-athletes and those working with them are able to recognize signs and symptoms of potential mental health issues. Behaviors such as missing classes, uncharacteristically poor academic or athletics performance, frequent physical complaints, disheveled appearances, and fighting with teammates or coaches can suggest an underlying mental health issue.

Educational sessions with student-athletes and staff about the recognition of mental health concerns and the importance of timely referral will help improve outcomes for those affected. Special emphasis should be made to discourage unqualified individuals from attempting to counsel or treat student-athletes in need of professional care.

While diagnosis and treatment of physical injuries and illnesses are critical to the success of student-athletes, so should management of their mental health needs.

COMMUNICATION AMONG MEMBERS OF THE MENTAL HEALTH SERVICES TEAM. Communication among appropriate team members enhances appropriate follow-up and helps track progress. As confidentiality is always a chief concern, it is important early on to identify those individuals with whom the student-athlete will allow to share information, and to obtain appropriate written releases as indicated.

The mental health services team should meet weekly to discuss the care of student-athletes. These sessions help identify those student-athletes who are not attending appointments or making progress toward their goals. HIPAA-compliant text messaging or emailing can also help facilitate communication among providers.

MEDICATION MANAGEMENT. It is important to help student-athletes manage medications that may be prescribed to them. Many medications, such as antidepressants, may have undesirable side-effects or provide inadequate efficacy, which leads to poor compliance. Consideration should be given to having one provider, such as the team physician, prescribe all medications when indicated. The team physician frequently interacts with the student-athletes and athletic trainers. As such, this strategy may improve communication of adverse effects and will allow monitoring of refill requests to ensure compliance and appropriate use.

CRISIS MANAGEMENT. A student-athlete may present in “crisis” at any time. Issues such as active suicidal or homicidal ideation, acute psychotic episodes, or death of a family member, teammate or staff often require immediate professional attention. Having an established crisis management plan prevents lapses in care and improves outcomes. Every student-athlete who is at risk of a crisis should have a “safety plan” developed with a member(s) of the mental health team. He or she should be provided with contact numbers and a written plan of how to access services at any time if a crisis should arise. In addition, collaborating in advance with local resources such as crisis stabilization units, mobile crisis evaluations, or emer-

gency rooms at hospital facilities will streamline care when needed.

RISK MANAGEMENT. Mental health service members and athletics department staff should be aware of their responsibilities to report specific behaviors to appropriate institution officials or law enforcement officials when indicated. Examples of such behaviors may include expressing intent to harm another person or suspected sexual involvement with a minor. Educational sessions with university officials involved in risk management are strongly encouraged so each mental health services team member is aware of his or her legal responsibilities while providing care.

TRANSITION OF CARE. A final component for establishing mental health services is the transition of care for student-athletes who are leaving the athletics department. As student-athletes graduate, transfer, are dismissed from teams or are removed from continued participation due to their condition, a plan should be in place for the timely and orderly transition of their care to another provider. Helping the student-athlete identify a primary care physician, mental health care professional, or other provider in his or her community will ensure appropriate follow-up and continued care. Providing written information about mental health resources available to the student-athlete in his or her community may also facilitate his or her care. Finally, providing the student-athlete with a sufficient supply of prescription medications until he or she can establish care with another provider, and arranging for delivery of medical documentation to appropriate providers, will ensure a smooth transition of care.

* * * *

While diagnosis and treatment of physical injuries and illnesses are critical to the success of student-athletes, so should management of their mental health needs.

Mental health services should be a part of the comprehensive care provided to student-athletes at the collegiate level. In successfully integrated healthcare programs,

mental health issues are treatable, and positive outcomes through timely access to care are likely.

Even though available resources vary from one athletics department to another, all institutions should be able

to establish certain basic components for establishing mental health services. Care that encompasses the entire well-being of the student-athlete is certain to translate into success both on and off the playing field.



Chris Klenck was named team physician at the University of Tennessee, Knoxville, in November 2006 after a primary care sports medicine fellowship at Indiana University Medical Center. During his fellowship training, Klenck was an assistant team physician for the Indianapolis Colts preseason training camps and at Purdue University (his alma mater), and he worked the NFL Scouting Combines in Indianapolis. He has NCAA championships experience and served as a team physician in the Indiana high school ranks. Chris earned his doctor of pharmacy degree from Purdue before completing his doctor of medicine degree at Indiana University School of Medicine. He is a member of the American Academy of Pediatrics, American College of Physicians, American Medical Society for Sports Medicine and American College of Sports Medicine.

Interassociation Recommendations

BY TIMOTHY NEAL

The athletic trainer holds a unique position in college sports. In addition to being charged with protecting student-athlete health and safety, the athletic trainer often is a friend and companion – sometimes even a confidant – for the hundreds of student-athletes in his or her care. In fact, it is the athletic trainer who is often alongside even during a student-athlete’s worst moments. Usually, those worst moments entail a physical injury that ends the student-athlete’s season or career, and in some cases may threaten the student-athlete’s life.

Increasingly, though, some student-athletes’ worst moments are not physical in nature, but are a result of psychological concerns that affect the student-athlete’s well-being.

As such, the following is an executive summary of the NATA-sponsored, Interassociation Consensus Statement: “Recommendations in Developing a Plan for Recognition and Referral of Student-Athletes with Psychological Concerns at the Collegiate Level.”

These recommendations should help athletic trainers create a student-athlete “psychological concerns plan” in their athletics departments, and encourage them to collaborate with university departments to better assist student-athletes and manage institutional risk.

Background

Studies are starting to reveal the growing prevalence in the types, severity and percentage of mental illnesses in young adults ages 18 to 25, the same age group that includes most college students and student-athletes. Data indicate that approximately one in every four to five youths in America meets criteria for a mental health disorder, with severe impairment across a lifetime.

The U.S. Substance Abuse and Mental Health Services Administration reported in 2012 that 45.9 million American adults age 18 or older (20 percent of the survey population) experienced a mental illness in 2010. The rate of mental illness was more than twice as high in those in the 18- to 25-year-old range (29.9 percent) as it was in those age 50 years and older (14.3 percent).

Given that more than 460,000 student-athletes participate in NCAA intercollegiate sports, it’s likely that every athletic trainer will encounter at least one student-athlete with a mental health issue during his or her career.

Behaviors to monitor

Most student-athletes manage the stressors of being both a student and an athlete without any long-term con-

sequence to their mental well-being. Some student-athletes, however, will not be aware of how a stressor is affecting them – or if they are aware of their potential psychological concern, they will not inform anyone but may well act out in a non-verbal way to alert others that something is bothering them.

Following are some of the behaviors athletic trainers should monitor that may indicate a psychological concern in a student-athlete:

- Changes in eating and sleeping habits
- Unexplained weight loss or gain
- Drug or alcohol abuse
- Gambling
- Withdrawing from social contact
- Decreased interest in activities the student-athlete previously considered enjoyable, or taking up risky behavior
- Talking about death, dying, or “going away”
- Loss of emotion or sudden changes of emotion within a short period
- Problems concentrating, focusing or remembering
- Frequent complaints of fatigue, illness or being injured that prevent participation
- Unexplained wounds or deliberate self-harm
- Becoming more irritable or having problems managing anger
- Irresponsibility, lying
- Legal problems, fighting, difficulty with authority
- All-or-nothing thinking
- Negative self-talk
- Feeling out of control
- Mood swings
- Excessive worry or fear
- Agitation or irritability
- Shaking, trembling
- Gastrointestinal complaints, headaches
- Overuse injuries, unresolved injuries, or continually being injured

Circumstances that may affect a student-athlete’s mental health

By nature of the profession, athletic trainers are accustomed to dealing with injury. But as has been pointed out earlier in this publication (Chapter 4), the athlete’s psychological response to an injury can manifest in many ways.

INJURY. Whenever a student-athlete is injured, those

caring for the student-athlete should consider a possible psychological response to the injury. Any injury, especially a season-ending or career-ending injury, or a chronic injury that needs constant attention to participate, may become a source of stress to the student-athlete. Additionally, a student-athlete returning from a significant or time-loss injury may also experience a fear of re-injury.

CONCUSSION. Our evolving awareness of the after-effects of concussions includes the cognitive and psychological consequences on the student-athlete. After a concussion, the student-athlete should be monitored for any changes in behavior or self-reported psychological difficulties, both while recovering from the concussion and during their return to play after the injury.

ADHD. The prevalence of behavior disorders includes attention deficit hyperactivity disorder (ADHD) at 8.7 percent of the population. Some legitimate medications for this disorder contain NCAA-banned substances, namely stimulants; however, student-athletes with ADHD may need these medications to support their academic performance and general health. The NCAA has specific requirements for student-athletes with ADHD who want to compete while taking a banned stimulant.

ALCOHOL AND SUBSTANCE ABUSE. Despite the risk of negative results, including diminished performance and the loss of scholarships, some student-athletes use illegal substances and alcohol at higher rates than do age-matched non-athletes. Student-athletes also report more binge drinking than the general student population because they view alcohol use as “normal.”

Approach and referral

The stigma that is still stubbornly attached to mental health issues can inhibit a student-athlete from seeking an evaluation and care. Approaching a student-athlete with a concern about his or her mental well-being can be an uncomfortable experience for anyone, including an athletic trainer. It is important that you have the facts correct, with context, relative to the behavior of concern before arranging for a private meeting with the student-athlete. The conversation should focus on the student-athlete not as an athlete, but as a person. Empathetic listening is vital. Encouraging the student-athlete to seek a mental health evaluation can be put in perspective, reminding the student-athlete that his or her psychological health is just as important as physical health. As Newman University

men’s basketball coach Mark Potter said in Chapter 1 of this publication, permission to seek help is sometimes the best tonic for the problem.

Once a student-athlete self-reports wanting an evaluation, or agrees to go for a mental health evaluation, the student-athlete should be referred expeditiously to a mental health care professional. If possible, help set up the initial appointment. Having an established relationship with

SUGGESTIONS FOR APPROACHING STUDENT-ATHLETES WITH POSSIBLE MENTAL HEALTH CONCERNS

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

counseling services or community mental health professionals is highly recommended to expedite referrals.

If student-athletes demonstrate or voice an imminent threat to themselves, others or property (which, in many cases, rises to a code-of-conduct violation), or they report feeling out of control or unable to make sound decisions, then an emergent mental health referral is recommended. A university’s psychological concerns plan should include the protocol for emergent referral.

Confidentiality

The issue of informing the student-athlete’s coach or parents invariably comes up. In a routine referral, inform student-athletes that while their referral is confidential, it may be helpful if they informed their coach and parents of their appointments. The student-athlete is not compelled to do so, but the athletic trainer should emphasize that coaches and parents are concerned about each student-athlete’s well-being, and keeping health care providers and coaches informed of their mental health care (without disclosing confidential information) is no different than any other forms of physical care. Encourage the student-athlete to inform his or her coach or parents, but do not insist on it.

When referring to community-based mental health care professionals where the student-athlete's medical insurance may be used, it is important to inform student-athletes that their parents or guardians will receive notification of their mental health care treatment from their insurance company in the form of an explanation of benefits notification.

Campus counseling services and catastrophic incidents

It is important that the campus counseling center has a relationship with the athletics department, and that its mental health professionals understand the unique variables of student-athletes. It helps to identify an individual within the athletics department who is the primary contact. Because health and wellness falls under the purview of the athletic trainer, it is acceptable that the athletic trainer serve as the point person for referrals.

Stress reactions after a catastrophic incident are typical human reactions to the event. Many, if not most, of these reactions are self-limiting and will resolve with support, time and natural resilience. However, whenever a reaction persists, referral for mental health support is indicated. After a catastrophic incident (for example, death of a student-athlete or coach, or a disabling injury), offering early psychological intervention for those potentially affected has shown to be more effective in resolving traumatic stress than waiting before mental health care is implemented.

Risk management and legal counsel

University administrators face the challenge of managing the risks associated with mental health within the student-athlete population. To prepare for and respond to mental health incidents, administrators should be aware of risk management implications and be involved in developing the psychological concerns plan.

Legal considerations promote the idea that an inter-

SUGGESTIONS FOR INSTITUTIONAL PROTOCOL AND POLICY

- Develop a written plan for identifying and referring student-athletes with possible mental health concerns to appropriate resources for evaluation and care.
- Establish a collaborative relationship with counseling services and/or community mental health professionals before they are needed for referrals.
- Identify an individual within the athletics department, such as the athletic trainer, who will be the primary point of contact with campus counseling services.

QUESTIONS FOR REFLECTION

- Do you have a strategy for how you would approach a student-athlete with potential mental health concerns?
- Are you aware of your institution's policy related to student-athlete mental health?

disciplinary approach, including individuals in various departments within the institution of higher education, should be a goal in confronting the complex issues of mental health and the student-athlete. Two good resources for a university general counsel on the issues involved are "Managing the Student-Athletes' Mental Health Issues" from the NCAA, and "Student Mental Health and the Law: A Resource for Institutions of Higher Education" from the Jed Foundation.

For in-depth information on how to develop your own institutional plan and develop an educational component on psychological health for your student-athletes, download the full NATA Consensus Statement on Developing a Plan for Recognition and Referral of Student-Athletes with Psychological Concerns at the Collegiate Level at www.nata.org.



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In addition, Neal served as the NATA liaison to the NCAA Football Rules Committee from 2004-09, writing language for the helmet contact penalty, defenseless opponent penalty, and the horse-collar tackle penalty in college football.

Mental Health Checklists

BY SCOTT GOLDMAN

Clinical and sub-clinical changes in mood and mental states can affect the ability of student-athletes to function effectively – on the field of play, in the classroom and during their lifecourse. Many mental health disorders are at least partially rooted in biology. However, environmental stressors – including stressors associated with being a student-athlete – can play a critical role in whether these vulnerabilities turn into burdensome health conditions. One of the best ways to limit the negative consequences of most mental health conditions is early detection and treatment. This is where athletics departments and sports medicine departments can play a critical role: establishing prevention programming and reducing stigma around care-seeking, setting a plan to encourage effective early detection, and communicating to all stakeholders about how to manage emergency and nonemergency mental health issues.

The following four checklists can help athletics departments and sports medicine departments assess and plan for managing mental health issues among student-athletes. For more information and resources, see the NCAA Sport Science Institute website (www.ncaa.org/mentalhealth).

Checklist No. 1 Prevention And Preparation

1. CONDUCT A NEEDS ASSESSMENT

- Get input from all relevant stakeholder groups. Learn about perceptions of student-athlete mental health/performance needs, ideas for enhancing mental health performance services for student-athletes and barriers to change. These stakeholder groups will vary by campus but should include:
 - Athletes (talking to your Student-Athlete Advisory Committee is a good place to start).
 - Sports medicine and athletic training staff members.
 - Athletics administrators.
 - Coaches and other staff who have direct contact with student-athletes.
 - Faculty athletics representatives.
- If you are concerned about getting honest feedback from these stakeholder groups, consider using an anonymous needs assessment form (an example is available at www.NCAA.org/health-and-safety/sport-science-institute).
- Be sure to talk with your compliance director about concerns she/he may have about pursuing enhanced mental health/performance services for your student-athletes, or to review rules associated with these types of services.

2. BUILD RELATIONSHIPS

- Contact your state psychology licensing board (<http://www.ceunit.com/psychologistsstateboards.htm>) to help identify individuals who could serve as competent referral sources for your student-athletes on your campus and in your community.
- If your campus has a counseling center or other mental health service for students, arrange to meet with the director. Consider asking some of the following questions to get the conversation started:
 - How often do student-athletes use the campus counseling center?
 - Given identified student-athlete needs related to mental health, what do you recommend to better meet these needs?
 - What is the average wait for a student to get services?
 - Have you had specific counselors identified as liaisons to certain areas of campus?
 - Is there anyone in the center who has a background in athletics, or who would be interested to learn about the unique culture of athletics?
 - If a particularly high-profile student-athlete needed to receive counseling services, is there any provision you could offer to protect his/her privacy?

- Would someone on your staff be willing to provide outreach programs to our student-athletes, or at least come and introduce yourselves to our student-athletes each year?
- How do you handle psychotropic medication referrals?
- What kind of psycho-educational assessment services do you offer?
- Whether working with an on-campus resource (such as the counseling center or psychology department) or an off-campus provider (such as a private practitioner), make sure the provider has the following traits:
 - They are a licensed mental health professional.
 - They have expertise and/or credentialing in clinical AND performance services.
 - They understand and appreciate the unique needs of student-athletes.
- Initiate interactions with the mental health provider and your student-athletes when there is not a need for service. These non-clinical interactions will establish a rapport between the provider and your student-athletes, which will make it easier when the provider's services are needed. Some non-clinical interactions include:
 - Presentations about sport psychology to teams.
 - Attending staff meetings with coaches, academic counselors and sports medicine personnel.

3. MAKE A PLAN

- Before an incident, develop a general plan to address mental health issues and make sure your staff is aware of it. Your plan should be written into your policy and procedures. The plan should include:
 - Flexibility.
 - How to refer and triage.
 - How to educate staff.
 - What to do after hours.
- Know your school's policies and procedures for on-campus mental health issues. Ensure that your plan and program are consistent with the campus' general student population.
 - Know your school's "duty-to-report" policy on mental health issues.
 - Know how your school manages "conflict of laws." For example, do licensed mental health providers on your campus follow HIPAA or FERPA?
- Establish a liaison between the mental health care provider and the athletics department.

Checklist No. 2

Managing a Nonemergency Mental Health Issue

When student-athletes come to you in emotional distress and they do not present an immediate threat to the safety of themselves or others:

1. DEMONSTRATE COMPASSION

Some helpful tips for calming the student-athlete and demonstrating compassion are:

- Remaining calm yourself — maintain calm body language and tone of voice.
- Listen to the student-athlete. Allow him/her to express his/her thoughts. Provide him/her a forum in which he/she can be heard. It's OK to have a moment of silence between you and the student-athlete.
- Avoid judging the student-athlete.
- Provide unconditional support. You do not have to solve his/her problem.
- Normalize the student-athlete's experience and offer hope.

2. GATHER INFORMATION

- Ask questions, including questions of safety (“Are you thinking of hurting yourself?” and “Are you thinking of suicide?”)
- Asking the important questions will NOT plant the idea in his/her head.
- By asking questions about suicide, you will receive valuable information. If he/she hesitates or confirms, you know to elevate the intervention (see “Managing an Emergency Mental Health Issue” checklist).

3. MAKE A REFERRAL

- Present the student-athlete with treatment options.
- When you identify a student-athlete who would benefit from mental health services, but he/she doesn't appear to be aware of this need:
 - Inform the student-athlete matter-of-factly that you believe he/she would benefit from counseling. Base your recommendation on his/her behaviors, or identify specific behaviors that you have noticed and are concerned about.
 - Ask the student-athlete how he/she is feeling, how his/her actions are affecting his/her life, and if he/she has done anything about it so far.
 - Leave open the option for the student-athlete to accept or refuse the recommendation.
 - Encourage time to “think it over.” But, remember to follow up.
 - If the student-athlete refuses to attend counseling, leave the issue open for possible reconsideration.
 - Notify the student-athlete's team athletic trainer, the director of sports medicine, and the mental health provider affiliated with your department.
 - If the recommendation is accepted, help create a plan to schedule an appointment, and follow up with the student-athlete in a timely manner. You may call the mental health provider with the student-athlete. If you call with him/her, you will know that an attempt to schedule has been made and when the student-athlete's appointment is, which can assist you in follow-up.
 - Inform your mental health provider that a referral had been made.

4. RESPECT BOUNDARIES AND ABILITIES

- Know what you're comfortable doing and what you're not comfortable doing.
- Don't promise secrecy. If necessary, you can say to the student-athlete, “It took courage for you to disclose this information to me. And, by telling me, it says you want to do something about what is going on. The best thing we can do is to inform someone else, such as a mental health provider, who can give you the care you need.”

Checklist No. 3 **Managing an Emergency Mental Health Issue**

1. IDENTIFY WHETHER THERE IS AN IMMEDIATE THREAT TO SAFETY

- To identify whether the situation is an immediate threat to safety, ask the following:
 - Am I concerned the student-athlete may harm himself/herself?
 - Am I concerned the student-athlete may harm others?
 - Did the student-athlete make verbal or physical threats?
 - Do I feel threatened or uncomfortable?
 - Is the student-athlete exhibiting unusual ideation or thought disturbance that may or may not be due to substance use?
 - Does the student-athlete have access to a weapon?
 - Is there potential for danger or harm in the future?

2. MANAGE IMMEDIATE RISKS

- In the case of an immediate risk to safety:
 - Keep yourself safe — do not attempt to intervene.
 - Keep others safe — try to keep a safe distance between the student-athlete in distress and others in the area.
 - Get help from colleagues.
 - If the student-athlete seems volatile or disruptive, alert a co-worker for assistance. Do not leave the student-athlete alone. However, do not put yourself in harm's way if he/she tries to leave.
 - Call 911 or campus security, or have the person taken directly to the emergency department at the nearest hospital.
 - ◊ When you call, be prepared to provide the following information:
 - Student-athlete's name and contact information.
 - Physical description of the student-athlete.
 - ◆ Height, weight, hair and eye color, clothing, etc.
 - Description of the situation and assistance needed.
 - Exact location of the student-athlete.
 - If the student-athlete leaves the area or refuses assistance, note the direction in which he/she leaves.
 - Follow campus and department protocols and policies.
- If possible, offer a quiet and secure place to talk.
 - Listen to the student-athlete; maintain a consistent, straightforward and helpful attitude.
 - If the student-athlete is expressing suicidal ideation:
 - ◊ Listen.
 - ◊ Show your genuine concern.
 - ◊ Emphasize risk to safety.
 - ◊ Do NOT leave the person alone.

How to ask about suicide:

“Are you/Have you been thinking about suicide?”

“Are you/Have you been thinking about killing yourself?”

“Sometimes when people are (your observations), they are thinking about suicide. Is that what you're thinking about?”

How NOT to ask about suicide:

“You're not thinking about suicide, are you?”

3. CONTACT A MENTAL HEALTH CARE PROVIDER

- Make arrangements for appropriate university intervention and aid.
- Call the mental health provider to initiate next steps of care.
- If medical care seems appropriate, head to the nearest hospital or call 911.
- If the student-athlete is expressing suicidal ideation, make a referral for a suicide risk assessment.
 - On-site mental health professional.
 - Local hospital.
 - Local crisis line/mobile assessment team.
 - ◊ Suicide hotline: 1-800-784-2433 or 1-800-273-Talk.

Checklist No. 4 After Managing a Mental Health Issue

1. Initiate follow-up care

- Identify what is needed for follow-up care.
- Identify available resources.
- Initiate continuity of care:
 - How is the mental health issue going to be managed within the athletics department?
 - If the issue is not to be managed within the athletics department, how do you make appropriate referrals and transitional steps to ensure the safety and well-being of those involved?

2. Debrief and plan for the future

- Schedule a meeting with athletics department staff involved with the intervention and athletics department staff who will be involved moving forward. While maintaining appropriate confidentiality:
 - Identify the strengths of the intervention approach.
 - Identify what did not work with the intervention approach.
 - Identify what improvements could be made to the departmental protocol for prevention, early detection and management of mental health issues.

For more resources, see www.NCAA.org/health-and-safety/sport-science-institute

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*It is our responsibility
to provide the services and care
to help each student-athlete reach
his or her full potential.*
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