MENTAL HEALTH + 
THE ATHLETE

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NDATA Annual Meeting, April 22, 2017
Objectives

**Identify**
Identify the relationship between injuries and concussions and mental health concerns.

**Understand + Implement**
Understand and implement best practice guidelines regarding mental health concerns.

**Recognize**
Recognize the role of the athletic trainer in the referral process and management of mental health concerns.
Caveats

• Defining mental health symptoms
  • Self-report screening inventories vs. structured or semi-structured interviews

• Not many studies done in this area
  • Prevalence of mental health diagnoses in athletes?
  • No large-scale epidemiological studies

• Details from case examples have been changed to disguise athletes

• Share on social media (if so inclined)!
  • #AthleteMentalHealth, @DrErinHaugen
Challenges of Mental Health

• Mental health is individualized and complicated
  • “You can’t treat a bullet wound with a Band Aid”
  • Personality characteristics

• Symptoms exist on a continuum
  • Subthreshold symptoms may not come to your attention

• “Normative” symptoms
  • Amenorrhea is NOT “normal”

• It’s there...even if you don’t recognize it
IDENTIFY

The relationship between injuries/concussions and mental health concerns
Athletes + Injury

• Not always well-equipped to deal
  • What’s left when sport is not there?
  • “Weak”

• Recovery can be unpredictable
  • Physically & emotionally
  • Many fear reinjury upon return to sport

• Different role on team
  • Social support important
  • Social network may complicate recovery
Psych Factors Associated with Injury

• “Injury-prone” athlete profile doesn’t exist

• Common factors
  • Stressors
  • Poor coping abilities
  • Situational-dependent emotional states

• Competitive anxiety (disorder level?)

References: Junge (2000)
Injury + Mental Health

- Injury = Stressful life event

- Emotions: depression, anxiety, fear, anger, confusion, frustration

- Changes
  - Schedule (travel vs. non-travel)
  - Social Support (coaches, teammates, family)
  - Academic impact (concussion vs. ortho)

References: Heijne et al. (2008); Reardon & Factor (2010); Smith & Milner (1994); Tracy (2003); Wylleman et al. (2004)
Depression + Injury

- Depression associated with
  - Higher pain scores
  - Greater likelihood of injury
  - Longer RTP

- Transitions trigger depressive episode (e.g., injury)

References: Appaneal et al. (2009); Galambos et al. (2005); Henderson (1999); Yang et al. (2007)
Depression + Concussion

- Overlap in symptoms
  - Sadness, irritability, fatigue, sleep changes

- DP: poorer neurocognitive performance
  - Reaction time, visual memory

- Rates may be same for males + females
  - More concussion associated with more likely DP
  - Higher in retired athletes

- Higher DP (somatic) may prolong concussion recovery

- Long term may be at greater risk for severe depression

References: Erlanger et al. (1999); Guskiewicz et al. (2007); Kerr et al. (2014); Kontos et al. (2012)
Depression + Concussion

- 23% post-concussion (vs. 11% at BL)

- Depression at baseline (pre-concussion) predicts MH sx post-concussion
  - 4.5 times more likely than no baseline depression
  - 3.4 times more likely to experience anxiety post-concussion

- Course of depression varies across studies
  - Higher DP 1 week post-injury than ortho injuries; decreased 1wk to 1mo
  - Higher DP up to 14 days post-concussion

References: Appaneal et al. (2009); Kontos et al. (2012); Roiger et al. (2015); Vargas et al. (2015); Yang et al. (2015)
Suicide + Injury/Concussion

• Current SA engage in suicide behaviors at lower rates
  • More serious injury
  • Highly involved male athletes at greatest risk

• Higher suicide rates in retired athletes, especially FB

• Sport related loss is associated with suicide
  • Injury, retirement, cut from team
  • Shame

References: Sabo et al. (2005); Smith & Milliner (1994)
Anxiety (or Stress) + Injury/Concussion

- Anxiety symptoms (stress) + injury
  - Occur 2 to 5 times more under high stress, including high academic stress

- Major injuries: higher life stress

- Little is known about anxiety disorders
  - Higher levels of GAD
  - High trait and competitive anxiety
  - Burnout

- Anxiety at baseline (pre-concussion) NOT associated with increased anxiety post-concussion

References: Finkbeiner et al. (2016); Lavallee & Flint (1996); Gulliver et al. (2015); Mann et al. (2016); Petrie (1993); Williams & Roepke (1993); Yang et al. (2015)
ADHD + Injury/Concussion

- Self-identified ADHD
  - 50% at least 1 concussion
  - 2.93x more likely to have 3+ concussions

- Head trauma can often lead to ADHD-like symptoms (e.g., inattention)
  - Careful about stimulant use

- Concussed athletes may experience more impulsivity

- No research re: injury and ADHD

References: Alosco et al. (2014); Kerr et al. (2014); Nelson et al. (2016)
Eating Disorders + Injury/Concussion

- Research: mostly related to how ED contribute to injury (stress fractures)

- No research re: ED sx post-injury (including concussion)

- Removal from play will likely be associated with change in eating habits
  - Possible concern about weight/shape
  - Way to cope with emotions (control)
  - May also see increase in use of substances (stimulants) to manage weight
Substance Use + Injury/Concussion

• Repeat injuries are most likely to occur if consume alcohol

• Increased substance use
  • Marijuana
  • Alcohol
  • Opioids

• 52% NFL players used opioids for injury with 71% reporting misuse
  • Use in retirement was 3x general population

• Indirect relationship
  • Depression associated with substance use (so higher during injury?)

• Alcohol-related unintentional injury (ARUI)

References: Cottler et al. (2011); Finkbeiner et al. (2016); Gmel et al. (2007)
Summary

• Depression is most well-researched: increased risk
• Substance use: possible increased risk
• Little is known about anxiety, eating disorders, ADHD
• HIGHLY individualized
UNDERSTAND + IMPLEMENT

Best practice guidelines regarding mental health concerns
NCAA Best Practices (2016)

• Screening is good...and not so good...
  • False positives or false negatives

• Why are YOU screening?

• Be realistic

• What’s your plan?
  • Cutoff scores
  • Serious items
What is Being Done?

- 39% of sports med departments surveyed had written MH plan
  - DI highest; strongest predictor of screening
- ¾ asked about previous ED, AX, DP diagnosis
  - Less than ½ administered formal survey
- ½ asked about substance use
- 31% didn’t screen for anything; 20% screened for all 6
  - DI: screened for 3; DII + III: screened for 2
  - Higher ratios of SA to AT screened for fewer MH
  - Clinical Psychologist present tended to screen for more

References: Kroshus (2016)
When to Screen?

- Within context of pre-participation examination

- After injury and throughout rehab

- Changes
  - Major life events (especially loss)
  - Eligibility, legal problems
  - Behavioral, emotional
  - Playing status

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<th>Option 1</th>
<th>Administer all questionnaires recommended by the NCAA</th>
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<tr>
<td>Option 2</td>
<td>Administer some questionnaires recommended by the NCAA</td>
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<td>Option 3</td>
<td>Ask screening questions and administer questionnaires if yes</td>
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Various Approaches
Depression

Formal Screening

• NCAA: HANDS

• CES-D (research)

• PHQ-2 (0-3 scale)
  • Little interest/pleasure in things
  • Feeling down, depressed, or hopeless

Informal Signs

• Unexplained changes in sport performance and/or mood

• Physical complaints (vague, unexplained)

• Reduced quickness, reaction time

• Criticalness (self, others)

• Lack of desire (sport, other activities)

• Overtrained, burnout

• Increased errors (penalties, fouls)
Anxiety

Formal Screening

• NCAA: BAI (mostly somatic anxiety)

• GAD-2 (0-3 scale)
  • Feeling nervous, anxious, or on edge
  • Not being able to stop/control worry

• PDSS-SR: 5 items

• SPS-6: 6 items

Informal Signs

• Hypersensitivity to body sensations

• Negative thinking, WCS

• Perfectionism

• Strong somatic symptoms (at practice)

• Stomachaches, headaches, nausea

• Excessive fear of re-injury
Eating Disorders

Formal Screening

- NCAA: SCOFF
- EAT-26: weight-control behaviors
- EDE-Q: body dissatisfaction
- FAST: developed for female athletes

Informal Screening

- Loss of muscle tone
- Scratches on hands
- Swollen salivary glands
- “Good athlete” characteristics
- Amenorrhea
- Exercising outside of workouts
- Not eating with teammates (travel)
- Increased injuries, slowed recovery time
Substance Use

Formal Screening

• NCAA:
  • AUDIT-C (alcohol)
  • CUDIT-R (cannabis)

• DAST (drugs): 10 to 28 items

Informal Signs

• Irresponsible in commitments
• Use in risky situations
• May appear depressed/lethargic or anxious/jittery
Sleep

**Formal Screening**
- NCAA
  - STOP-BANG (sleep apnea)
  - ISI (insomnia)
- Ask about sleep duration and sleep quality
  - Falling, staying asleep
  - Waking up early
  - Fatigue

**Informal Signs**
- Dark circles, lethargic, sluggish
- Irritability
- Getting emails, texts at strange hours
- May be due to other MH issue (depression, anxiety)
ADHD

Formal Screening

• NCAA: ASRS-v1.1

• Inattention can be due to many things (depression, anxiety, sleep, ADHD)

• Psych evaluation (with testing) likely helpful

Informal Signs

• Academic difficulties (poor grades, takes long time to do work)

• Avoiding homework

• Poor attention in sport

• Being late, poor task management

• Forgetfulness (appts, assignments, plays)
Suicide + Non-suicidal Self-Injury (NSSI)

Formal Screening
- HANDS, CES-D have suicide question
- SBQ-R: 4 items
- ASK if they are considering suicide or harming themselves
  - Don’t be scared of the answer
  - Have a plan to respond (walk-in services, ER)

Informal Signs
- Unexplained wounds (especially cuts, scratches, burns, bruises)
  - Wrists, thighs, stomach
- Giving away possessions
- Putting affairs in order
- Previous suicide attempts/self-injury (especially recent)
- Perfectionism, emotional intensity with few outlets
Other Suicide Signs

- Suicide talk
  - “It would be better if I wasn’t here”

- Suicidal ideation (thoughts)

- Suicide attempts (e.g., overdosing) past and present

- Plan to commit suicide
  - Researching ways

- Giving away valuable possessions or saying goodbye to loved ones

- Hopelessness, helplessness, excessive guilt

- Suddenly happier or calmer (without explanation)

- Excessive alcohol or drug use

- Talking about harming or killing someone else

- Self-injury (e.g., cutting, burning) or unexplained wounds
  - May also be a sign of violence or eating disorder
Mental Health Emergencies (P & P)

• What is considered a MH emergency? Sexual assault?
• Under what circumstances is an athlete removed from play (e.g., eating disorder symptoms, suicide attempts/gestures)?
• Who do you call (e.g., 911, campus counseling center)?
• When is the athlete transported to the hospital (or who makes that decision)?
• When does the Athletic Department get involved or notified?
• When does the family get involved or notified?

National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
## Risk Factors for MH Emergencies

- Recent experience of trauma
- Sexual identity issues
- Diagnosis of depression
- History of substance abuse
- Significant health problems/injury
- Impulsive behavior
- Previous suicide attempts
- Family history of suicide

- Impulsive or aggressive tendencies
- Hopelessness or helplessness
- Local epidemics of suicide
- Isolation
- Barriers to accessing mental health treatment
- Unwillingness to seek help for mental health issues
- Loss (relational, social, academic, financial)
- Concussions

References: Maniar & Sommers-Flanagan (2009)
RECOGNIZE

The role of the athletic trainer in the referral process + management of mental health concerns.
Role of Athletic Trainers

• Likely **THE** first point of contact for MH issues
  • Be ready
  • Identify → Refer

• Manage expectations
  • “I just want to be over this.”
  • What would you say for a physical injury?

• Be clear about limits of privacy
  • If you can’t provide complete confidentiality, DON’T offer it
ATCs + Social Support

• Less sx at RTP
  • 87% less depression
  • 78% less anxiety

• Right support at right time
  • Emotional: at injury, RTP, rehab slow
  • Informational: as time passes, stuck in rehab

References: Udry (1996); Yang et al. (2014)
Culture of Mental Health

• How do you talk about MH?
• How do you respond when others talk about MH?
• Addressing it sooner WILL lead to less problems
• Create a culture accepting of MH issues/challenges

“This is therapy, I’m not trying to ‘psych you out.’”
Important Points

- Athletes may not know that they are experiencing mental health issues
  - May see these emotional changes as normative
  - Might not even be able to identify emotions
  - May not recognize that treatment can help them NOT feel this way

- They aren’t immune to stressors

- Some types of thinking that are associated with poor MH are common in the sport environment

Make getting help EASY.
63% of athletes open to future help
(American College Health Association, 2013)

YET

Athletes less likely to receive help

WHY?
Barriers

- Stigma is #1
  - Discomfort ("crazy", "weak", "athletes don’t go to therapy")
  - Perceptions of others (teammates, coaches, family)
  - Previous experiences?
- Discomfort with emotion/talking
- Time demands

References: Gulliver et al. (2012); Watson (2006); Wahto et al. (2016)
Encourage Help-Seeking

• Positive expectations associated with greater help-seeking behavior

• Movements to de-stigmatize athlete mental health
  • Michael Phelps, Allison Schmitt, numerous examples on The Players’ Tribune
  • Michigan’s Athletes Connected: www.athletesconnected.umich.edu
  • Student Athlete Mental Health Initiative: http://www.samhi.ca/

You don’t have to be sick in order to get better.

References: Watson (2005)
Beginning the Conversation

• How would you handle a physical injury?
  • Talk privately
  • Focus on the PERSON
  • Share concerns clearly, compassionately, and without judgment
    • May be your or someone else’s (teammate) data

• Confidentiality
  • Let them know who has to know
  • Ask who they want and don’t want to know
  • Be prepared to manage teammate questions

• If athletes get upset that’s okay
  • You are doing this because you care about them
When It’s More Serious

- May have to be removed from play
  - Coach, MD, ATC decision
  - Difficult decision: sport helping vs. hurting the athlete

- ANY suicide, NSSI, homicide behaviors
  - Immediate evaluation by MH provider
  - Remove harmful objects, don’t leave athlete alone
When It’s More Difficult

- Eating disorders
- Substance use
  - Self-medication
  - Fear punishment or stigma
- Don’t see it as a problem (and may not impact sport/academics yet)
Additional Tips

• MH issues can color how athletes hear what you say
  • “Can you repeat back what you heard? I want to make sure I’m coming across clearly.”
  • “So, to recap, this is what we discussed and here’s the plan going forward.”
  • “I will take care of contacting the psychologist for an intake. You will call your parents and let them know what’s going on. I’ll check in with you at practice today about this.”

• Remember this can be SCARY and OVERWHELMING
  • Make it as easy as possible
  • Let them know they’re not alone in this
  • You’re not trying to get rid of them
Team Approach

• Reasonable expectation to coordinate care with providers
  • MH providers (especially if limited sport involvement)
  • 58% of ATCs satisfied with feedback from clinicians (!!!)

• Coaches

• Family
  • What are guidelines in your department about their involvement?
  • May be more likely to seek help when referred by family vs. coach or teammates

• Administration

• Teammates

References: Sudano and Miles (2016); Wahto et al. (2016)
What Providers Should Athletes See?

• Clinical + sport-specific training (ideally)
  • Unique athlete, sport characteristics
  • May not be possible given your location (telehealth?)

• Sensitive to athlete time demands
  • Early morning, evening hours
  • Open to attending practices (if desired)

• Medication vs. therapy vs. psychological evaluation
  • Consider preference, side effects, symptom severity
  • Eval is likely necessary when considering ADHD diagnosis
Where Should Athletes Go?

**On Campus**
- Free or low cost
- Accessibility
- Therapist may be student or licensed provider
- Confidentiality
  - Know Policies & Procedures
  - Will AD know?
- Visibility to students
- Will have crisis services

**Off-Campus**
- Cost and/or insurance
- Transportation issues
- Therapist will be licensed or becoming licensed
- Confidentiality
  - Nothing without ROI (unless concern of harm)
- Visibility to community
- Crisis services vary
Building Your Mental Health Team

- Make sure they are a LICENSED provider (e.g., LP, LPCC, LICSW) in your state
  - Is that “mental toughness” guru qualified to deal with MH issues?
- Experience with sports? What do they need to be up to speed?
- Session info
  - How quickly can intake be offered?
  - Frequency of appointments?
- Communication with ATCs, coaches, team physicians?
  - How often? What modality (e.g., email, text, phone)?
- What athletes do they work best with? Worst?
NCAA Innovations in Research + Practice Grant

• Awards $100,000 to data-driven pilot programs to enhance SA well-being and mental health

• Campus-level programming

• Deadline for proposals likely December 1, 2017 (based upon last year)
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**Questions?**