MENTAL HEALTH ISSUES IN THE HIGH SCHOOL ATHLETE

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Goals and Objectives

• Understand and recognize the prevalence of mental health issues in student athletes
• Be familiar with the risk and protective factors for suicide
• Identify possible triggering events
• Be familiar with depression and its links to overtraining and concussion
• Recognize various presentations of anxiety
• Become familiar with ADHD, eating disorders, and bullying
• Develop a care team and treatment plan for mental health disorders and emergencies
• Understand legal and educational components of mental health issues
Background Information

- Student athletes often define themselves by their identities as athletes.
- Factors such as injuries, conflicts with coaches and teammates, and changes in interest level in their sport can increase the risk of mental health issues or worsen an already present concern.
- Identification of these risk factors or triggers and implementation of a care plan is key to caring for a student athletes’ mental health.
Triggering Events

• Certain events may trigger a new mental health concern or exacerbate an existing condition.
  – Family or relationship issues
  – Lack of playing time
  – Violence- assault, domestic violence
  – Death of friend or family
  – Maladaptation to school issues
  – Changes in interest in sport (burnout)
  – Lack of sleep
  – Substance abuse
Physical Activity can compromise health
Overtraining (20–60%)

Injury (10–20% warranting clinical intervention)

Burnout (10%)
Correlates with depression and major depressive disorder.5,7

Risk for sudden cardiac death (2.5 fold) and other non-cardiovascular conditions (2.3-fold)

Eating disorders (17.2–32%)

Iron deficiency, gastrointestinal symptoms, diabetes mellitus

Immunological suppression, incidence of allergies and infection

Depression (21.4%)
Concerns for athletes

Variation in:
• Diagnosis
• Treatment

Doctors in sports environment:
• under intense pressure from management, coaches, trainers and agents to improve performance in the short term
• Faced with a myriad of ethical dilemmas that compromise the well-being and treatment of the athlete.
Vulnerabilities to Mental Illness

Social world of many organized sports (2)
- Requires high investment of time and energy
- Loss of personal autonomy
- Disempowerment for athletes

Sport environment (3)
- Result in ‘identity-foreclosure’
- Leaving athletes few other avenues through which to shape and reflect personality.
- High athletic identity linked to psychological distress when this function of identity is removed, and to overtraining and athlete burnout.
Identity frequently tested

Uni-dimensional identity = all eggs in one basket

Less likely or able to compartmentalise sources of their identity

Over-reliance on sporting network for support

Identifying oneself as an athlete is central importance

Highly identified with and influenced by team

Cannot buffer from emotional highs and lows of sport
Vulnerabilities to Mental Illness

Injury, competitive failure, ageing, retirement from sport and other psychosocial stressors

- precipitate depression in athletes (4)

Risk-taking behaviours

- hazardous drinking, driving while intoxicated and unprotected sex (5)
- Alcohol is a depressant and negative coping technique used by athletes
PRESSURE OF LIFE BALANCE
i.e. Student, work, relationships

• ‘Homeostasis’ essential for performance and growth and repair.
• Students pressures of exams, coursework, training and competing.
• Recovery element of training compromised.
• Additional teams to represent.
• Athletes with a family, job, children, girlfriend etc. can find it hard to deal with the demands of intense training on top of everything else.
• Self-pressure: high motivation and expectations

Role model status

• The pressure to be a role-model leaves it hard for athletes to make the mistakes their peers make without being under the scrutiny of fans, the media, coaches and managers.
• Athletes who experience success very early in life can struggle with such a title.

↑ public recognition & ↑ public scrutiny

• Many athletes enjoy being recognised by the public BUT brings with it additional pressures.
• Self-pressure to always be “the star” which is unrealistic when other factors like injury or illness are to be factored in.
Rest and recovery are essential components for athletic performance. Coaches need to reinforce this to athletes. Coaches also need to be aware when they are pushing for their own needs as opposed to the greater good of the athlete. An athlete who feels understood and valued will ‘want to’ commit and make the sacrifices necessary for performance as opposed to feeling like they ‘have to’ commit.

Experience of injury compared to experiencing a bereavement. Athletes struggle with a body that does not perform or operate to its normal capabilities. Can become very isolated within the sports setting and their team, left out. Athletes are tested and pushed when injured which serves to fuel the psychological trauma experienced.

An athlete needs to continually think of what they eat and drink, how much sleep they get and how they get themselves “into the zone” for optimal performance. Physically striving to push the body. Depression, body dysmorphia, anorexia and bulimia are just some of the documented conditions athletes suffer in trying to deal with the pressures that come with being a performer.

Pressure to perform by coaches

Time constraints

Dealing with injury/ career termination

Mental and physical demands in terms of intense training
Current approach to mental illness in athletes

- stigmatisation
- denial
- Inaccurate and unhelpful = deprives the athlete of effective care (6)

Dichotomous paradigms of “psychological” versus “physical” disease
Common Mental Health Disorders
Anxiety, panic and phobias:

| Anxiety       | • feeling of fear we all experience when faced with threatening or difficult situations.  
|               | • Helps us to avoid dangerous situations  
|               | • Makes us alert and motivates us to deal with problems. |

| Panic         | • A sudden unexpected surge of anxiety which makes you want to leave the worrying situation. |

| Phobias       | • (e.g. Agoraphobia) are fears of a situation or thing that isn’t dangerous and which most people don’t find troublesome. |

When these feelings become too strong they can stop us from doing the things we want to.
Stress becoming “distress”

A lack of stress means your body is under-stimulated

- feeling bored and isolated
- In an effort to find stimulation, many people do things that are harmful to themselves (such as taking drugs) or society (for instance, committing a crime).

Too much stress

- Range of health problems including headaches, stomach upsets, high blood pressure, stroke or heart disease.
- cause feelings of distrust, anger, anxiety and fear, which can destroy relationships at home and at work.
Stress

Often the result of some event or trigger:

- Negative (such as the death of a loved one (acute), redundancy, divorce or relationship ended (chronic),
- Positive (a new partner, new job or going on holiday).
# Stress

**Negative stress-management techniques:**
- Drinking alcohol, using drugs or smoking cigarettes.
- Denying the problem.
- Overeating.
- Angry behaviour.

**Positive stress-management techniques:**
- Take a power nap.
- Relaxation: massage, meditation, yoga etc.
- Express yourself artistically/creatively (e.g. acting, playing an instrument, writing poetry or singing).
- Have a laugh.
- Be gentle to yourself – positive ‘self-talk.”
Causes of anxiety, panic and phobias

• Genes - (trait anxiety).
• Circumstances - (state anxiety) sometimes it's obvious what is making you anxious. When the problem disappears, so does the anxiety. However, some extreme situations are so threatening that the anxiety goes on long after the event (PTSD).
• Drugs - recreational drugs like amphetamines, LSD or ecstasy can all make you anxious.
• Life experience - bad experiences in the past or big life-changes such as pregnancy, changing job, becoming unemployed or moving house.
Depression in children: symptoms

- At least 2% of children under 12 struggle with significant depression.

- By teenage years this has risen to 5% - i.e. at least one depressed child in every classroom.

- Simply appearing unhappy much of the time, feelings so extreme or persistent they get in the way of normal activities.

- Exhaustion

- Headaches, stomach aches, tiredness and other vague physical complaints that appear to have no obvious cause.

- Spending a lot of time in bed but sleeping badly and waking early in the morning.

- Doing badly at school or not coping with things that used to be manageable.

- Major changes in weight.

- Being unusually irritable, sulky or becoming quiet and introverted.

- Losing interest in favourite hobbies.

- Having poor self-esteem or recurrent feelings of worthlessness, hopelessness.

- Contemplating suicide.
Causes of depression

• Losing a loved one (or in children, a good friendship breaking up)
• Illness, stress, family problems (marital disharmony or breakup)
• Abuse
• School problems (such as bullying, exam fears).

Some children are more resilient to difficulties than others

• Genetics and family tendencies: may also explain susceptibility and why the levels of certain brain chemicals become abnormal in depression.

Depression is also a feature of many other illnesses and conditions.

‘Organic' causes include:
• An underactive or overactive thyroid gland
• Vitamin B12 deficiency
• Viral infections
• Traumatic brain injury
Difficulties spotting it:

- Children/Adolescents are less capable of expressing feelings = often react to their moods in a more physical way.
- Some are clearly sad, withdrawn and tearful, others may become hyperactive, troublesome bullies.
- Symptoms for longer than 3/4 weeks = GP.
- Talk about suicide should *always* be taken seriously = get expert advice.
Bipolar Disorder

Bipolar (also known as manic depression) causes severe mood swings, that usually last several weeks or months and can be:

• Low mood, intense depression and despair.
• High or ‘manic’ feelings of joy, over-activity and loss of inhibitions.
• A 'mixed state' such as a depressed mood with the restlessness and over-activity of a manic episode.
Bipolar Symptoms

**Depression**
- Feelings of unhappiness that won’t go away
- Agitation and restlessness
- Loss of confidence
- Feeling useless, inadequate or hopeless
- Unable to think positively
- Can't concentrate or make even simple decisions
- Loss of appetite
- Sleeping problems including waking early in the morning
- Lack of interest in sex
- Avoiding other people
- Thoughts of suicide

**Mania**
- General elation
- Feeling more important than usual
- Full of energy or ideas; moving quickly from one idea to another
- Unable, or don't want to sleep
- More interested than usual in sex
- Making unrealistic plans
- Overactive, talking quickly
- Irritable with other people who can't go along with your mood or ideas
- Spending money recklessly
Eating disorders

Is a broad name for a number of problems we face with food in our society.

Anorexia and bulimia

Deep fear of being overweight

Obsession with restricting calories

Starvation affecting body functions and hormones

• Bulimia: comfort in feeling full but dreads taking on the extra calories. Induce vomiting, causing long-term problems for their throat and teeth on top of psychological problems.

Common behaviour of someone affected by an eating disorder includes:
• Mentally keeping a balance between calories taken in and calories used up
• Deep-seated feelings of anxiety if they consume a few calories too many
• Self-loathing, depression or panic if they haven’t lost any weight or put a little on
• Many anorexics and bulimics know the damage they are doing to themselves but are still unable to stop. This increases feelings of despair and self-loathing, causing their condition to continue.
Causes of eating disorders

• Evidence that eating disorders can run in families.
• Socially:
  - Images of physical perfection
  - Encouragement to eat foods packed with calories made up of saturated fat and simple carbohydrates.

Psychologically, at the root of an eating disorder:
• Distorted body image
• Low self-esteem
• Anxiety for some control
• An expression of deep emotions such as depression or trauma that can’t be put into words
Post-Traumatic Stress Disorder

**Causes**
- Getting diagnosed with a serious illness.
- Having (or seeing) a serious road accident.
- The unexpected injury or violent death of someone close.
- Continuing physical or sexual abuse.
- Conflict or war experiences

**Symptoms of PTSD**
- Usually start within six months, and sometimes only a few weeks after the trauma.
- After the traumatic event you can feel grief-stricken, depressed, anxious, guilty and angry.

May also:
- Have flashbacks and nightmares, reliving the event in your mind, again and again (forced to think about what happened and decide what to do if it happens again)
- Avoid thinking and feeling upset about it by keeping busy and avoiding anything or anyone that reminds you (helps you not to become exhausted from remembering a trauma)
- Be ‘on guard’ – you stay alert all the time, can’t relax, feel anxious and can’t sleep (helps react quickly to another crisis).
- Vivid memories = adrenaline levels high = feel tense, irritable, unable to relax or sleep
- Feel physical symptoms – aches and pains, diarrhoea, irregular heartbeats, headaches, feelings of panic and fear, depression.
- Start drinking too much alcohol or using drugs (including painkillers).
### Attention-Deficit Hyperactivity Disorder

#### Symptoms of ADHD

<table>
<thead>
<tr>
<th>Symptom</th>
<th>How a child with this symptom may behave</th>
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</thead>
<tbody>
<tr>
<td>Inattention</td>
<td>Often has a hard time paying attention, daydreams</td>
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<tr>
<td></td>
<td>Often does not seem to listen</td>
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<tr>
<td></td>
<td>Is easily distracted from work or play</td>
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<td></td>
<td>Often does not seem to care about details, makes careless mistakes</td>
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<td></td>
<td>Frequently does <strong>not</strong> follow through on instructions or finish tasks</td>
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<td></td>
<td>Is disorganized</td>
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<td></td>
<td>Frequently loses a lot of important things</td>
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<td></td>
<td>Often forgets things</td>
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<td></td>
<td>Frequently avoids doing things that require ongoing mental effort</td>
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<tr>
<td>Hyperactivity</td>
<td><strong>Is in constant motion</strong>, as if “driven by a motor”</td>
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<tr>
<td></td>
<td>Cannot stay seated</td>
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<td></td>
<td>Frequently squirms and fidgets</td>
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<td></td>
<td>Talks too much</td>
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<td></td>
<td><strong>Often runs, jumps, and climbs when this is not permitted</strong></td>
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<tr>
<td></td>
<td>Cannot play quietly</td>
</tr>
<tr>
<td>Impulsivity</td>
<td>Frequently acts and speaks without <strong>thinking</strong></td>
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<td></td>
<td>May run into the street without looking for traffic first</td>
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<td></td>
<td>Frequently has trouble taking turns</td>
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<td></td>
<td><strong>Cannot wait for things</strong></td>
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<td></td>
<td><strong>Often calls out answers before the question is complete</strong></td>
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<tr>
<td></td>
<td>Frequently interrupts others</td>
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</tbody>
</table>
Substance and Alcohol Abuse

• 86% of high school students have seen a classmate drink, smoke, or use drugs during the school day.

• Having an untreated mental illness will increase the likelihood of substance or alcohol use.

• Opioid abuse is an epidemic and is becoming rampant in many high schools.
Suicide

• 4700 young adults between the ages of 14-24 die by suicide annually in the US
• 1 in 6 high school students consider suicide
• 1 in 13 high school students attempt suicide one or more times
• Firearms are the most common method of death by suicide. Suffocation, and poisoning are next most common.
• For every woman who dies by suicide, 4 men die by suicide.
  – Women are 3 times more likely to attempt suicide
Suicidal feelings in children and teenagers

- Symptoms which may be due to depression include moodiness, irritability, poor concentration, tearfulness and being withdrawn. Loneliness, guilt and self-hatred can lead to a feeling of hopelessness and despair.
- Changes in appearance, hygiene or health.
- More tired, have sleep problems, poor appetite and have lost interest in their usual hobbies.
- Children often feel isolated, afraid of talking to their family or friends and often don’t know who to turn to.
- Adolescents especially may find it hard to put into words how they feel but instead act out their emotions in a way that their family may not understand.
Suicidal feelings in children and teenagers

- They may have family problems – parents separating or who have problems of their own such as money problems which the child feels, inappropriately guilty about. Death of a grandparent or other family member, neglect, abuse, isolation, bullying and physical illness are all frequent triggers to teenage depression and suicide.

- Drug and alcohol use are increasingly common in teenagers and also play a part in the development of depression and altered behaviour which can lead to a suicide attempt.

- Younger women are more likely to resort to deliberate self-harm and attempted suicide, rather than suicide itself.
Treatments

- **Talking therapies**
- **Cognitive behavioural therapy (CBT).**
- Essential to help them understand, how they can deal with the underlying problems in their life and how they can develop a more positive view of their world.
- Like adults, children with depression can't just 'snap out of it' or 'pull themselves together'.
- **Medication**
Barriers to mental health help-seeking in young athletes (Gulliver, Griffiths & Christensen; 2012)

- **Stigma:** perceived as being weak (males), leads to those working with athletes not referring them to a mental health professional, embarrassment, media impact
- **Worry about what others will think** (coach, teammates and family/friends)
- **Lack of mental health literacy** (not knowing about mental health disorders or what the symptoms are or when/where to seek help)
- **GP relationship**
- **Lack of self-recognition** (others recognising it before them)
- **Negative past experiences of help-seeking** (problem relating to the provider or breech of confidentiality)
- **Time constraints** (no money or transport)
Facilitators to mental health help-seeking in young elite athletes (Gulliver, Griffiths & Christensen; 2012)

- Having an established relationship with a provider (already knowing a counsellor or doctor)
- Being aware of your feelings and being able to express them, emotional competence
- Encouragement from others
- Positive attitudes of others (especially coach, family and friends)
- Pleasant previous experiences
- Access to internet and online mental health services.
Team Approach

- Coaches, team physician, ATCs, school nurse, school counselor, community mental health providers, crisis counselors
- Monitor Behaviors:
  - Changes in eating and sleeping
  - Wt. loss or gain
  - Withdrawal
  - Decreased interest in activities
  - Difficulty concentrating
  - Mood swings
  - Excessive worry or agitation
  - Negative self talk
  - Increased physical complaints
Mental Health Emergency Action Plan

- Respond with empathy and support
- Enact the school crisis response plan
- Ensure the safety of the student in crisis and others
- Collaborate with the health care team
  - Connect immediately with the needed resources
- Mobilize the student’s support system
- Follow-up with the referrals
Legal Issues

• State laws may vary in regards to reporting threats or emergencies.

• Threat assessment
  – “a significant risk” constitutes a high probability of substantial harm, not just a slight increase, speculative, or remote risk to the health or safety of the student or others

• Policies in place in regards to release of confidential information
Future Research

• Identification of mental health issues in high school and collegic athletes is a top priority for the NCAA and NFHS.

• There are numerous research projects that are ongoing and are focusing on:
  – Specific risk factors
  – Screening questionnaires
  – Preventative resources
  – Treatment algorithms
Conclusions

• The most important factors in helping student athletes with a mental health concern are:
  – Education, early recognition, effective referral
• Understanding the stressors placed on student athletes as well as possible co-morbid illnesses will help identify mental health issues in this population.
• Developing a plan to address mental health issues and emergencies will make recognition and referral more effective and will minimize risk.
Academic Sources

Resources

• “Interassociation Recommendations for Developing a Plan to Recognize and Refer Student-Athletes With Psychological Concerns at the Secondary School Level: A Consensus Statement” *Journal of Athletic Training* 2015;50(3) 231-249.


• “Mental Well-Being and Sport Related Identieis in College Students.” *Sociol Sport J.* 2009 Jule 1;26(2):335-356

• “Prevention, Diagnosis, and Treatment of the Overtraining Syndrome: Joint Consensus Statement of the European College of Sport Science and the American College of Sports Medicine.” 2012 ACSM.

• “Preinjury somatization symptoms contribute to clinical recovery after sport-related concussion.” *American Academy of Neurology.* 2012