See Something, Say Something: *Identifying Mental Health Concerns in Student-Athletes*

Melissa Marotta Houser, M.D.
Chief Resident
Middlesex Hospital Family Medicine Residency Program
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Disclosure & Conflict of Interest

No conflicts of interest or financial relationships

Case

- 19 yo male soccer player severe MCL sprain, here on scholarship, out of play x 3 weeks
- Has missed several treatment sessions
- Lost 10 lbs
- Loss of interest in school, social activities
- Sleeping 3-4 hours a night, looks exhausted
- "I feel worthless that I can't play"

Today's Objectives

1. List common behavioral health problems in the population of collegiate athletes.
2. Describe the role of athletic trainers in working with athletes with behavioral health issues.
3. Identify signs and symptoms of behavioral health issues in athletes.
4. List methods for behavioral health referrals

Introduction

- NATA: 29% college students struggle with mental health
- Significant barriers to seeking care
- NCAA (2013): Appx 1/3 of collegiate athletes struggle, but less likely to report
- Present with wide range of subtle signs & behaviors
  - If it's on your radar, you will see it first
- Athletic trainers may be first-line for screening and intervention
  - Time spent, role model (influence), early detection
- New NATA (2015) guidelines
- You need to know how to recognize & refer

Common Behavioral Health Issues in Athletes

- **Mood Disorders**
  - **Depression**
  - **Bipolar disorder**
  - **Common mimics**
  - **Assessing Safety**
- **Anxiety Disorders**
  - **Panic**
  - **GAD**
  - **Social anxiety**
  - **OCD**
- **Eating Disorders**
- **Substance Use Disorders**

"Bad Days" (vs Clinical Problems)

- Specific triggers
- Short duration, rapid rebound
- Little to no dysfunction – physical, emotional, cognitive, athletics, academics, relationships, legal
- Focused problem-solving is sufficient

Why Now?

- Age group
- Prior episodes – high risk of relapse
- College as point of transition
- Pressure – sports, academics, social
- Disruption of stability – injury, trauma, psychosocial
- Physical stress – overtraining, concussion
- Change in support factors
- Sleep
- Nutrition
- Relationships
- Substance use

Depression

Depression: Signs & Symptoms

Behavioral	Cognitive	Emotional
Social withdrawal	Negative self-talk	Mood swings
Decreased performance	"All or nothing" thinking	Excessive worry/fear
Disruption of function	Poor concentration	Low self-esteem
Lateness, irresponsibility	Difficulty making decisions	Lack of motivation
Substance use	Suicidal thoughts	Feeling out of control
Legal issues	Obsessive thoughts	Agitation/irritability

Physical
poor sleep, weight change, fatigue, weakness, GI sx, headache, injuries

Depression & Athletic Injury

- Stress Response Model of injury
  - Cognitive, emotional, behavioral responses
    - Moderated by personality & coping skills
- Effects on individual identity as athlete and as team member
- Preventive education may be helpful
- Emotional responses to injury are normal – problematic if excessive, worsening, persistent or causing dysfunction

Depression Mimic: Overtraining Syndrome

- Systemic inflammatory response to intense exercise without appropriate recovery
- Warning Signs
  - Mismatch between perceived exertion & HR
  - Chronic fatigue & muscular pain
  - Mood & Anxiety
  - Sleep disturbances
  - Appetite changes
  - Frequent infections
- Who's at risk?

Depression Mimic: Post-concussive Syndrome

- Minor traumatic brain injury – structural damage, neurotransmitter disruption
- Physical, emotional, psychological symptoms
- Weeks, months, 1+ years
- Risk factors – prior concussion, being female
- Symptoms
  - Headaches
  - Dizziness
  - Fatigue
  - Irritability
  - Anxiety
  - Insomnia
  - Loss of concentration and memory
  - Noise and light sensitivity

Depression & Suicide

- Suicide #2 cause of death in college students
- ACHA (2013): 31.3% undergrads "so depressed that it's difficult to function," 7.4% considered suicide
- Asking the questions does NOT "plant" ideas

Possible Warning Signs for Suicide

- Talking about wanting to die
- Looking for a way to kill oneself
- Talking about feeling hopeless or having no purpose
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing use of alcohol or drugs
- Acting anxious, agitated, recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

Safety Assessment

- Your job is to triage & refer
- Ask directly, and avoid leading questions:
  - "Sometimes when people feel this bad, they think about hurting themselves. Are you thinking about hurting yourself?"
  - "Are you thinking about killing yourself?"
  - "Are you thinking about hurting anyone else? Are you thinking about killing anyone else?"
- Refer for further risk assessment

Anxiety

Anxiety

- Generalized anxiety disorder
- Panic disorder
- Post-traumatic stress disorder
- Obsessive-compulsive disorders
- Social anxiety

Anxiety: What You'll See

- Worry thoughts that disrupt functioning
- Domains – academics, athletic performance, others
- "What if…?"
- Catastrophizing – worst case scenario
- Panic attacks – heart racing, SOB, sweating, shaking, feeling of impending doom, feeling out of control
- Poor sleep
- Attempting self-medication with substances
- May be related to underlying comorbid disorder – should be evaluated by physician
- Effects on performance – focus, negative emotion, increased risk of injury

Eating Disorders

Eating Disorders

- Types
  - Anorexia nervosa
  - Bulimia nervosa
  - Eating Disorder Not Otherwise Specified
  - Binge-eating disorder
- 1.7% prevalence of diagnosable eating disorders, but this is a broad continuum
- You are likely to see subclinical disordered eating with chronic, dysfunctional thoughts and behaviors
- This is not about food/eating – serves a purpose (i.e., control)

Disordered Eating: What You'll See

- +/- change in weight
- Preoccupation with body shape and appearance (self and/or others), food
- Restrictive behaviors – rigid "food rules," may notice more when traveling
- Compensatory behaviors - laxative or diuretic use, purging, compulsive exercise
- Physical findings – nails, callus, teeth
- Triggers: transitions, stress, injury

Substance Use Disorders

Substance Abuse

- Alcohol, marijuana, stimulants, other drugs
- Heavy drinking is prevalent and "normalized" in college athletes
- Effects on athletic/school performance, health, and safety
- Specific risks – why do we care?
  - Alcohol – performance, medical consequences (hepatic, neurologic, cardiovascular), dangerous decision-making
  - Marijuana – reaction time, coordination, apathy, risk of precipitating psychosis
  - Stimulants – cardiac, sleep, irritability, overexertion, diversion

Your Role as Athletic Trainers

Approaching an Athlete

- Your role: express concern and compassion, connect with resources
- Give the athlete permission to seek treatment
- Approach privately
- "I am concerned and would like to help"
- Ask how athlete is feeling, how things are going at school, practice, games
- If no disclosure: "I need to make sure you are ok. The way to do that is to have you talk with someone."

When An Athlete Approaches You…

- Stop what you are doing
- Reassure that you are here to help
- Listen. Let the athlete speak. Silence is ok.
- Use empathic, non-judgmental statements
- Screen for suicide risk
- "This is very common. There is help out there, and this will get better."
- Validate courage in coming to talk with you
- Respect confidentiality – but let athlete know you will be informing team physician in order to facilitate getting the right help, acknowledge exception to confidentiality (danger to self or others)
- Discuss referral for next steps – and why

"Pitching" a Referral

- "I think (counseling) would be helpful because…" (list specific concerning behaviors)
- Ask how symptoms are impacting athlete's life
- "It took courage to come to me. By telling me, it shows that you want to do something about what's going on."
- Emphasize confidence in mental health system - diagnose, help identify triggers, teach new coping skills
- Encourage time to "think it over." But needs short-interval follow-up.
- Collaborate with your team physician

Talking with Athletes about Substance Abuse

- Athletes unlikely to perceive a problem
- May already be dependent on the substance
- Denial very common
- May fear punishment
- "I am concerned. The only way to know for sure is to be evaluated by a professional with expertise and experience in this area."
- Make referral and follow up

Acute Psychiatric Crisis

- Identify if there is immediate safety threat
  - Am I concerned about harm to self or others?
  - Did athlete make verbal/physical threat?
  - Do I feel threatened or uncomfortable?
  - Is athlete showing unusual thinking (+/- related to substance use)?
  - Does athlete have access to weapon? Pills?
  - Is there potential for future danger?
- Keep yourself and others safe
- Do not leave athlete alone. Ask colleagues for help.
- Call 911 – goal is for athlete to be brought to ED for eval
- Listen, express concern, emphasize risk to safety

Where to Refer Athletes

- Non-urgent: Your school's Student Wellness Services
- Urgent: 911
- In some CT counties, 211 → Mobile Crisis

Summary

- You will see athletes with behavioral health issues. You are often the “first line” to identify and connect with resources.
- Your job is not to solve the problem – your job is to recognize, screen for imminent threat of harm, and refer.
- You have a unique, privileged role and influence to help your athletes get the care they need.

Questions?

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