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"This program was very informative about the different types of mental illnesses and how to help yourself and others who have a mental illness. My other educational experiences have breezed over the factual information, and they spoke vaguely about what you can tangibly do in relationships to help others ... this study helped us to understand what is actually happening, why it is happening, and what we can do to help and even prevent it from happening. This program, unlike others, has actually convicted me, rather than just feed me information, websites, and telephone numbers. Because of this program, I have reached out to my therapist from freshman year to speak with him again about things that have really bothered me recently, and I have also felt called to be more intentional in the relationships I have with those I know need help."

– Athlete participant

For more information on how to implement this program on your campus, please contact:

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Tackling Stigma: A Pilot Program to Promote Mental Health Literacy and Help-Seeking in Student-Athletes

PROBLEM

- Student-athletes are susceptible to experiencing mental health problems that disrupt optimal functioning, performance, and well-being. However, many student-athletes who struggle with mental health problems underutilize psychological services.
- Stigma has been implicated as the main barrier that prevents student-athletes from seeking help.
- This 4-week interactive program targets stigma, mental health literacy, and attitudes and intentions toward seeking psychological help among college student-athletes.

PROGRAM DESCRIPTION

- In this 4-session program, athletes receive education about mental health issues commonly faced by student-athletes, as well as knowledge and practical skills on how to talk to a teammate about mental health concerns. Program components include promotion of campus resources, athlete testimonials, group discussion, videos, and activities to enhance student-athletes' awareness of mental health and treatment options.
- **This is the first project to incorporate four science-based stigma reduction interventions into a single program with student-athletes:**
 - Mental Health Literacy: Information about common mental health issues faced by student-athletes
 - Empathy: Perspective-taking, training on helping skills and how to talk to a teammate in need
 - Counter Stereotyping: Presentation, discussion, and education about common mental health myths
 - Contact: Video documentary about a real-world athlete who has dealt with mental health concerns

PROGRAM OUTCOMES

- Results from this pilot program of 33 Division I student-athletes revealed:
 - **Increased mental health literacy**
 - **Reduced stigma toward mental illness**
 - **More positive attitudes and greater intentions toward seeking psychological help**
 - 97% of student-athletes rated the program as effective to very effective, 100% rated the quality of the program as good to excellent, and 97% reported that they were mostly to very satisfied with the program
- The program has positive implications for future help-seeking behavior

INTERESTED? WE HAVE 3 LEVELS OF OPTIONS TO SUPPORT IMPLEMENTATION ON OTHER CAMPUSES:

1. **Program Manual** – Curriculum and intervention protocols, all program materials (e.g., slides)
2. **Program Manual + Training and Consultation** – All program materials, as well as virtual or in-person training to provide assistance to local professionals implementing the program
3. **In-Person Delivery of the Program** – We implement the program on-site at your campus



NCAA Innovations in Research and Practice Grant Program

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and Help-Seeking in Student-Athletes

Final Report

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Problem Statement

The prevalence of mental illness and distress among student-athletes is comparable to, and for some disorders, greater than, that of the general population. Student-athletes are often at an increased risk for experiencing anxiety, depression, disordered eating, gambling, substance abuse, and adjustment problems (e.g., transition, injury). Symptoms of depression are experienced by as many as 33% of athletes (Cox, Ross-Stewart, & Foltz, 2017) and eating disorders are experienced by 13.5% of athletes (compared to 4.6% of non-athletes; Sundgot-Borgen & Torstveit, 2004). Additionally, pathological gambling is a common problem (Kerber, 2005). Student-athletes are considered an at-risk subpopulation of college students because they drink significantly more alcohol and engage in heavy drinking more often than their non-athlete counterparts (Martens, Dams-O'Connor, & Beck, 2006). Due to mental health problems, collegiate athletes experience a multitude of adverse consequences that impact academic, athletic, and social functioning.

Despite needing treatment for mental health problems, only 10% of student-athletes who experience anxiety and depression seek professional help compared to 30% of non-athlete students (Eisenberg, 2014). Stigma has been implicated as the main barrier to student-athletes seeking mental healthcare (Biggin, Burns, & Uphill, 2017; Bird, Chow, Meir, & Freeman, 2018; Gulliver, Griffiths, & Christensen, 2012a; Moreland, Coxe, & Yang, 2018). For example, student-athletes fear they will be perceived as weak if others find out they are in treatment, which prevents them from receiving timely and appropriate help (Lopez & Levy, 2013). Stigma accounts for 66% of the variance in mental health help-seeking attitudes in student-athletes above and beyond gender and treatment history (Wahto, Swift, & Whipple, 2016), and student-athletes have higher stigma than non-athletes (Kaier, Cromer, Johnson, Strunk, & Davis, 2015). Interventions designed to reduce stigmatization toward people with mental illness are especially needed because it negatively impacts help-seeking to the greatest extent (Eisenberg, Downs, Golberstein, & Zivin, 2009).

Sport-specific awareness programs have been developed to address mental health knowledge and stigma in athletes (Breslin, Shannon, Haughey, Donnelly, & Leavey, 2017). Such programs predominantly focus on mental health literacy, with particular attention to increasing knowledge about mental disorders to aid recognition, management, or prevention (Jorm, 2000). Mental health literacy interventions have been somewhat successful in improving mental health knowledge and confidence to help someone with a mental disorder (Bapat, Jorm, & Lawrence, 2009; Gulliver et al., 2012b; Van Raalte, Cornelius, Andrews, Diehl, & Brewer, 2015). However, stigma and help-seeking outcomes are more difficult to change, as evidenced by low effect sizes. Due to a lack of follow-up assessment, sustained benefits of interventions are unknown (Breslin et al., 2017). Furthermore, only explicit stigma has been measured which is subject to social desirability bias and results in underestimations by ignoring implicit stigma (Monteith & Pettit, 2011).

While educating and promoting awareness of mental disorders is an important step toward destigmatizing mental illness in student-athletes, it is insufficient for decreasing stigma, particularly implicit bias. Targeted, structured, and systematic programs are needed to change the culture of mental health on college campuses. There are several promising intervention strategies

designed to reduce stigma that have been used with non-athlete populations such as perspective-taking (Galinsky & Moskowitz, 2000), counter stereotyping (Devine, Forscher, Austin, & Cox, 2012), and contact (Clement et al., 2011). Thus, the purpose of this project was to develop, implement, and evaluate a 4-week intervention program designed to reduce stigma toward mental illness, enhance mental health literacy, and improve help-seeking attitudes and intentions among student-athletes.

Literature Review

Student-athletes face numerous personal and social barriers that may prevent them from seeking psychological services. Stigma has been implicated as the main barrier to student-athletes seeking mental healthcare. Stigmatization means that there is a socially driven label (e.g., “not normal”) associated with individuals who seek psychological help (Smith, 2007). This tends to be particularly emphasized in the athletic setting (Leimer, Leon, & Shelley, 2014) where help-seeking behavior is often associated with being “mentally weak” (DeLanardo & Terrion, 2014). Student-athletes fear that they will be perceived as weak if others find out they are in treatment, which prevents them from receiving timely and appropriate help (Lopez & Levy, 2013).

There are three types of stigma that impact mental health help-seeking behaviors. *Perceived public stigma* (i.e., stigmatization by others) is an individual’s perception regarding stereotypes, prejudice, and discrimination held by the public toward people with mental illness (Corrigan, 2004). *Self-stigma* reflects the internalization of public stigma by incorporating others’ stereotypes and prejudices about people with mental illness into beliefs about oneself (Vogel, Wade, & Haake, 2006). *Personal stigma* represents an individual’s personal attitudes toward people with mental illness (Griffiths, Christensen, Jorm, Evans, & Groves, 2004). Athletes who hold higher perceived public stigma also tend to be more likely to also exhibit greater personal stigma toward those who seek psychological treatment (Kaier et al., 2015). Similarly, athletes may internalize these negative views and thus carry more self-stigma through acceptance and application of negative attitudes or beliefs of others toward oneself (Corrigan & Watson, 2002). If an athlete identifies as part of a stigmatized group, this may be detrimental to self-esteem (Corrigan, 2004). Furthermore, seeking counseling may be considered risky if student-athletes perceive that their coaches or teammates will view them differently for seeking psychological help (Lopez & Levy, 2013). Athletes may fear negative consequences such as doubts about their ability to perform, loss of playing time, and discrimination (DeLanardo & Terrion, 2014). Similarly, athletes may believe that seeking mental health treatment may damage their public persona and reputation, and thus be less likely to seek out campus resources (Leimer et al., 2014). This association between counseling and negative consequences is likely linked to athletes’ internalized stigma toward help-seeking.

Negative attitudes and stereotypes (i.e., stigma) toward mental illness and help-seeking can be explicit or implicit. Explicit stigma is considered to be more conscious and controllable, while implicit stigma reflects more automatic, subconscious beliefs (Greenwald & Banaji, 1995). Implicit measures such as Implicit Association Tasks (IAT; Greenwald, McGhee, & Schwartz, 1998) have the ability to capture underlying attitudes and beliefs (e.g., personal stigma) beyond explicit measures, and have been shown to predict automatic and spontaneous behaviors such as body language; whereas explicit measures are more conducive to predicting controlled

behaviors, such as duration of speech (Asendorpf, Banse, & Mücke, 2002; Monteith & Pettit, 2011).

Recent studies examining mental health stigma among both college students and the general public most commonly use explicit measures to assess perceived public, self, and personal stigma, which draw upon self-report questionnaires or interviews (e.g., Eisenberg et al., 2009; Grant, Bruce, & Batterham, 2016). Those sampling college student-athletes tend to do the same (e.g., DeLenardo & Terrion, 2014; Kaier et al., 2015; Leimer et al., 2014; Wahto et al., 2016). Yet responses on explicit measures of personal stigma (i.e., one's attitude toward people with mental illness) may be biased, influenced by demand characteristics, social desirability bias, dishonest reporting, or poor self-awareness of one's own attitudes or beliefs (Monteith & Pettit, 2011). Multiple studies and meta-analyses have found weak correlations between measures of implicit and explicit stigma (e.g., Hofmann, Gawronski, Gschwendner, Le, & Schmitt, 2005; Monteith & Pettit, 2011) suggesting that stigma is a complex construct that requires careful assessment. Furthermore, implicit measures have been shown to detect stronger negative response bias against mental illness than what is captured through explicit measures alone (Teachman, Gapinski, Brownell, Rawlins, & Jeyaram, 2003). While the need for utilization of both implicit and explicit measures in stigma research has been emphasized (Monteith & Pettit, 2011), to our knowledge, this method has not yet been employed in studies examining mental health stigma among college student-athletes.

Attitudes toward seeking professional psychological help impact intentions to seek help (Hammer, Parent, & Spiker, 2018), and both are key contributors to mental health service utilization (Moreland et al., 2018). When investigating relationships among stigma, attitudes toward counseling, intentions to seek help, and help-seeking behavior in college students, it has been shown that perceived public stigma is positively related to self-stigma, that self-stigma is negatively related to counseling attitudes, and that counseling attitudes are positively related to willingness to seek help (Vogel, Wade, & Hackler, 2007). Student-athletes may underutilize mental health services as this population reports higher levels of public stigma (Hilliard et al., 2018; Kaier et al., 2015) and more negative attitudes toward mental health counseling when compared to non-athlete students (Hilliard et al., 2018; Watson, 2005). Research on actual help-seeking behavior for mental health issues is difficult to conduct; however, the Reasoned Action Approach (Fishbein & Ajzen, 2010) proposes that actual help-seeking behavior is best predicted from an individual's intentions to seek help.

Reducing stigmatization in order to promote and increase help-seeking attitudes and intentions among collegiate student-athletes is the key to treating the prevalence of mental illness among this population. Evidence-based programs are needed to change the culture of mental health on college campuses in order to normalize and promote accessibility to available resources. This was the first project to incorporate four evidenced-based stigma reduction interventions (i.e., mental health literacy, empathy, counter stereotyping, and contact) into a comprehensive program with student-athletes.

Conceptual Framework

The campus-level pilot program we developed is theory-based, drawing primarily from Self-Determination Theory, with empirically-supported interventions. These interventions were designed to directly target stigma through education, training, experiential activities, and reflective exercises. Students often come to campus trainings with considerable prior knowledge or preconceptions, suggesting the benefits of interactive activities designed to reinforce helpful pre-existing perceptions and correct less helpful perspectives (Swanbrow Becker & Drum, 2015a). Mental disorders with the highest prevalence rates in student-athletes were emphasized, including anxiety, depression, disordered eating, stressor-related disorders (e.g., adjustment), and substance use. This program supports a call from researchers to enhance access to mental health support on college campuses by providing students and significant others with tools to intervene both at the individual level with those at risk as well as through changing the culture to impact the campus ecology (Swanbrow Becker & Drum, 2015b). The four evidenced-based stigma reduction interventions in our program include mental health literacy, empathy, counter stereotyping, and contact. The conceptual and empirical background for these interventions are presented below while the specific details regarding intervention implementation is described in the Methodology and Data Collection section.

Mental Health Literacy

Mental health literacy is defined as an individual's "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm et al., 1997, p. 184). It generally consists of knowledge about the prevalence of mental disorders, the ability to recognize signs and symptoms of specific mental disorders, knowledge about risk factors and causes, knowledge and beliefs about self-help interventions, knowledge and beliefs about available professional help resources, attitudes which facilitate recognition and appropriate help-seeking, and knowledge of how to seek mental health information. A lack of mental health literacy has been identified as a barrier to seeking help in elite athletes aged 16-23 years (Gulliver et al., 2012a). Further, individuals with higher mental health literacy typically have lower levels of personal stigma (Copelj & Kiropoulos, 2011; Griffiths et al., 2004; Kiropoulos, Griffiths, & Blashki, 2011; Lauber, Nordt, Falcato, & Rossler, 2004; Ventieri, Clarke, & Hay, 2011) and report lower perceived stigma (Copelj & Kiropoulos, 2011).

Empathy

Empathy is the capacity to share and understand other's internal states, which allows us to connect with one another. Empathy-building interventions focus on either enhancing individuals' ability to *experience* empathy (i.e., experience-based) or *express* empathy to others (i.e., expression-based; Weisz & Zaki, 2017). There are three intertwined and interactive subcomponents of empathy (Zaki & Oschner, 2012): *mentalizing* (ability to draw inferences about another person's thoughts and feelings), *experience sharing* (vicariously experiencing another person's emotional state), and *empathetic concern* (desire to alleviate another person's distress). Interventions that target one or more of these subcomponents can increase individuals' empathy towards stigmatized groups. Experience-based empathy interventions that involve imagining oneself as a stigmatized member of an outgroup—such as those who are prejudiced

against or the mentally ill—can increase empathy towards members of these groups by providing a deeper understanding their thoughts and feelings (Galinsky & Moskowitz, 2000). Interventions that aim to improve individuals' empathy in order to reduce stigma and prejudice often utilize a perspective-taking method (Devine et al., 2012). Imagining the self from the perspective of an individual from a stigmatized group and instructed to consider their internal states increases the psychological closeness to those in that group and is hypothesized to reduce both the expression and the accessibility of stereotypes that are held by individuals towards those who are stigmatized (Devine et al., 2012; Galinsky & Moskowitz, 2000). According to Galinsky and Moskowitz (2000), the likelihood of perspective-taking improves when one has endured the same “slings and arrows as the targeted person” (p. 709). Perspective-taking interventions, utilizing empathy as a mechanism of change has been utilized to reduce stereotypes, prejudice, and racial bias (Devine et al., 2012; Galinsky & Moskowitz, 2000).

Expression-based empathy interventions teach individuals to recognize another person's internal state *and* respond appropriately (Weisz & Zaki, 2017). Such interventions focus on enhancing one's empathic displays, which helps communicate to the target that the perceiver understands and shares their suffering. Empathy-relational skills training and watching videos of difficult interactions are typically used in expression-based empathy interventions to improve emotion recognition and empathic responding (e.g., Riess, Kelley, Bailey, Dunn, & Phillips, 2012). It is important to note that in order to effectively express empathy, one must first experience empathy; thus, experience- and expression-based interventions should be used in conjunction.

Counter Stereotyping

There is ample evidence that suggests there are multiple stereotypes of mental illness and those who have mental disorders (Byrne, 2000; Townsend, 1979). These stereotypes create an “us versus them” mentality towards those with mental illness, thus perpetuating and intensifying their stigmatization (Byrne, 2000). Therefore, one intervention to combat these stereotypes is to educate individuals about the stereotypes of mental illness and to provide them with counter stereotypes, or information that is opposite of the cultural stereotypes of those with mental illness (Byrne, 2000; Gocłowska & Crisp, 2013). By teaching accurate information to prevent stereotypic inferences, individuals adopt an informed mindset with greater cognitive flexibility. Providing these counter stereotypes helps individuals break from old schemas and create new schemas surrounding those they have previously stigmatized (Byrne, 2000; Gocłowska & Crisp, 2013). Counter stereotyping has been used as an intervention in previous research to combat and reduce stereotypes, stigma, prejudice, and racial bias (Blair, Ma, & Lenton, 2001; Devine et al., 2012; Gocłowska & Crisp, 2013).

Contact

The contact hypothesis (Allport, 1954) posits that experiencing interpersonal contact from another group can reduce prejudice and increase empathy towards that group. Contact interventions aimed at reducing stigma toward mental illness typically involve persons who are experiencing a mental illness either directly (in-person) or indirectly (through video), interacting with those who are not experiencing such an issue; for example, sharing their story about how mental illness has impacted their life and how they sought help. Video-based contact

interventions have gained interest from researchers in recent years, as this type of contact delivery makes disseminating materials easier due to its cost effectiveness (Clement et al., 2011). Video-based contact interventions have been seen to reduce mental illness stigma in healthcare students and professionals (Stubbs, 2014). Furthermore, a recent meta-analysis showed this type of intervention as an effective way of reducing mental illness stigma in adolescents and adults (Corrigan, Morris, Michaels, Rafacz, & Rusch, 2012). Video-based contact interventions highlighting former student-athletes struggles with mental illness have been used in conjunction with educational materials to target mental health knowledge and attitudes in a sample Division I collegiate athletes (Kern et al., 2017). Results from this study indicate that the combined contact- and education-based intervention improved knowledge about depression, increased likelihood to seek help for a personal problem, and decreased stigma. Regarding stigma, participants were more willing to accept someone who had received mental health treatment as a close friend.

Methodology and Data Collection

Participants

Participants were 33 student-athletes (Male = 13, Female = 20) from a single NCAA Division I institution. There were 16 student-athletes who participated in the first group of the program and 17 who participated in the second group. A majority of the participants were Freshmen ($n = 15$), but Sophomore ($n = 11$), Junior ($n = 2$), Senior ($n = 4$), and Graduate ($n = 1$) level students were also represented. Participants reported a mean age of 19.2 years ($SD = 1.45$) and identified as White ($n = 23$), African American ($n = 3$), Hispanic ($n = 3$), and Mixed ($n = 4$). Student-athletes in the study represented various different teams within the institution's athletic department. These teams included Swimming ($n = 14$), Cross Country ($n = 5$), Softball ($n = 6$), Track and Field ($n = 4$), Football ($n = 2$), Baseball ($n = 1$), and Soccer ($n = 1$). A total of 13 participants (39.4%) had previously received treatment from a mental health professional while 2 participants (6.1%) were currently receiving treatment. Of the total sample, 5 participants (15.2%) had previously received formal education/training about mental illness in student-athletes. A total of 23 (69.7%) student-athletes attend all four sessions (7 attended 3 sessions, 3 attended 2 sessions).

Program Components

The program consisted of four sessions and was delivered by two co-interventionists who have substantial experience implementing prevention and intervention programs with student-athletes. For each session, we created a PowerPoint with notes, worksheets (if applicable), and a detailed timeline delineating the approximate time for each slide(s) and interventionist role. The intervention sessions were based on the current literature, and were engaging by incorporating psychoeducation, group discussion, experiential activities, reflection, video, modeling, and training.

Session 1: Mental health literacy. This component focused on educating and creating awareness about mental health issues that are most relevant to student-athletes. Areas included the mental health continuum ranging from thriving and resilience to severe functional impairment; causes and consequences of mental disorders; prevalence rates, signs, and symptoms of mental disorders; barriers to help-seeking; ways to manage mental health; resources

available on campus; and how to help a teammate who might be experiencing a mental health issue. Mental disorders with the highest prevalence rates in student-athletes were emphasized, including anxiety (e.g., generalized anxiety disorder, social anxiety disorder, panic disorder), depression (e.g., major depressive disorder, dysthymia), disordered eating (e.g., anorexia nervosa, bulimia nervosa, binge-eating disorder), stressor-related disorders (e.g., adjustment disorder, acute stress disorder), and substance use. For each area, we first posed a question to participants to stimulate discussion (e.g., What are some of the causes of mental disorders?) and then proceeded by presenting information, reinforcing accurate responses and elaborating on content that they did not mention. The session concluded with a group debrief (e.g., What parts of today's session stand out for you the most?; What was most surprising?).

Session 2: Empathy. This component focused on targeting empathy in two ways: perspective taking to experience empathy toward a person with a mental health concern and how to express empathy toward a person with a mental health concern. For perspective taking, participants listened to a 10-minute script about a student-athlete who has a mental illness, experienced stigmatization, and sought professional help. While listening to the script, participants were prompted to take the perspective of the student-athlete in the story by paying attention to their internal thoughts and feelings. A worksheet was provided for participants to individually take notes (e.g., How do you think this student-athlete was feeling?), and was subsequently followed by a group debrief. The second half of this session focused on how to provide empathy, including characteristics of empathy (e.g., connecting with the emotion that someone is experiencing) and empathy skills (e.g., reflection of feeling, validation). To complement this information, a video was shown that discusses the components of empathy and how empathy is different than sympathy. Further, participants learned how to have a difficult conversation with a teammate or peer who might be experiencing a mental health concern. To this end, participants first watched and processed (group debrief) a video showing a student with a mental health issue interacting with her roommate who has recently noticed some signs and symptoms and is in a helper role. Next, the co-interventionists modeled a similar conversation with one playing the role of the helper and the other playing a distressed student-athlete. Finally, participants were provided the opportunity via role play to practice being in a helper role and to utilize empathy skills. A group debrief was employed following the role play activity (e.g., What was it like to be the helper?).

Session 3: Counter stereotyping. In this component, participants were exposed to information that contradicts common stereotypes, myths, and misconceptions about mental illness in student-athletes. Participants were divided into small groups for this session. For each stereotype/misconception, (a) a statement about mental health was presented, (b) in small groups, participants discussed whether the statement was true or false *and* were instructed to provide a reason to support their answer, (c) answers and reasons were shared as a large group, and (d) the interventionists presented content relevant to the statement, particularly information that was counter. Eight statements were used for this activity including “Only athletes in aesthetic and lean sports have eating disorders” and “Athletes who are struggling with mental health concerns are not mentally tough.” In addition to these eight statements, the session concluded by presenting other common stereotypes such as “People with mental illness can snap out of it” and “Mental illness is not a real medical problem.” The session concluded with a group debrief (e.g., How do stereotypes about mental illness impact help-seeking?).

Session 4: Contact. Video-based contact interventions ease dissemination and include material similar to in-vivo contact, such as an individual with mental illness discussing their story including symptoms, treatment, and persona recovery (Chan, Mak, & Law, 2009; Corrigan, Larson, Sells, Niessen, & Watson, 2007; Stuart, 2006). Thus, this component involved a video depicting a former student-athlete's struggle with mental illness throughout her collegiate and professional career. A one-hour documentary film tells the story of Chamique Holdsclaw's experience with mental illness including obstacles, impact on functioning, help-seeking process, and persistence in the face of challenges. A worksheet was distributed for participants to take notes during the video. The session concluded with a group debrief (e.g., How has the film changed your thinking about mental health and mental illness?; How did shame about her illness affect Chamique's ability to seek out and get help at different points in her journey?).

Program Evaluation Plan

Programmatic outcomes were evaluated short-term and over time using quantitative and qualitative methods. Key mental health quantitative outcomes (stigma, mental health literacy, attitudes toward counseling, help-seeking intentions; Breslin et al., 2017) were measured at pre-intervention, post-intervention, and a 1-month follow-up with psychometrically valid measures. These included explicit measures of personal and perceived public stigma toward mental illness (Griffiths et al., 2004), Self-Stigma of Seeking Help Scale (Vogel et al., 2006), implicit association tasks (IAT; Greenwald et al., 1998), Mental Health Literacy Scale (O'Connor & Casey, 2015), Attitudes Toward Seeking Professional Psychological Help – Short Form (Fischer & Farina, 1995), and Intentions to Seeking Counseling Inventory (Cash, Begley, McCown, & Weise, 1975).

At post-intervention assessment, student-athletes completed a Program Evaluation in which participants rated the overall effectiveness of the program from 1 (*ineffective*) to 5 (*effective*), the quality of the program from 1 (*poor*) to 4 (*excellent*), and satisfaction with the program from 1 (*quite dissatisfied*) to 4 (*very satisfied*). In addition, the Program Evaluation included a series of open-ended questions to further evaluate the program (e.g., How did you understand mental health issues in student-athletes before you participated in the program? How do you understand it differently now?; How does this program compare to other education or information you have received about mental health and mental illness in student-athletes?; How can you take action to help overcome stigma?; What did you find to be most useful about the program?; Do you have any suggestions for how the format, content, or delivery of the program could be improved?).

At the end of each session, participants completed a Session Evaluation, which included an item assessing the overall effectiveness of the session from 1 (*ineffective*) to 5 (*very effective*), as well as a series of open-ended questions to evaluate the utility of each intervention component (e.g., What was the most important thing you learned from today's session?; How might you apply what you learned from today's session?; What was the most unclear point from today's session?).

Procedure

Following university institutional review board approval, participant recruitment, informed consent, and pre-assessment data collection were initiated. A variety of recruitment methods were used including announcing the study at athletics department events, emailing coaches, posting and distributing flyers, an email blast that went to all student-athletes, and snowball sampling. Informed consent and assessments were performed by a research assistant one-on-one with each participant. At pre-assessment, participants completed (a) demographic questionnaire, (b) measures of mental health literacy, self-stigma, public stigma, personal stigma, attitudes toward counseling, and intentions to seek counseling (presented in random order), and (c) IAT. Post-assessment included the same measures as pre-assessment (excluding the demographic questionnaire), *and* the Program Evaluation. The follow-up assessment was administered 1-month after the post-assessment.

The program was conducted with two groups of student-athletes (Group 1 = 16, Group 2 = 17). It was comprised of weekly 1-hour sessions over four consecutive weeks occurring on the same day and time each week. The program was delivered face-to-face within a group setting by the two interventionists who were joined by a research assistant for organizational purposes. Each session followed a detailed timeline and protocol to ensure standardization. At the end of each session, participants completed the Session Evaluation. Participants were incentivized by food and beverages at each session and a \$50 gift card following completion of the study after the 1-month follow-up assessment was completed.

Findings

Preliminary Analysis

A multivariate analysis of variance (MANOVA) test was conducted to examine baseline differences between Group 1 ($N = 16$) and Group 2 ($N = 17$) on the seven primary variables of interest: mental health literacy, self-stigma, personal stigma, perceived public stigma, implicit stigma, attitudes toward seeking professional psychological help, and intentions to seek counseling. Results revealed no significant differences between the groups, Wilks' $\lambda = .71$, $F(7, 25) = 1.45$, $p = .23$. Lack of differences between groups provides justification to combine the groups for subsequent primary analysis.

Primary Analysis

Within-subjects, repeated measures analysis of variance (RM-ANOVAs) tests were conducted for mental health literacy, self-stigma, personal stigma, perceived public stigma, and implicit stigma using pre-intervention, post-intervention, and 1-month follow up data. An RM-MANOVA was conducted for attitudes toward seeking professional psychological help and intentions to seek counseling due to significant and moderate correlations between these variables at each time point. Effect size using η^2 is determined as small (.01), medium (.09), and large (.25).

Mental health literacy. An RM-ANOVA determined that mean scores for mental health literacy

differed statistically significantly between time points, $F(1.70, 54.38) = 19.80, p < .0005, \eta_p^2 = .38$ (large effect size). Post hoc tests using the Bonferroni correction revealed a statistically significant increase in mental health literacy from pre-intervention to post-intervention ($p < .0005$) and from pre-intervention to 1-month follow-up ($p = .001$). Importantly, the increase in mental health literacy from pre-intervention to post-intervention was maintained at 1-month follow-up, as evidenced by the non statistically significant change from post-intervention to 1-month follow-up ($p = .18$).

Self-stigma of seeking help. An RM-ANOVA determined that mean scores for self-stigma differed statistically significantly between time points, $F(2, 64) = 7.03, p = .002, \eta_p^2 = .18$ (medium to large effect size). Post hoc tests using the Bonferroni correction revealed a statistically significant decrease in self-stigma from pre-intervention to post-intervention ($p = .003$), and a marginally statistically significant decrease from pre-intervention to 1-month follow-up ($p = .06$). Importantly, the decrease in self-stigma from pre-intervention to post-intervention was maintained at 1-month follow-up, as evidenced by the non statistically significant change from post-intervention to 1-month follow-up ($p = .10$).

Personal stigma. An RM-ANOVA determined that mean scores for personal stigma did not differ statistically significantly between time points, $F(2, 64) = 2.15, p = .13, \eta_p^2 = .06$ (small to medium effect size).

Perceived public stigma. An RM-ANOVA determined that mean scores for public stigma did not differ statistically significantly between time points, $F(2, 64) = 2.21, p = .12, \eta_p^2 = .07$ (small to medium effect size).

Implicit stigma. An RM-ANOVA determined that mean scores for implicit stigma did not differ statistically significantly between time points, $F(2, 64) = .36, p = 0.70, \eta_p^2 = .01$ (small effect size).

Attitudes toward seeking professional psychological help and intentions to seeking counseling. An RM-MANOVA determined that mean scores for attitudes toward seeking help and intentions to seeking counseling differed statistically significantly between time points, Wilks' $\lambda = .70, F(4, 126) = 6.16, p < .0005, \eta_p^2 = .16$ (medium to large effect size). Post hoc tests using the Bonferroni correction revealed a statistically significant increase in attitudes toward seeking help from pre-intervention to post-intervention ($p = .002$) and from pre-intervention to 1-month follow-up ($p = .02$). Importantly, the increase in attitudes toward seeking help from pre-intervention to post-intervention was maintained at 1-month follow-up, as evidenced by the non statistically significant change from post-intervention to 1-month follow-up ($p = .43$). For intentions to seeking counseling, post hoc tests using the Bonferroni correction revealed a statistically significant increase from pre-intervention to post-intervention ($p = .002$) and from pre-intervention to 1-month follow-up ($p = .02$). Importantly, the increase in intentions to seeking counseling from pre-intervention to post-intervention was maintained at 1-month follow-up, as evidenced by the non statistically significant change from post-intervention to 1-month follow-up ($p = .10$).

The Table below presents the means and standard deviations for pre-program, post-program, and 1-month follow up outcome measures.

Pre, Post, and 1-Month Follow-up Outcome Data (N = 33)

| Scale | Pre-Program Mean (SD) | Post-Program Mean (SD) | Follow-up Mean (SD) |
|-------------------------------|------------------------------|-------------------------------|------------------------------|
| Mental Health Literacy | 123.36 (11.12) | 133.45 (14.66) ^a | 130.97 (15.08) ^{bc} |
| Self-Stigma of Seeking Help | 25.42 (5.28) | 22.33 (5.49) ^a | 23.06 (5.63) ^c |
| Personal Stigma | 9.45 (5.06) | 7.91 (6.54) | 7.79 (5.37) |
| Implicit Stigma | 0.10 (0.34) | 0.15 (0.39) | 0.14 (0.35) |
| Perceived Public Stigma | 20.36 (6.47) | 23.03 (6.26) | 20.73 (7.84) |
| Attitudes Toward Seeking Help | 27.45 (4.58) | 30.21 (5.07) ^a | 29.33 (4.17) ^{bc} |
| Intentions to Seek Counseling | 21.76 (5.28) | 25.33 (7.09) ^a | 24.27 (5.99) ^{bc} |

^a statistically significant change from pre-intervention to post-intervention.

^b statistically significant change from pre-intervention to 1-month follow-up.

^c non statistically significant change from post-intervention to 1-month follow up, thus indicating maintenance.

Note: Mental Health Literacy can range from from 35-160, where higher scores indicate greater literacy; Self-Stigma of Seeking Help from 10-50, Personal Stigma and Perceived Public Stigma from 0-36, where higher scores indicate more stigmatizing attitudes toward mental illness; Implicit Stigma from -2 to 2 where higher scores indicate more implicit stigmatizing attitudes toward mental illness; and Attitudes Toward Seeking Professional Psychological Help and Intentions to Seek Counseling from 10-40, where higher scores indicate more favorable attitudes and stronger intentions, respectively.

As hypothesized, mental health literacy, self-stigma, attitudes toward seeking professional psychological help, and intentions to seek counseling showed meaningful improvements from pre-intervention to post-intervention. In addition, mental health literacy, attitudes toward seeking professional psychological help, and intentions to seek counseling showed meaningful improvements from pre-intervention to 1-month follow-up, and the improvements made from pre-intervention to post-intervention were maintained at 1-month follow-up. We contend that these findings suggest that our program has positive implications for future help-seeking

behavior, as shown by the reduction in self-stigma and the improvements in mental health literacy, attitudes toward seeking professional psychological help, and intentions to seek counseling.

Program and Session Evaluation

At the conclusion of the program, student-athletes rated the overall effectiveness of the program from 1 (*ineffective*) to 5 (*effective*), the quality of the program from 1 (*poor*) to 4 (*excellent*), and satisfaction with the program from 1 (*quite dissatisfied*) to 4 (*very satisfied*). Results revealed Overall Effectiveness ($M = 4.55$, $SD = .56$), Quality ($M = 3.79$, $SD = .42$), and Satisfaction ($M = 3.73$, $SD = .52$). Overall, 97% of student-athletes rated the program as effective to very effective, 100% rated the quality of the program as good to excellent, and 97% reported that they were mostly to very satisfied with the program.

At the conclusion of each intervention session, student-athletes rated the overall effectiveness of the session from 1 (*ineffective*) to 5 (*very effective*). Effectiveness ratings for each session revealed the following results: Session 1 Mental Health Literacy ($M = 4.25$, $SD = .67$), Session 2 Empathy ($M = 4.62$, $SD = .56$), Session 3 Counter Stereotyping ($M = 4.41$, $SD = .69$), and Session 4 Contact ($M = 4.73$, $SD = .52$). Overall, 87.5% of student-athletes rated Session 1 as effective to very effective, 96.5% rated Session 2 as effective to very effective, 96.2% rated Session 3 as effective to very effective, and 96.7% rated Session 4 as effective to very effective.

While this report primarily focuses on the quantitative analysis of the variables of interest, preliminary examination of qualitative responses provides further illustration of participants' experiences of the program in regard to mental health, stigma, and help-seeking. Participant comments from the Program Evaluation indicated that our program was more extensive than education or training athletes had received previously on mental health in student-athletes. Multiple participants reported that the program helped them better understand mental health issues among athletes, and gave real world examples and tangible tools to have conversations with teammates about this topic. Some reported feeling confident in being able to advocate for mental health in order to fight stigma and promote a positive attitude toward seeking professional help. Some suggestions offered by participants were to utilize more interactive activities to make the program as dynamic as possible, recruit a more diverse sample of athletes (e.g., class year, sports teams), discuss what to do if you are the one experiencing a mental health issue, and add more testimonials followed by group discussions. It should be noted that formal qualitative analysis will be undertaken in the future to further illuminate student-athletes' experiences and reactions to the program. Presented below are some exemplar quotes from the five open-ended questions in the Program Evaluation.

When asked, how did you understand mental health issues in student-athletes before you participated in the program? How do you understand it differently now?

I understood that it was something common among athletes but not everyone faced their issues. I understand it differently now because I recognize that 1) it is okay to ask for help even if you aren't sure if you're having a mental health issue, 2) ways to spot mental

health issues in teammates and how to help, and 3) I know more about different types of mental health issues.

I understood that if you had mental health issues it was a bad thing and you would have to do the exercises and take medicine for the rest of your life. Now I know it is not a bad thing and the sooner you reach out and get help the better off you will be in the long run.

When asked, how does this program compare to other education or information you have received about mental health and mental illness in student-athletes?

This program was very informative about the different types of mental illnesses and how to help yourself and others who have a mental illness. My other educational experiences have breezed over the factual information, and they spoke vaguely about what you can tangibly do in relationships to help others ... this study helped us to understand what is actually happening, why it is happening, and what we can do to help and even prevent it from happening. This program, unlike others, has actually convicted me, rather than just feed me information, websites, and telephone numbers. Because of this program, I have reached out to my therapist from freshman year to speak with him again about things that have really bothered me recently, and I have also felt called to be more intentional in the relationships I have with those I know need help.

This program is unlike anything I have ever been a part of. I have never really been educated on mental health, besides time I have met with counselors. This program is in its early stages, but I strongly feel with time this can help change FSU's Athletics department efforts on mental health.

When asked, how can you take action to help overcome stigma?

To help overcome stigma, I can personally talk to fellow athletes who I believe are struggling with mental illness. I can explain to them how there is no issue with getting help, and give them information about possible resources. I can also tell stories I heard in our sessions about major athletes who fought mental illness. No one saw them as weak because of it.

You can take action to help overcome stigma by talking about it more to normalize the illness and make people aware that mental illness can affect anyone and that it is as real as a physical injury.

When asked, what did you find to be most useful about the program?

I found most useful the opportunity to hear from the instructors, my peers, and specifically my teammates about where they stand on the topic of mental health. Specifically, it was useful for me to hear about the specific characteristics of different types of mental health. Too often, I have looked at one of my teammates with contempt because of how back and forth she is with everything, but from this program, I can see more clearly that what she is going through and how she is responding to it is legitimate.

Learning about ways to help others if i notice they are having a mental health issue and learning how to be empathetic and well as learning about being open and positive about mental health issues. I feel like I would have confidence in going to seek help if I needed it.

When asked, do you have any suggestions for how the format, content, or delivery of the program could be improved?

I think the format worked really well, given the content. I really liked the discussion questions, because I got to speak with my teammates about something we don't commonly talk about. Although I know we were trying to keep the study to an hour, I wish we could have had a bit longer to talk with our group for each question.

It was more dynamic than what you would expect, but the more dynamic you can make the program the better it will become.

Implications for Campus Level Programming

Taken together, the results demonstrate that the program has positive implications for future help-seeking behavior, as shown by the reduction in stigma and the improvements in mental health literacy, attitudes toward seeking professional psychological help, and intentions to seek counseling. The structure of our program demonstrated effectiveness in tackling stigma at the pilot level; thus, programs such as this may be tested on a broader scale in order to increase mental health literacy, reduce stigma, and improve attitudes and intentions toward seeking professional help for mental health concerns. Campus level programming should consider integrating both psychoeducational and interactive components when designing interventions to increase mental health awareness, reduce stigma, and increase help-seeking among student-athletes. We recommend that future efforts include the following elements in such programming, to enhance desired outcomes: Presentation of relevant statistics, promotion of available mental health resources, contact (e.g., live, video) with current or former collegiate or professional athletes who have experienced and sought treatment for mental illness, and experiential training of concrete skills (e.g., experiencing and expressing empathy, active listening, having difficult conversations with teammates, referring a friend to a psychologist). In terms of recruitment, having coaches, other athletic staff, and mental health professionals promote and support mental health programming further increases likelihood of student-athlete engagement with the material. For example, if a coach is encouraging their athletes to participate in the program, the athletes may perceive less stigma from the coach in regard to mental health. Coaches and the support of significant athletic staff is essential in changing the culture of stigma in collegiate athletic settings.

Following recommendations from the NCAA Best Practices document, we also recommend that every university athletics department employ at least one full-time psychologist, with formal education and training in the sport setting, to attend to the mental health needs of student-athletes. Accessibility to mental health resources within the campus and athletics environment communicates a natural integration of mental health care alongside physical health care (e.g., sports medicine, athletic training). This in itself assists reducing stigma within sport. Programs

designed to increase awareness of mental health issues in student-athletes, but fail to discuss or provide resources on campus, run the risk of sending mixed messages. While addressing mental health literacy and improving attitudes and intentions to seek help are important and targeted directly within our program, an integral part of change is having resources available, accessible, and normalized within the collegiate athletic setting. Universities that are not actively investing in mental health care for student-athletes may inherently become a barrier to help-seeking for mental health concerns. On the other hand, accessible mental health treatment void of programming like ours that addresses barriers to help-seeking such as stigma, may prevent many student-athletes from not receiving appropriate help even if it is available. In any event, collaborative efforts are needed to address barriers to treatment and treatment itself, as psychologists who are employed full-time to treat mental health concerns of student-athletes may have limited bandwidth to do both.

To support the dissemination of the program to a range of member institutions, we will provide three options at varying levels of guidance, for university athletic departments interested in adopting the program. The first option (minimal involvement) is to obtain a Program Manual. The curriculum will include an overview of the purpose and goals, the rationale supporting the need for this training, learning objectives, session outlines, and activities. Developed materials will include PowerPoint presentations, intervention protocols, and worksheets to support interventions. These materials could be used by a professional (e.g., sport psychologist) to guide implementation of the program within their respective athletic department. For the second option (moderate involvement), we would provide the Program Manual as well as training and consultation (either virtual or in-person) to provide guidance to athletic staff (e.g., sport psychologist, mental performance consultant, coach, athletic trainer) assigned to implement the program at the local level. The third option (maximum involvement) would be in-person delivery of the program, in which we would come to the respective university's location to implement the program ourselves, as interventionists. Upon request, the program can also be adapted with minimal modifications for implementation with coaches, athletic trainers, and others in athletics departments who play a pivotal role in the recognition and management of student-athlete mental health problems. Since coaches' and other significant others' attitudes toward mental health and help-seeking can have a significant impact on athletes' attitudes and behaviors, coach education is an important area of focus for future research and program implementation.

In summary, we believe some best practices from this program include:

- Incorporating interventionists who are professionals in the fields of sport psychology and clinical/counseling psychology. However, we believe that the program could be implemented with fidelity by trainees under supervision (future study).
- Collaborating with key stakeholders in the Athletics Department is essential for recruitment.
- Using a range of modalities for intervention sessions (e.g., education, discussion, experiential activities, reflection, video, modeling, training) to enhance engagement and application.
- Having a moderate group size comprised of diverse participants generates dialogue among student-athletes, while creating a personalized and comfortable environment.

- Establishing a clear time schedule for each intervention session that prioritizes the most important material in the event that some material has to be omitted due to time constraints.
- Emphasizing that student-athletes can play an active role in changing the culture of mental health and well-being on college campuses, and educating and training them how to fulfill this role.
- Including quantitative and qualitative assessments for each session and the program as a whole.

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Tackling Stigma: Mental Health Literacy



Promoting Mental Health Literacy and
Help-Seeking in Student-Athletes

Project was funded by an NCAA Innovations in Research and Practice Grant
to improve the well-being of student-athletes



Program Overview

- Introduction of program facilitators
- Purpose of program/nature of sessions
- Logistics
- Expectations
- Confidentiality

Graig Chow (323) 203-2161

Coop (740) 497-0701



Introductions

- Name, major, sport, & class year
- Why did you join the program?
- What are you hoping to learn from the program?

When you think of student-athlete mental health issues, what comes to mind?





What are some of the causes of mental health disorders?

- Biological (e.g., genetics, other medical conditions)
- Environmental (e.g., trauma, life circumstances)
- Thoughts (e.g., negative beliefs about self)
- Maladaptive coping (e.g., substance use, avoidance)



What are some of the consequences of mental health disorders among student-athletes?

- General mental health
- Social
- Academic
- Athletic/Performance
- Physical Health
- Self-harm/Suicide



What mental health disorders are most common in student-athletes?

- Anxiety
- Depression
- Disordered Eating
- Stressor-Related Disorders
- Substance Use

There are behavioral, cognitive, emotional, and physical signs!



Anxiety

- 11.2% of college students diagnosed with an anxiety disorder
- Includes:
 - Generalized Anxiety Disorder
 - Social Anxiety Disorder
 - Panic Disorder



Anxiety

Generalized Anxiety Disorder

- Excessive worry about a number of events in daily life
- Difficulty controlling thoughts and focusing on tasks

Social Anxiety Disorder

- Fear in certain social situations (e.g., public speaking)
- Fear of doing or saying something that may cause embarrassment

Panic Disorder

- Unexpected fear or anxiety that peaks in intensity quickly
- Involves heart racing, loss of breath, tingling in fingers or feet, and/or fear of losing control



Depression

- Includes **Major Depressive Disorder** and **Dysthymia**
- 23-33% of student-athletes show clinical symptoms
 - Elite female athletes more likely to experience these symptoms compared to elite male athletes
- Symptoms include:
 - Sad or down mood most of the day
 - Feelings of guilt or worthlessness
 - Loss of energy or fatigue
 - Difficulty concentrating and making decisions



Disordered Eating

- Around 15% of athletes meet the diagnostic criteria for an eating disorder
- Highest mortality rate of any mental disorder
- Includes:
 - Anorexia Nervosa
 - Bulimia Nervosa
 - Binge-Eating Disorder



Disordered Eating

Anorexia Nervosa

- Restriction of energy intake relative to requirements
- Leads to less than normal body weight
- Intense fear of gaining weight

Bulimia Nervosa

- Binge eating followed by inappropriate compensatory behavior
- Compensatory behaviors are used to prevent weight gain (e.g., self-induced vomiting)



Disordered Eating

Binge-Eating Disorder

- Recurring episodes of eating large amounts of food
- Binge is characterized by:
 - eating more rapidly
 - eating until uncomfortably full
 - eating large amounts of food when not hungry
 - feeling depressed or guilty after eating
- Does not involve compensatory behavior



Stressor-Related Disorders

Adjustment Disorder

- An emotional reaction to an identifiable source of stress
- Prevalent in 11.5% of those aged 15-25
- Symptoms include:
 - Distress out of proportion with stressor (e.g., major life event, transitions)
 - Depressed mood, nervousness
 - Maladaptive behaviors from inability to cope



Stressor-Related Disorders

Acute Stress Disorder

- Exposure to actual/threatened death, serious injury, or sexual abuse
- 5-20% experience ASD after a trauma
- Symptoms include:
 - Intrusion (e.g., flashbacks)
 - Avoidance (e.g., trying to block out thoughts)
 - Negative mood



Substance Use

- 42% of NCAA athletes engaged in excessive drinking
- 37% of NCAA athletes reported taking banned substances during their career
- Common substances include:
 - alcohol, tobacco/nicotine, marijuana, amphetamines, cocaine, ecstasy/molly, LSD, methamphetamine, heroin, narcotic pain medication, anabolic steroids



Substance Use

Substance Use Disorder

- Impaired control over substance use
 - Desire to reduce use
- Social impairment
 - Failure to fulfill major roles
- Risky use
 - Use in situations that are physically dangerous
- Pharmacological
 - Tolerance and withdrawal



What are some of the barriers to seeking help among student-athletes?

- Lack of time
- Lack of available services
- Negative attitudes toward help seeking
- Stigma
- Athletic culture



What are some of the ways athletes can manage mental health issues?

- Maintain a healthy lifestyle
- Develop social support
- Stress Management
- Sleep quality and nutrition
- Therapy (CBT, PET, IPT, Psychodynamic)
 - Individual, group, tele-counseling
- Medication



Do you know the mental health services available on campus?

- Dr. Keely Kaklamanos – Director of Clinical and Sports Psychology
 - Moore Athletic Center
 - (850) 228-0252
- Florida State University Counseling Center
 - 2nd floor of the Askew Student Life Center
 - (850) 644-8255(TALK)



How would you help a teammate who was experiencing a mental health issue?

- Ask
 - “Is everything okay?”
- Listen
 - “Take your time, I know talking about these things must be really difficult”
- Support
 - “I’m here for you”
 - “What can I do to help?”



Debrief

- What parts of today's session stand out the most for you?
- What was most surprising?
- How has today's session changed your thinking about mental health?
- What is one thing you might do differently as a result of today's session?



End of Session Evaluations

Thank you

Reminder of Session 2 (time and date)



Tackling Stigma: Empathy

Promoting Mental Health Literacy and
Help-Seeking in Student-Athletes



Perspective Taking

- You are going to hear a story about a student-athlete who has a mental illness and is seeking treatment
- Pay particular attention to their internal thoughts and feelings
- Worksheet to take notes

*In the event that any of the information shared today brings up difficult emotions or creates distress, we will be available for assistance afterwards



Group Reflection

- How do you think this student-athlete was feeling?
- What do you think the student-athlete wanted?
- What do you think the student-athlete was worried about in seeking help?
- What barriers were present and how did this affect the student-athlete?
- How would you feel if this was happening to you?



How to Provide Empathy

- Think about a time when you had a personal or emotional problem
 - What types of responses did you receive from others?
 - What was helpful or unhelpful to you?

Empathy Video



<https://www.youtube.com/watch?v=1Evwgu369Jw>



How to Provide Empathy

- What is the difference between sympathy and empathy?
- Being “with” the person vs. Having pity for them
- Validating their experience vs. Dismissing it
 - Expressing care, appreciation, support
 - vs. “Just don’t worry about it” or “It’ll be fine”



How to Provide Empathy

- Genuineness
- Unconditional Positive Regard
 - Acceptance + Support
- Non-judgment
- Accurate Empathy
 - Ability to recognize another's feelings
 - Ability to experience another's feelings to some extent, by taking on their perspective



Empathy Skills

- **Attend and Listen**
 - eye contact, open body language, active listening, encouragers
- **Open-ended questions**
 - “Can you tell me more about that?”
- **Reflect feeling**
 - “It sounds like you feel overwhelmed”
- **Validate**
 - “That must be really difficult”
- **Normalize**
 - “It makes sense that you feel that way”
- **Summarize content**
 - “You’re feeling pressure to figure out what you are going to do after graduation and that’s making you feel anxious”



Empathy Video



Noles C.A.R.E.

JUST ASK. YOU CAN MAKE A DIFFERENCE.

Suicide Prevention at Florida State University

Scenario: Student to Student



Empathy Video

- What feelings/emotions was the person experiencing?
- What empathy skills were used by the helper?
- What would you have done differently as the helper?



What would it be like for a friend/teammate to come to you?

- Model
- Role play activity
- Take turns role playing . . .
 - A student-athlete struggling with a mental illness
 - A teammate responding to their experience using empathy skills



Group Discussion

- What was it like to be the helper?
- What did someone do/say that conveyed empathy?
- Which skills did you do well?
- Which skills were more challenging?
- Can you anticipate any challenges to helping your teammates/peers?



End of Session Evaluations

Thank you

Reminder of Session 3 (time and date)

Tackling Stigma: Counter Stereotyping



Promoting Mental Health Literacy and
Help-Seeking in Student-Athletes



Activity Instructions

- You will be presented with a statement about mental health
- In small groups, discuss whether the statement is true or false *and* provide reason/evidence to support your answer
- Share answers and reasons as large group
- We will present information regarding the statement

Only athletes in aesthetic and lean sports have eating disorders





- Athletes in aesthetic and lean sports are at greater risk, but athletes in other sports develop eating disorders as well
- Female athletes are more at risk, but both male and female athletes have eating disorders
- Eating disorders may look different for men and women, as they seek different socially constructed ideals (Ex. Women restricting calories to be thin, Men using steroids to be muscular)
- Different types of eating disorders: Binge eating, body dysmorphia, calorie restriction, compensatory behaviors (e.g., over-exercise, laxatives, vomiting)



Athletes who are struggling with mental health concerns are not mentally tough

- Being “mentally tough” does not mean you have to deal with issues alone—the most resilient and successful athletes know when, how, and from whom to seek support when they need it
- It is normal for life to affect sport performance
- Suppressing emotions isn’t always effective
- Being tough may include facing your fears of being vulnerable and getting help



If an athlete tells someone about their mental health concerns, then everyone will find out

- Benefits and limitations of discussing with coaches, teammates, athletic trainers
- Mental health professionals are bound by confidentiality standards
- Expectations to confidentiality

4.01 Maintaining Confidentiality

Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. (See also Standard 2.05, Delegation of Work to Others.)

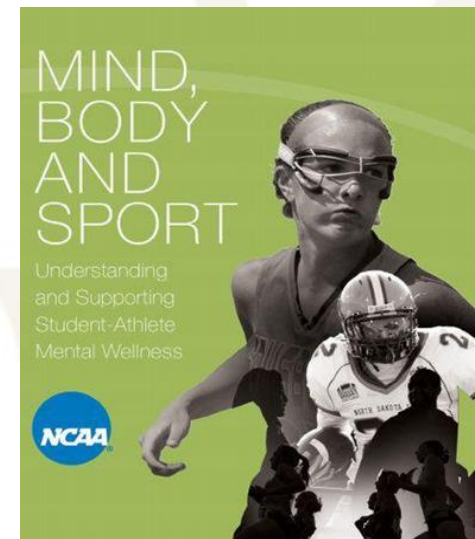


Talking about mental health concerns makes it worse

- Both male and female athletes can benefit from talking to a professional
- Avoidance strategies negatively impact mental health—talking with a trusted, supportive person can often result in feeling better
- Athletes who struggle with mental health concerns often appreciate when teammates express care and support
- These conversations better ensure that people get the appropriate support they need

Coaches will not be supportive of athletes with mental health concerns

- Coaches differ in terms of their education, training, and attitudes regarding mental health
- There are others you can go to if you do not believe your coach will be supportive
- Coaches can play a key role in helping athletes manage mental health concerns



Mental performance consultants treat the same issues as psychologists



Certified Mental
Performance Consultant
Dr. Graig Chow
850-645-2909



Psychologist
Dr. Donald English
850-644-8255



Psychologist
Director of Clinical and
Sports Psychology
Dr. Keely Kaklamanos
850-228-0252



Counseling should only be sought for athletes with severe mental health problems

- An athlete does not need a severe or diagnosable concern to benefit from counseling
- Athletes seek help for a variety of concerns
 - Ex. stress, worry, homesickness, low mood, relationship or family issues, grief and loss, transitions, identity, body image
- Scheduling a first appointment is a great first step—the counselor can help you figure out which resources would be most beneficial to you

Athletes with mental health concerns cannot perform at their optimal level

- Mental health concerns can affect your mind *and* body
- Performance depends on the individual's ability to manage and cope with mental health concerns
- Better mental health = more consistent performance





Common Stereotypes

- People with mental illness can snap out of it
- Mental illness will go away on its own
- Athletes with mental illness can solve it on their own
- Mental illness is not a real medical problem
- If an athlete has a mental illness nothing can make it better
- Mental illness can be prevented
- People who take medication to treat their mental illness must stay on it forever



Debrief

- Did any of the statements/myths surprise you? How so?
- How do stereotypes about mental health impact help-seeking?
- What did you learn from today's session?
- How can you go about debunking stereotypes to help change the culture of mental health on campus?
- Are there any barriers you still see that might stand in your way of seeking help or encouraging someone else to seek help?



End of Session Evaluations

Thank you

Reminder of Session 4 (time and date)



Tackling Stigma: Contact

Promoting Mental Health Literacy and
Help-Seeking in Student-Athletes

Chamique Holdsclaw

- Documentary tells the story of one superstar athlete's experience with mental illness
 - Obstacles, impact on functioning, steps taken to get help, and persistence in the face of challenges
- Worksheet to take notes
- *In the event that any of the information shared today brings up difficult emotions or creates distress, we will be available for assistance afterwards





Group Reflection

- What parts of the film stood out most for you?
- How has the film changed your thinking about mental health and mental illness?
- Several times in the film, Chamique talks about *“sweeping [her emotional problems] under the rug.”* What might have caused her to do this?



Group Reflection

- How did shame about her problems/illness affect Chamique's ability to seek out and get help at different points in her journey? How did she ultimately overcome her own sense of shame?
- William Rhoden, the sportswriter, says in the film, *"Mental health and athletics at the highest level are almost antithetic, because mental health is about seeking help, being vulnerable, talking openly about your issues, and success in competitive sports is not showing weakness, not showing vulnerability, not asking for help."* What might make it easier for competitive athletes to reach out for and receive help?



End of Session Evaluation

Thank you

Reminder of Post-Assessment
(Sign-up Sheet)