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The Role of Athletic Trainers in the Mental Health Care of Student-Athletes

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To the Graduate Council:

I am submitting herewith a thesis written by Dominic J. Palumbo entitled "The Role of Athletic Trainers in the Mental Health Care of Student-Athletes." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Recreation and Sport Management.

Robin L. Hardin, Major Professor

We have read this thesis and recommend its acceptance:

Lars Dzikus, James H. Bemiller

Accepted for the Council:

Dixie L. Thompson

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

The Role of Athletic Trainers in the Mental Health Care of Student-Athletes

A Thesis Presented for the
Masters of Science
Degree
The University of Tennessee, Knoxville

Dominic Joseph Palumbo
May 2021

Dedication

I want to dedicate this project to everyone who has fed my desire to learn and challenge myself each and every day. Through the ups, the downs and the numerous long days and nights, the support I have received has been incredibly humbling and motivating. To my parents, thank you for affording your only child the opportunity to follow his dreams. To my professors, thank you for helping to cultivate the mind of a kid who wants nothing more than to have the next question answered. To my bosses and coworkers in UT Media Relations, thank you for at least trying to understand and comprehend why a media relations GA would want to complete a thesis on top of everything else this job has thrown at him, and for the love every step of the way.

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Abstract

The purpose of this study was to examine the role of athletic trainers (ATs) in the mental health care of NCAA Division I student-athletes. Previous research explored the current experiences of both student-athletes and ATs, along with the current models of care that are prevalent in Division I athletic training rooms. Research described both the student-athlete population and AT population as unique. According to Beauchemin (2014) the life of a student-athlete “presents challenges and stressors related to the athletic status that can lead to a compromised well-being” (p. 268). Mazerolle (2016) described the normal day of a collegiate AT as one that begins early in the morning, continuing through the final athletic event of the day. These unique lives lead to a unique relationship between athletes and ATs. The purpose of this study lies here—to discover what that relationship looks like and where the AT lies in the mental health care of said student-athlete. Eight participants from Southeastern Conference (SEC) schools spoke with the researcher about their experiences regarding the topic. One semi-structured interview was conducted with each participant. The semi-structured interview method was chosen as a way to give the interview an initial direction while allowing for a more conversational interview environment. The quote transcripts were then analyzed using Braun and Clarke’s (2006) method of thematic analysis. After analyzing the data, I constructed four main themes: *first line of defense, building relationships, holistic care team, and scope of practice*. Examining the experience of collegiate ATs and their role in the mental health care of student-athletes can allow collegiate athletic department administrators to better evaluate the resources they currently have for student-athlete mental well-being, along with what resources may be needed in the future.

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Chapter I: Introduction

The topic of this study relates to the mental health of student-athletes who compete in the NCAA in the United States, specifically at the Division I level (Sudano et al., 2017). The decision to choose athletes at the Division I level of the NCAA is a result of the number of resources Division I schools have at their disposal that can be evaluated, such as the number of athletic trainers (ATs) on staff, the various health and nutrition facilities being used, along with the numerous sport performance facilities constantly being built and used on these institutions campuses (ASHE, 2015).

Current research—as will be discussed in the coming sections—indicates that collegiate student-athletes are some of the most at-risk or vulnerable individuals for mental health diagnoses (Hilliard, Redmond & Watson, 2019). Those diagnoses include, but are not limited to anxiety, depression, eating disorders, etc. (Hilliard, Redmond & Watson, 2019). Student-athletes are at-risk not only because of their age but because of the nature of their collegiate experience in comparison to non-athlete students (Gayles, 2009). They are generally placed on partial or full scholarships to play their respective sport and attend the institution they have agreed to play for (Jolly, 2008). They will be given resources to assist with their experience, whether its coaches, strength trainers, state-of-the-art facilities, and as much food as they want to help them on the playing surface, or tutors, academic staffs, and required study halls to help them in the classroom (Jolly, 2008). Where current research has fallen a tad short is who they go to and what the institution provides should the student-athlete be struggling in any way with their mental health.

The second area current research covers, is the experience of the ATs that are a portion of the resources the institutions provide to assist the athletes on the playing surface. The AT's work long hours, both treating the athletes and completing their own day-to-day tasks (Mazerolle et

al., 2010). They spend a majority of their days in some form of direct contact with the athletes they work with each day (Lacy, Bowman, & Singe, 2020). What this infers is that if there is any one person, or one group of people who athletes may share their experiences with, it could and often is, their ATs. That is where the purpose of this study lies. In that relationship between ATs and their student-athletes and how that relationship impacts the mental health care of collegiate student-athletes.

Purpose of Study

The purpose of this study is to examine the role of athletic trainers in the mental health care of NCAA student-athletes.

Relevance of Topic

The relevance of this topic stems from the growing interest in the fields of both the mental care of young adults and the relationship that topic has with the lives of NCAA student athletes. As society progresses in America two things in the public eye continue to grow: college athletics and research surrounding mental health care of young adults (Cosh & Tully, 2013; Gayles, 2009; Mazerolle et al., 2010; Mazerolle et al., 2016; Potuto & Hanlon, 2007; Ryan et al., 2018; Sudano et al., 2016). Student-athletes are a subgroup of young adults in America, thus relating the subjects that are the focus of this study. ATs coincide with the relevance of this topic, because of the amount of time they spend in direct contact with the student-athletes they work with every day, along with a unique work experience that in many ways mirrors the life of a student-athlete (Mazerolle et al., 2010).

To expand, student-athletes and ATs are both unique populations. Student-athletes have a livelihood and college experience that is vastly different from those who are non-athlete students (Rubin & Moses, 2017). This unique life places them more at risk for potential mental health

diagnoses (Ryan et al., 2018). Many schools have resources available to student-athletes should any mental health issues arise, but the availability and presence of those resources vary from school to school (Born, 2017). What can be inferred is that due to the nature of the position an AT is in, they are a prime candidate to be at the forefront of any potential mental health issue a student-athlete may experience, while also helping them navigate towards those available resources (Gayles, 2009; Mazerolle et al., 2016). This is due to the nature and uniqueness of the experiences of both ATs and student-athletes. Along with the amount of time they spend together (Mazerolle et al., 2013) there is the foundation for a unique relationship to form between the two parties.

This study aims to dissect what the availability of those resources actually is and where ATs lie in the potential chain of care of their student-athletes. An AT is relevant in this chain of care because of the aforementioned amount of time they are with student-athletes every day (Mazerolle et al., 2013, p. 12), along with the relationship they have with the student-athlete. This means that the likelihood of dialogue regarding mental health occurring between an AT and a student-athlete has the potential to be very high, which is where the relevance of this topic resides.

ATs have a unique and foundational relationship with a population of people who are at a high risk of experiencing mental health issues or diagnoses. If something were to happen to a student-athlete regarding their mental health, it is likely that an AT will be there and be present to help assist the student-athlete in some way. This topic is relevant in discovering what the role of an AT is in this process, what true resources both they and the athlete have at their disposal, what further resources may be needed, along with defining what the true role of an AT is.

Key Terms

The following working definitions of terms will be used in this study.

NCAA Division I: The highest—often referred to as the most elite—level of collegiate athletics sponsored by the National Collegiate Athletic Association (NCAA).

Mental Health: The Oxford Dictionary defines mental health as: a person’s condition with regard to their psychological and emotional well-being.

Mental Health Care: The care provided to help assist a student-athlete who may be struggling with their mental health in any way.

Mental Health Diagnosis: What is often referred to as mental illness, the terminology has been slightly altered to provide a person-first narrative to the study. Mental Health America (2021) states that the use of person-first language is critical to one’s recovery from a mental health diagnosis and allows the person to be seen as a person and not as their mental health condition.

Athletic Trainer: An individual who is the primary medical provider and medical care giver for—in the case of this study—a Division I athletic program in the SEC.

Scope of Care: The bounds of the position of care that athletic trainers are able to provide given their position in the athletic departments that employ them. The care they are able to provide is also contingent upon the various perceived roles of an athletic trainer by administration, the athletes, coaches, and the athletic trainers themselves.

Student-Athlete: An individual who participates on a Division I athletic program and attends the institution whose athletic program they participate for.

Chapter II: Literature Review

Student-Athlete Experience

“Student-athletes on most college campuses today represent a special population of students with unique challenges and needs different from their non-athlete peers.” (Gayles, 2009, p. 33).

Day-to-Day Experience

The student-athlete population is a population that at many autonomous five Division I institutions is largely separated from the non-athlete student population (Rubin & Moses, 2017). Their days are generally filled from sunup until sundown. According to Beauchemin (2014) the life of a student-athlete “presents challenges and stressors related to athletic status that can lead to a compromised well-being” (p. 286). Their days generally begin early in the morning with a lift or a team workout. After they finish the workout, shower and grab something to eat, they are whisked away for a full day of classes. In between classes they may attend study sessions, group meetings or they may simply go to the library to catch up on work. After a day of academics, they head back to the training facility for a three-to-four-hour practice session. After practice, they shower and change, eat dinner and will more than likely sit through a multi-hour “voluntary” film session. Then by the time they’re done it will generally be late in the evening and they may or may not have time to finish their homework before going to bed (Beauchemin, 2014).

Nationally, on a typical week when their sport is in session, 82.1% of collegiate student-athletes have reported spending over 10 hours a week practicing their sport, while 40.2% have reported spending over 10 hours a week playing their sport (Potuto & O’Hanlon, 2006). This time with their sport directly affects the performance seen in the classroom. As Gayles (2009) noted, it is clear that student-athletes are completing degrees at a higher rate in comparison to

students in the general population (p. 37), however, when this data is extrapolated the numbers show a different outcome. First, male students tend to perform at lower achievement levels when they enter college, compared to their peers and second, those student-athletes who enter college with lower levels of academic achievement in high school tend to have lower first-year grades (Gayles, 2009, p. 37). Student-athletes are often times forced to choose between whether to study for a big exam or to get extra reps in the gym before or after a big game (Gomez et al., 2018).

It is a life that—while filled with opportunity—can cause a student-athlete to truly separate themselves from the rest of their school’s student population (Rubin et al., 2017). There is often a conflict between the culture of a school’s athletic department and the culture of the campus (Rubin et al., 2017). This conflict of cultures is directly where the life of a student-athlete is located. They are asked to live out the culture of both a school’s campus and its athletic department, often being forced to choose to live one or the other out of necessity (Cosh & Tully, 2014).

They are often kept away from the non-athlete population from the second they step foot on campus (Jolly, 2008). They will often be housed in an athlete only dorm (Jolly, 2008). They will be given the privilege of eating in an athlete only dining facility. They are around fellow athletes all day, every day, isolating them further from the rest of the institution they attend.

Non-athlete students have a number of advantages when it comes to being a true *student* over their athlete counterparts (Jolly, 2008; Whitehead, 2020). For starters, they have the advantage of having full control over their course, study, and life schedule (Jolly, 2008). Most student-athletes—especially at the Division I level—are told what classes to take, and they will often be enrolled in 15 credit hours without much of a choice as to which classes they are allowed to take (Jolly, 2008). This is to ensure that should the athlete need to drop any course,

they will not fall below the 12-credit hour threshold needed to maintain NCAA eligibility (Meyer, 2005).

The focus on the eligibility of the student-athletes derives itself from the fact that the focus is not necessarily placed on development or growth as an athlete or a person, but on performance (Whitehead, 2020, p. 150). Whitehead (2020) described NCAA division I athletics as *elite* sport where the approach of each program is a performance-centric—or a performance at all costs—approach (p. 151). This approach lengthens the divide between being a student and an athlete.

In a study that observed the relationship between student-athletes and their studies, O’Neil (2020) found that student-athletes as a whole are a group with numerous relationships with both sport and academic participation. The study showed that overall student-athletes who were enthusiastic about their lives as a whole were experiencing greater engagement in school and sport, along with their global-psychological well-being (O’Neil, 2020). These numbers should prove that student-athletes who are fully engaged in both aspects of their lives will perform better and even exceed performance expectations. However, in most division I athletic departments, student-athletes will tend to choose majors that are academically less rigorous to combat their already busy schedules—these majors tend to include fields in a school’s communication department (Jolly, 2008). They are majors that tend to relate to potential fields an athlete may consider when their playing days end, however they are also majors that often correlate with an athlete’s practice and game schedule (Jolly, 2008). Because the classes tend to coincide with practice and game schedules, they will often be in class with a majority athlete population (Gomez et al., 2018). This, once again, furthers of the divide between being a student-

athlete and a non-athlete student and another example of the effects of the performance-based approach of collegiate athletics.

In and around athletic programs there are individuals who can help blur this line to make being a student and an athlete a cohesive experience. Ryan et al. (2018) indicated that there are things coaches can do to combat the separation of student and athlete, while also further strengthening the coach to athlete relationship. In a study conducted by the NCAA called “GOALS” (NCAA, 2015) they found that 73 percent of all NCAA athletes across divisions believe that their coach cares about their well-being. With this number already this high, it’s clear that the culture created by a programs head coach can help to reduce the barriers faced by student-athletes that will be discussed later, while also improving performance both on and off the playing surface. Along with coaches, there are numerous staff members within each program and throughout athletic departments who can assist, impact and help to improve the student-athlete experience, namely, athletic trainers, which will be discussed in more detail in further sections (ASHE, 2015).

It is clear that the lives of student-athletes are incredibly unique. Where this also factors in, is how it relates to the prevalence of mental health diagnosis’ among student-athletes. While they are two separate sections of research, one is almost always synonymous with the other.

Prevalence of Mental Health Diagnoses in Student-Athletes

Due to the separation of lives as a student and an athlete, while also experiencing the separation from the rest of the student population, student-athletes can often be at a higher risk of experiencing some form of mental health diagnosis, along with the risk behaviors that come with it (Cosh & Tully, 2014). Cosh & Tully (2014) further discussed that athletes tend to struggle and will have less motivation to pursue non-sport careers and make decisions about their futures

when participating in both sport and student life. This will cause them to be more at risk for diagnoses such as anxiety, depression, and eating disorders when they eventually walk away from their sport in the future (Cosh & Tully, 2014). This point delves into the issue surrounding NCAA athletes and their willingness and ability at times to be proper students at their respective institutions.

As research on this topic becomes more prevalent, more credibility is placed behind the statistics that are released each year. A number of recent studies have estimated that more than 20 percent of adults will experience a mental illness in a given year, with the highest rates among college students (Kroshus, 2016). It is estimated that prevalence of depression among student-athletes is similar to the limited numbers found among non-athlete students which hovers between 17 and 20 percent (Kroshus, 2016). We also see a similar prevalence in disordered eating among both female student-athletes and female non-athlete students which sits around 25 percent (Kroshus, 2016).

With this being said, it is clear that a large number of young adults in college experience some form of mental health diagnosis during their time as students (Bird et al., 2020). Student-athletes are a sub-population of young adults in college and experience additional stressors that are linked to disorders such as anxiety, depression, bi-polar disorder, eating disorders etc. (Ryan et al., 2018). They experience the rigors of a schedule that brings pressure to perform in the classroom, on the field, pressure from coaches and even family members (Brown, 2014). While the pure numbers of just how many student-athletes suffer from some sort of mental health diagnosis are unclear, the student-athlete population may be more susceptible to mental health disorders due to the demands of their experience (Ryan et al., 2018). Further, according to Born (2017), in research conducted on the NCAA student-athlete population as a whole, it is estimated

that anywhere from ten to fifteen percent of NCAA student-athletes, experience psychological issues that are severe enough to warrant some form of counseling (p. 1223). He noted that it is estimated that around 4,600 athletes attempt suicide each year and that roughly 40,600 will have suicidal thoughts year and while these numbers seem high, he said that both of these numbers are very likely to be too low (Born, 2017, p. 1224).

According to Ryan et al. (2018), anywhere from 10 percent to 21 percent of student-athletes will suffer from the effects of depression. Similarly, another study showed that 31 percent of male student-athletes and 48 percent of female student-athletes reported symptoms of either anxiety or depression each year for the academic years of 2008-2012 (Brown, 2014; Ryan et al., 2018). They also found that a large percentage of athletes will misdiagnose their own symptoms. Therefore, while they are more than likely suffering from some form of mental health diagnosis, the athletes themselves are often unsure as to what their symptoms stem from (Bird et al., 2020). Rather than viewing them as a problem, athletes will often view their symptoms as a result of having a busy schedule, not getting enough sleep, etc. (Ryan et al., 2018).

It goes without question that student-athletes are experiencing the negative effects of mental health diagnoses (Bird et al., 2020; Born, 2017). While many develop them during their time in college, many of these athletes are struggling before they even arrive on campus (Kroshus, 2016). When athletes are seen struggling, it is rare to see them seek the help they need. This lack of help seeking behavior is derived from barriers that inhibit this behavior (Hilliard, Redmond & Watson, 2019). Regardless of whether or not a student-athlete arrives on campus with a mental health diagnosis, or develops one after they arrive, the need for them to seek help is the same. While it is troubling to see the pure numbers of student-athletes who

suffer, what is seemingly more troubling is what tends to prevent them from seeking the help they need.

In relation to barriers, scholarship has addressed both the general barriers non-athlete students face (e.g., fear of being seen as weak, not wanting to disappoint peers or superiors, and not wanting to see themselves as having a “problem”) (Corrigan, 2004) and the prevalence of resources at a student-athletes disposal (e.g., counselors, sport psychologists, and measures put in place at institutions to diagnose both current and incoming student-athletes) (Hilliard, Redmond & Watson, 2019). The first area touches on many of the same barriers that non-athlete students may face when struggling with a mental illness. Where the experience of the student-athlete differs is their barriers, much like the symptoms of their illnesses may be heightened due to the nature of their experience as both a student and an athlete (Gayles, 2008; Gomez, Bradley & Conway, 2018). Their lives demand the struggles and stresses of both an athlete and a student, thus combining the heightened chances of suffering from a mental health diagnosis in both regards.

The second area highlights the uniqueness of the student-athlete experience even further. At many Division I institutions the campus culture presents an environment where non-athlete students have a plethora of resources at their disposal such as counseling centers, licensed psychologists, and even small group events to help assist them with any issues they may experience during their time as undergraduate students (Gibbons et al., 2019). For student-athletes the resources available to them, are all of the same resources. As stated earlier, 73 percent of student-athletes reported that they feel like their coaches care about their well-being (Ryan et al., 2018). However, Ryan et al. (2018), along with the NCAA GOALS study (2015) found that while a majority of student-athletes would feel comfortable talking about their mental

health with their coaches, the percentage is much lower among female athletes in comparison to male athletes (62 percent for men as opposed to 49 percent of women). This is important, because it drives home the point that while coaches are often incredible people, who care about their athletes, their main job is to win games and they cannot do everything and it is important that student-athletes are able to discuss these issues with someone who has a concrete understanding of their daily lives.

Most, if not all Division I athletic programs currently have licensed dietitians, athletic trainers, strength coaches, sport performance professionals, and state of the art performance facilities (Torres-McGehee et al., 2012). With all of these incredible benefits, what many schools lack is a full staff of licensed psychologists or mental health counselors whose jobs are solely tied to treating any mental health struggles experienced by student-athletes (Ryan et al., 2018). When looking at each of the 14 Southeastern Conference institutions, there are a total of 23 licensed mental health professionals in the conference making an average of 1.64 per school. To put this number in perspective, SEC schools have an average of 478 total student-athletes. This means there is an athlete to mental health professional ratio of 291.17 to one (This information was compiled using each institutions publicly available athletics website).

It is this ratio that could become and possibly currently is, the largest risk factor to student-athletes who may be struggling with their mental health. With so few people available who are around the programs they play for on a regular basis, it can be difficult for student-athletes to find the motivation or even desire to want to talk to anyone (Corrigan, 2004). There are also three main factors that would make student-athletes more apt to report their symptoms and feelings to anyone. One is simply having access to professionals who understand the nature of the student-athlete experience, while the second is being able to schedule appointments

without interference from coaches or teammates (Ryan et al., 2018). This confirms the idea that universities should provide more people to help treat its athlete's mental health. Having more professionals, provides more access, which means athletes will feel much more comfortable sharing their experiences with those who are around.

What this study is looking to discover, is what current employees at a set of Division I institutions are doing—if anything—to help treat and care for student-athletes mental health, more specifically, athletic trainers. As will be discovered in the coming sections, athletic trainers have schedules that are extremely similar to those of student-athletes. They are around regularly in a number of different capacities, while playing numerous roles in caring for the people they see on a daily basis. Thus, posing the questions of, if a student-athlete is experiencing the effects of a mental health diagnosis, are there processes in place for them to follow if a student-athlete were to be struggling? If there isn't, what do they choose to do and how do they go about fulfilling those practices? These are the questions this study is looking to answer.

Experience of Collegiate Athletic Trainers

Day-to-Day Experience

Current research has found that collegiate athletic trainers hold a number of roles in the care of student-athletes. It is believed that the best AT's hold a number of roles and provide what is called integrative care (American Psychiatric Association, n.d.). The rough definition of the integrated care model states that the most effective care that can be provided to a student-athlete or any patient is a healthy balance between behavioral health services with other general and/or specialty health services (American Psychiatric Association, n.d.). This definition coincides with the role of an AT, because the National Athletic Trainers Association (NATA) states the role of an AT as follows:

A health care professional who collaborates with physicians. The services provided . . . comprise prevention, emergency care, clinical diagnosis, therapeutic intervention, and rehabilitation of injuries and medical conditions. Athletic trainers work under the direction of physicians, as prescribed by state licensure statutes. (Eason et al., 2018, p. 73)

This definition encompasses only the clinical side of the work of an AT.

On the surface, AT's are seen solely as health care providers. The World Health Organization (WHO) defines health as "A state of complete physical, mental, and social well-being, not merely the absence of disease," (1948, p. 100). Throughout the history of collegiate athletics, the model for caring for athletes has been a traditional medical model (Whitehead, 2020, p. 159). This model has held that an organism or human is healthy if it is free from pathogen or disease (Whitehead, 2020, p. 159). While this model is great for treating concrete diseases and injuries such as a cold or the flu, a torn ACL, or even a sprained ankle, where it fails is its ability to treat lifestyle related problems that arise. These problems include things like obesity, diabetes, and the issues that pertain to the topic of this study: mental health (Whitehead, 2020, p. 159). Gadamer (1996) described modern health as, "...not a battle being waged inside each of us—pathogens versus our healthy tissue. It is a global expression personal life-satisfaction, well-being, or quality of life" (p. 104).

This rough definition is the reason many ATs reach beyond the bounds of their jobs. Health is more than just treating someone with an injury or a common ailment, but it is impacting a patient's life as a living, breathing human being. These acts derive themselves from the pure amount of time AT's spend with their athletes.

According to Mazerolle et al., (2016), a general workday for an athletic trainer will run as follows. They will often arrive at the team facility between 6-7 a.m. They will get their training room cleaned and stocked for the day, before looking over reports and spreadsheets to see who needs what treatment for the day. Student-athletes will more than likely start arriving between 7-8 a.m. for morning workouts. The trainer will help them get taped, stretched out and checked to make sure there are no issues prior to the first bit of work for the day. Athletes will sporadically come in throughout the morning and midday in a similar fashion. During free moments an AT will find time to eat, stock their supplies and simply get administrative things done that must be completed every day. Then an hour or so before practice they will run through essentially the same process with each athlete before they take the floor or field as a team. The AT will watch practice and monitor the athletes in case anything may come up. After practice concludes they will assist student-athletes with post-practice treatment, creating plans for the coming weeks and helping create schedules for the athletes to follow when they are not able to be in the presence of their AT. After concluding all treatment, they will now be able to leave the facility generally anywhere from 7-8 p.m., before doing it all over again the next day. A 12-hour day is a normal day with no game, while a game could add up to four extra hours to an AT's day (Mazerolle et al., 2016). Being that their job is generally a seven-day-a-week endeavor, an average work week could include upwards of 80 hours spent at the facility during the regular competition season.

Of the 80 hours spent at the facility, roughly 50-60 hours on average is spent in the presence of the student-athletes they will see on a daily basis (Mazerolle et al., 2016). That equates to about 75% of their total work week being spent with and/or around student athletes. Whether it's helping them rehab or recover after a practice or workout, providing regular and normal treatment and care, or simply being present at practice and games.

The Mental Health of AT's

The amount of time ATs spend at the facility on a daily basis can lead to a number of mental health struggles. The most prevalent of those tend to be work-life balance and burnout (Baker & Wilkerson, 2018; Eberman et al., 2019). Burnout is characterized as emotional exhaustion, depersonalization, and a reduced feeling of accomplishment in one's job (Baker & Wilkerson, 2018). Poor work-life balance is the lack of a harmonious relationship between an individual's satisfaction with and engagement in both work and nonwork facets of life (Eberman et al., 2019). Both of these things can lead to a belief that they are unable to provide proper care to their athletes (Mazerolle et. al, 2010) while they are at work and not actually at home. Both burnout and a poor work-life balance can lead to many of the same mental health struggles faced by student-athletes including depression, anxiety and eating disorders (Mazerolle et. al, 2010). One of the first steps to possibly mitigating these issues is simply having more ATs on staff at each institution (Mazerolle et. al, 2010).

According to the National Athletic Trainers Association (NATA) guidelines that were put in place in 2003 spelling out the proper number of staff members that need to be on an athletic departments staff to effectively care for each of that institutions' student-athletes. They say that each student-athlete is seen as 'One health care unit,' and that each full-time athletic trainer should be responsible for no more than 12 health care units in order to provide proper care. Across Division I sport medicine departments, the average number of full-time AT's is seven, covering an average of 16 sports per school (Mazerolle et al., 2010). If you take the average 450 athletes per division I institution and divide that number by 12, there should be roughly 37 full-time trainers to effectively care for every Division I NCAA student-athlete (NATA, 2003). This is where the divide lies in many collegiate athletic departments.

While the NATA guidelines are not representative of a legal standard, they should be used by institutions as a practical guide to determine the needs for their own athletes (Mazerolle et al, 2010). While the Southeastern Conference (SEC) institutions average just over 14 full-time athletic trainers per school, allowing for many employees to only have to cover one single sport this still means that the expectations for their provided care tends to increase, thus creating different stressors along with long hours on the job.

Due to the long number of hours spent inside the team facilities it can be incredibly easy for AT's to develop work-family conflict and poor life and job satisfaction (Mazerolle et al., 2008). According to Mazerolle et al. (2008), work-family conflict can often lead to increased feelings of job burnout, poor life satisfaction and may even lead to an intention to leave the institution they are employed by. This is all evidence that the life of an AT can become insanely hectic and will prove the analysis in the next section that details the proposal of new models of care that will benefit both the student-athlete and the life of the AT's caring for them.

Models of Care

In most collegiate athletic training rooms there exist two current, primary models of care. One is the academic model and the second is the medical model. The academic model revolves around the AT's being both AT's and academic instructors, keeping them separate from the athletic department, whereas the medical model places AT's as athletic department employees (Eason et al., 2015).

At most division I institutions—this includes every institution except one that is highlighted in this study—a medical model for athletic training is used. In the medical model the AT's report directly to the Athletic Director, the coach they work for, or the primary athletics physician (Eason et al., 2015). Eason et al. (2015) discovered that while the medical model can

create role congruency and a higher chance for a positive work-life balance, they also found that it can often create a conflicting situation of role conflict and intersender conflict (pp. 37-38).

To combat these potential negative relationships, there are two proposed models of care. The first is what is known as an integrative outreach model that provides a full and holistic look at the mental care of NCAA student-athletes (Beauchemin, 2014). The second is called a patient-centered model which looks to create a collaborative relationship between student-athletes and their athletic trainers that allows the trainers to act in accordance with the athletes they work with as opposed to the traditional model, where trainers answer solely to their administrators (Baker & Wilkerson, 2018).

The integrative outreach model has been shown to be effective in its ability to educate student-athlete about mental health, provide sport psychology concepts, and raise attitudes and awareness of mental health support systems in place to help reduce the stigma surrounding mental health, while developing enhanced performance and self-care skills (Beauchemin, 2014). This model will allow for student-athletes to learn about what they may or may not be feeling, how to care for themselves in certain situations, while also creating an inter-athletic department environment that instead of combatting what they may be feeling, will encourage student-athletes to come forward (Beauchemin, 2014; Eason et al., 2015). This model will help to greatly reduce the barriers placed upon student-athletes when it comes to their mental health (Beauchemin, 2014). Those specific barriers will be discussed in greater detail in a later section of this literature review.

The patient-centered model creates a system where instead of school athletic directors making the decisions regarding what AT's work with which sport and who is hired for what specialty, that these positions will be hired by university medical or health centers (Baker &

Wilkerson, 2018). This method of care will allow for athletic trainers to act both independently of the university and in the best interest of the student-athletes they are working with. It places a priority on the needs and welfare of the student-athlete, rather than on the desire and need to win and compete placed on AT's by many university's athletic directors, coaches and administration (Baker & Wilkerson, 2018).

These methods of care in the future could be found to be incredibly beneficial to the student-athlete experience, because they take the priority away from solely keeping the athletes on the playing surface and place it on the overall care and well-being of the athletes (Beauchemin, 2014; Carrie & Gay, 2018; Eason et al., 2015). These models will also allow for AT's to come into work each day and complete the job they were hired to complete in the best interest of the people they are serving each day (Mazerolle et al., 2008). They will also lend themselves to be beneficial to the unique lives' student-athletes live each day that tend to make them different and unique in comparison to non-athlete students on college campuses (Gayles, 2009; Ryan et al., 2018).

The ATs in this study will detail each of these facets of their own experiences at their respective institutions. It is important to remember that each participant will have differing experiences, yet each experience may thematically connect. This is where the researcher will look to derive meaning in how collegiate ATs take part in the mental care of student-athletes.

Chapter III: Methodology

Methods

The nature of this study called for the use of qualitative methods. Qualitative methods are suited to elicit the meaning and nature of a given experience (Strauss & Corbin, 1998).

Qualitative methods in this study required the use of semi-structured interviews. Semi-structured interviewing provided an initial framework and a direction for the interview to follow, while allowing for the participants to go fully in-depth regarding their experiences with the research topic (Grindsted, 2005).

Semi-Structured Interviewing

Semi-structured interviews can be described by Fylan (2008) as, “Simply conversations in which you know what you want to find out about, but the conversation is free to vary and is likely to change substantially between participants” (p. 65). Semi-structured interviews differ from structured interviews in that a structured interview looks to verify the beliefs, behavior, opinions, and values of the interviewee, while the semi-structured interview allows the interviewer to see how the interviewee attributes all of the those factors to the world they live in (Grindsted, 2005). A weakness of this method is that there can often be interviewer-bias, thus removing some of the interviews’ validity (Grindsted, 2005).

The themes of the semi-structured interview were athletic trainer day-to-day experience, currently established chain of care for student-athletes, the potential referral process, and current mental health professionals on staff. The semi-structured interview approach allowed for each interview to have an initial direction, while leaving room for open dialogue that expanded upon topics discussed between the researcher and the participant. It provided an opportunity for the participant to feel more comfortable as the interaction went on, shifting the interaction in essence

from an interview to a conversation, which in turn allowed each participant to attribute their experiences to the worlds that they lived/live in (Grindsted, 2005).

Sample

Potential participants were chosen from a group of 184 athletic trainers. Those 184 trainers were compiled using Southeastern Conference (SEC) athletic department websites, with every AT coming from each of the 13 member schools of the SEC, excluding the University of Tennessee. The University of Tennessee was excluded from this study to avoid any potential conflict of interest between myself and the participants. The potential participants were notified of the study based on two factors. Were they certified ATs and did they work at an institution in the SEC? No preference was based on sport, years of experience, age, hometown, or gender in the hopes of not limiting the scope of the study and the potential participant pool.

This form of participant selection is known as purposive sampling. Purposive sampling provides the researcher the opportunity to identify and select the most information rich cases that are related to the chosen topic of interest (Palinkas, 2015). In this study, that set of information rich participants were a group of Division I ATs. This group was information rich, because most certified ATs at the Division I level in the SEC it was observed, tend to have the highest chance of having multiple degrees and the institutions they work for, tend to have the largest number of resources in all aspects of athletics.

The information of each potential participant was gathered using the athletic websites of the 13 SEC member institutions that were selected. Their e-mail addresses, sport responsibility and names were compiled in an excel spreadsheet where each group of trainers was sorted by their respective school. Each school averaged 14.2 full-time athletic trainers. Multiple schools

referred to their athletic training department as sports medicine, but the full-time employees' official titles continued to refer to them as athletic trainers.

Demographics

Eight ATs from the SEC chose to participate in this study. Four male and four female participants chose to participate, with sport responsibilities ranging from football to Olympic sports such as track and field and tennis. Overall, two participants were the primary AT for their institutions football program, two worked with the collective tennis programs, one of the tennis ATs also worked with track & field, one participant worked with baseball, another with swimming & diving, another with softball, and the final participant had no current primary sport obligations, but was in a supervisory role. A full list of participant names and sport responsibilities can be found in Appendix B, table 1.

Sample Size

Eight participants were chosen once saturation of the group was reached. I reached out to 184 potential participants, eight responded to the inquiry, signed the consent form and participated in an interview. Each of those eight individuals were interviewed and were participants through the duration of the study. The interviews themselves were also not conducted until full sample saturation was reached, i.e. when it was clear that only eight individuals would take part in the study following both the initial and follow-up e-mails. While the sample size could be considered small, sources have shown how beneficial having a “smaller” sample size can be in qualitative work.

Chaudry (2021) completed a study with four participants looking at the effects of Islamophobia faced by Muslim students in higher education in Great Britain. The author discovered that while the sample size was small—meaning the experiences of the participants

could not be generalizable to the population as a whole—the experiences of the participants provided a rich contribution towards that field of study (Chaudry, 2021). Sandelowski (1995) harped on Chaudry's (2021) final point by stating:

An adequate sample size in qualitative research is one that permits—by virtue of not being too large—the deep, case-oriented analysis that is a hallmark of all qualitative inquiry and that results in—by virtue of not being too small—a new and richly textured understanding of experience.

Procedure

Approval to interview and transcribe the interviews of potential candidates was needed and granted by the IRB committee at the University of Tennessee Knoxville. After obtaining approval, Zoom interviews were utilized to obtain data for this study.

The potential participants were notified via e-mail and were asked if they were willing and able to participate in this study. The e-mail they were sent can be found in Appendix A. If a potential participant responded with interest in participating in the study, they were sent a follow up note letting them know they would be notified about a potential interview in the coming weeks. Once a time and date was decided upon, the participant was sent a consent form that provided them answers to any immediate questions they may have had and information about what to expect in the interview, along with what their rights are as a participant. Once the form was signed and returned, the interview was set to take place.

Following the initial recruitment communication, only two potential participants responded. As a result, a follow up e-mail was sent. Upon response to the follow-up e-mail the same process to the initial interview took place in regard to setting up an interview with the participant. That follow up e-mail can be found in Appendix B. Following the second e-mail

participant/sample saturation had been reached. Thus, Zoom interviews were conducted with the eight potential participants who responded to either the initial or follow-up e-mail. Each interview lasted for an average of 41 minutes and 48 seconds, while ranging from 22 minutes and 51 seconds to as long as 58 minutes and 50 seconds and were conducted using the aforementioned semi-structured interview method. A question guide of the interviews can be found in Appendix C, while a list of the demographics of each participant can be found in Appendix D.

The interviews were conducted using my Tennessee Zoom account and recorded and transcribed in their entirety. Following each interview, the audio files were loaded onto my computer and stored in a folder on my Tennessee Knoxville Google Drive account, which is protected using my unique Net-ID and password. After being loaded onto my computer, I permanently deleted the files from the recorder to prevent further risk to the participant. This was due to my phone not being password protected at the time of the study. Each audio file was then loaded into the computer program Audacity to assist with thoroughly transcribing each interview. If transcribing needed to stop at any point, the audio file was deleted from Audacity and loaded back in when it was time to resume the transcription process, thus preventing any potential hampering with the computer application when it was not being used since my computer was not password protected at the time.

The typed interview transcriptions were stored in a new folder on the same Tennessee Knoxville Google Drive, which is IRB protected using his Tennessee Net ID and password. Each participant was given a pseudonym to ensure the confidentiality of the participants identity throughout the research process. Once the transcriptions were completed, the audio recordings were destroyed to protect the participants identities and to minimize any potential risk.

After each transcription was completed, the files were sent to their respective participant to check the transcriptions for accuracy and clarity of shared information. Each participant had two weeks to respond and edit their respective transcription, before it was to be assumed that everything that was typed up was both accurate and clear. Once approval was granted for each transcription, the documents were analyzed for various trends and themes.

This process of member checking provides the research participant with the opportunity to check the accuracy of and/or amend any portion of their specific interview transcript (Brear, 2019). Member checking is referred to as a process that provides a holistic approach to finding transactional and transformative validity (Cho & Trent, 2006, pp. 320-321). In this study, member checking allowed the participants to validate and review their own words prior to the analysis of the data. In this study, four participants responded with recommendations and changes. Once those changes were reviewed and made, the data analysis process was undertaken.

Analysis

The data was analyzed using a Thematic Analysis approach. The approach is described by authors Braun and Clarke (2006) as, “a method for identifying, analyzing, and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail” (p. 79). The authors laid out the process six clear and concise steps that the researcher followed throughout the analysis phase of the study.

Step 1: Familiarizing Yourself with Your Data

Step one of this process may be the most important step. In step one the researcher spent time thoroughly transcribing each completed interview audio file as close to verbatim as possible. Following the confirmation of each transcription using member checking, the researcher participated in a deep reading of each interview.

During the initial portion of step one no notes were taken through each reading. This act, along with transcribing each file of audio could be seen as an “interpretive act” that allowed the researcher to create initial meanings of the collected data (Braun & Clarke, 2006, pp.87-88). This process—albeit time consuming and at times frustrating—was an important step in informing the researchers early stages of analysis (Braun & Clarke, 2006, p. 88) moving into step two: generating initial codes.

Step 2: Generating Initial Codes

This step is clearly described by Braun and Clarke (2006) as, “Working systematically through the entire data set, giving full and equal attention to each data item, and identify interesting aspects of the data items that may form the basis of repeated patterns (themes) across the data set” (p. 89). In this phase, the researcher was able to address the initial internal questions that arose when familiarizing himself with the data. Braun and Clarke in this phase ask researchers to firstly code for as many potential themes as possible—even if those themes may not hold weight later (2006, p. 89). Secondly, to keep the context of the study in mind throughout the initial coding phase, and lastly to be mindful that codes may fit into no themes, one theme, or multiple themes (Braun & Clarke, 2006, p. 89)

With this in mind, the researcher worked through each transcript with a pencil and a highlighter in hand. Potential codes were initially highlighted to show importance. If there was a consistent reiteration of certain coded items, the researcher went back and circled those items to signify immediate importance. Examples of initial codes were: mental health, relationships, medical providers, and counseling/counselor. These initial codes laid the foundation for step three: searching for themes.

Step 3: Searching for Themes

In this stage of analysis, the researcher is responsible for analyzing those initial codes, while considering how each code may or may not fit together to form larger and more overarching themes (Braun & Clarke, 2006, p. 89). Through this process, the researcher created an initial code book to sort each of the codes found in step two. The questions and individual quotes were copied and pasted into a rough excel sheet, with the perspective codes placed into the adjacent cells. This allowed the researcher to see the full picture of step two and began the initial thoughts for the current step.

With the code book created, the researcher printed off a fresh set of quote transcriptions, this time with four colors in hand. An orange highlighter represented the processes the institutions had in place for the athletic trainers to follow, while a yellow highlighter was used to identify the areas where an AT acted on their own accord, separate from the university. A purple pen was used to help identify where the initial codes fit with the yellow highlighted items, while a blue marker was used to do the same with the items highlighted in orange. The researcher also added notes in the margins of the text to continue to assist with the process of forming and organizing codes into potential themes.

Once each transcript was read and highlighted again four initial themes presented themselves: the focus seems to be on building relationships with the student-athletes, getting athletes to the next level of care, AT's are the first line of defense for any mental health diagnosis, available resources due to NCAA legislation. Inside each of these themes was a number of subthemes. Each subtheme fit into its respective place, with multiple subthemes fitting under more than one overarching initial theme. This discovery was important, because it

provided an initial framework for the data that was collected, while leaving room for improvement heading into step four: reviewing themes.

Step 4: Reviewing Themes

Step four involves revising the set of candidate themes that were established in step three (Braun & Clarke, 2006, p. 91). The researcher must look at each candidate theme as it pertains to its individual quote transcription and how it fits into the entirety of the data set. The process of doing so involves re-reading and at times re-coding each piece of the data set to ensure that the candidate themes fit with one another.

As it pertains to this study, the researcher dissected each candidate theme by re-reading each transcription to confirm initial trends. In this phase extra notes were taken in the margins of the transcriptions, confirming already established trends, while highlighting new trends as they appeared. This is where the researcher took the code book from step three and further compared and even contrasted the various quotes and codes that appeared. This is where the broad ideas began to become more specific with each reading of the data. While this was one of the shorter steps in the coding process, it allowed the researcher to confirm and at times change the findings from step three to reach step five: defining and naming themes.

Step 5: Defining and Naming Themes

After a thorough review of the themes was conducted, the goal of step five was to define and refine the soon-to-be presented themes. Defining and refining means to find the essence of what each theme is about (Braun & Clarke, 2006, p. 92). This meant searching through the initial code book to find not just the trends, but the umbrella terms that covered each trend.

The researcher in this step worked almost backwards in that he first further refined the candidate themes from steps three and four into his four final themes, which were: first line of

defense, building relationships, holistic care team, and scope of practice. What took place next was creating definitions (i.e. defining) for what each theme meant in relation to the entire compiled data set. After the themes were defined, a third set of transcripts was printed out, with four colors in hand again, with each color representing each individual theme. Each transcription was marked only for the four themes.

The final piece of this step came in the form of the final code book that featured each theme, the respective subthemes that presented themselves, a definition of each and an example pulled directly from the data set that proved each theme and subtheme. The final theme chart and definitions can be found in Appendix B Table 2. Once the themes were refined and defined, the researcher was able to commence in completing the final step: producing the report.

Step 6: Producing the Report

Step six of this process occurs when a set of fully worked out themes has been established and involves the final analysis of the extrapolated data (Braun & Clarke, 2006, p. 93). The final write-up must provide sufficient evidence of the discovered themes within the data using excerpts from each transcription that help to truly capture the essence of each theme (Braun & Clarke, 2006, p. 93). The fully produced report can be found in chapter four, with ensuing discussion to be found in chapter five.

Along with the six-step process laid out by Braun & Clarke (2006), the researcher throughout the coding process took part in active field note taking during each interview. At the conclusion of each interview, time was set aside for reflexive journaling to review each interview and gather pervasive thoughts about the conversation that was just had. Malacrida (2007) stated that reflexive activities such as journaling can allow the researcher to better deal with any emotions or feelings that may arise during the qualitative research process. In this study,

reflexive journaling allowed for the researcher's thoughts to all be put together, so when the coding process commenced there was a general framework for what potential codes and themes could be. This process was repeated after each review of the transcripts to further specify and narrow down each set of themes during each step of the coding process.

Chapter IV: Results

Themes

I constructed four themes during the process of the study with supporting information being provided by various subthemes. These themes helped to convey the current experience of SEC ATs when it comes to the mental health care, they provide to the athletes they work with. The four themes are: *first line of defense, building relationships, holistic care team, and scope of practice*. See table 2 in Appendix B for a complete list of themes and subthemes. See Appendix E for the full question guide used for each interview.

First Line of Defense

First line of defense refers to how multiple participants described themselves. They stated that they were often the first person who should be able to head off any mental health diagnosis that may come up in the life of the student-athlete, because of the sheer amount of time they spend each day with their student-athletes. These situations where the AT's are made aware of mental health diagnoses often arise through the subsequent conversations that occur, because of the amount of time the student-athletes spend in the presence of their AT. Daniel described what first line of defense fully means and even provided an introduction into the initial steps he may take if a situation does arise:

Luckily, we have very good resources here. I would like to think, and I know a number of my colleagues believe this, is that the athletic trainers are the first line of any kind of mental illness. Because of the amount of hours we spend with these athletes, that's why we would be the first contact in the event of something happening, or them having something they want to share. Usually, if there is ever a time where a student-athlete has something going on and we're just not equipped to handle it, or we just don't want to take

on the full burden of what's going on, we luckily have a director of mental health and she oversees this department within our sports medicine department.

Edward continued with this theme of conversation in the closing moments of his own interview:

I think this opinion may be biased, but athletic trainers are the 1A line of defense. We're the first person that's going to see it. We're the first person that's going to hear it and probably ten times out of ten, we're going to be the first person that's there to do something about it, because we're around so much.

He used the exact words of the theme before the theme had been discovered, a trend that would continue throughout the interview process.

Direct Contact

Direct contact refers to the pure number of hours the AT's spend with their student-athletes. Each AT described a full day in their job as lasting anywhere from 10-14 hours whether their sports were in-season or not. Of this time, roughly 50 percent of those hours and often times more were spent in direct contact with athletes.

Christine said:

I would say the majority of my time (is spent with athletes). In a 12-hour day I don't think I would be exaggerating to say that at a minimum, about eight of them are spent with student-athletes. In that time, I do try to spread out my time. We are unique in that our academics do take precedent, so if a kid has any academic commitment, I try to work around that to get them in with me. So, I do spread out rehab and other appointments throughout the day and it's not just right before or after practice. I might see a kid at 6 a.m., but he has stuff right when practice ends, so then I may not see him until 3 p.m.

Edward described the differences in schedules between Fall and Spring softball but noted that the amount of time with his student-athletes doesn't really change:

It's a very different schedule depending on the time of year. Our Fall season is broken into an in-season and an out-of-season schedule. That means there are eight or 12 weeks where we can be at the facility for 20 hours a week. Then, outside of that time period they can only be required for eight hours a week. For that eight-hour portion, the days can get pretty long. We'll start with individuals, which means we'll have two to four girls in a group basically from 8 a.m. to typically twoish, but sometimes because of class schedules it can be four. So, during that eight-hour portion it's pretty much all day.

He went on to describe that, that time allows him to schedule one-on-one rehabs, before getting into the team portion of the Fall season that looks very similar in structure to the Spring. In the Spring, he went on to say, "...the Spring especially has more high-stakes rehabs, because we have games—I will typically schedule their rehabs one-on-one where it's me, my student, and then the athlete. That sort of setting will be in the morning and then we'll have practice in the afternoon." It is clear that regardless of the season, Edward is in regular direct contact with his athletes.

Becca and Gertrude each described the differences they've seen in their careers with Football. Whether it was a difference in the time practice would start, or when they would need injury reports in each day, the days and time spent in direct contact with their athletes would do just about anything but decrease.

Becca said:

When I first arrived here, our football staff was arriving between 5:15 and 5:30 in the morning. That was under the first head coach I worked with. We had student-athletes in

the athletic training room starting around that same time, because injury reports needed to be in by 6 a.m. Once we worked through the initial morning group, the rest resembled a typical collegiate setting where the athletes filter in and out throughout the day. Lunch was scarfed down before the athletes came in for pre-practice taping. Practice would get going around 1 o'clock. After a typical long practice, I would get home by 7:45.

Gertrude stated:

We practice in the morning. We get here at about 5-5:30 in the morning, the guys are rolling in for taping and treatment around 6. Then, they have team meetings at 7:30, so we're setting the field up during that time. We head out to practice around 9, but really, they're out there around 8:15-8:30. Then, we're usually off the field at 11. Then, it gets really crazy, because our guys start classes at 11:40 most of the time, so we have to squash in their rehabs in that short amount of time, which means from 11-noon we're slammed. Then, they have class most of the day, so we don't really get to see them back a whole lot.

We might have a few guys here and there, but usually my afternoons are filled with paperwork.

...Then, our head athletic trainer has his football staff meeting around 4, so we might wait until he gets down to have a little staff meeting, which gets us out of there by 5-5:30.

Gertrude went on to discuss the differences between practicing in the morning vs. the afternoon and how that affects the length and scope of her days.

With the first coach I worked with, we practiced in the afternoon, so I've actually gotten to see both sides. I prefer practicing in the morning for my own personal life... There are definitely perks, but when you practice in the afternoon I wouldn't get home until 8 or 9

o'clock, but then I would still need to be back at 6 a.m. the next morning, because they would have weight workouts at 8 a.m. So, when we worked out that way the days were significantly longer, because we wouldn't get out of practice until 7 p.m. and then the only time they could work out was early in the morning, because they still had class all day.

Each AT described the process of their days, highlighting just how much time they spend at work with a ton of that time being spent in direct contact with their respective sets of student-athletes. Whether it was in-season or out-of-season the days rarely looked much different other than as Hailey stated, "The nature of what is actually happening."

Safe Space

Safe space refers to how a number of the AT's described and viewed the student-athletes time in the actual athletic training room. The training room is seen as a place for student-athletes to discuss any set of topics they want or need to, without the fear of a coach or important individual overhearing them, while also being a place for them to improve in any way they need to. The athletic training room being described as a safe space was seen as a necessity, because of how much time the AT's spend with their athletes. Abner said:

I would say the athletic training room a lot of the time is sort of an athletes escape from whatever else they've got going on in their day. So yes, I am around them a lot. I would say myself and the strength coach are probably around them the most. The NCAA dictates to the coaching staff certain periods of time where they can't have interaction with student-athletes. (I don't have that.) I'm a medical provider for the team, so I can reach out to them in any capacity. I don't have any limitations, so on a daily basis, treatments are their time to get better, so matter what that is.

Christine discussed not only having the training room be a safe space, but the importance of creating that safe space type of environment:

Personally, I look at the athletic training room as a safe space where they can talk about anything and a lot of times we do talk about difficult things, because they're important and it affects how they're feeling...I feel like I try to promote an environment where my athletes feel they can come and talk to me about anything. I think all of us try to do that here and that's a goal of mine. I want them to know that I care about them as a person. I've said to athletes who are recovering from a serious injury, "I don't really care if you ever get back on the field again. I care that you can walk around and hold your kids one day if that's what you want."

Creating a safe environment creates a sense of trust between the ATs and their student-athletes. This sense of trust allows the ATs to be better equipped to care for their athletes, while allowing for the relationship between the AT and the athlete to organically grow.

Becca continued this trend by discussing how the environment she created provided her athletes with the opportunity to open up in ways they normally wouldn't have. She said:

I never had a conversation I didn't like. While some of them made me sad or uncomfortable, I never backed away. Remember, my undergraduate degree was in health education, so all of these topics were concepts I felt comfortable with...mental health, drugs, sex. These are all things they wanted to talk about at this age, but maybe couldn't talk to their mom's about. I was sort of ground zero for them."

This ability to provide a space for athletes to feel comfortable talking about their lives beyond the field helped to foster and build the ever important relationships and rapport with the athletes that could help any athlete who may currently or eventually struggle with their mental health.

Building Relationships

This theme was mentioned in depth by seven of the eight participants and is the most integral part of an AT being able to help and care for their athletes. The relationships themselves stem from the amount of time the AT's spend with their athletes and from their ability to create a safe space in the training room, on the court/field, or wherever they may be treating their athletes. Edward gave a poignant quote about just how important and "fundamental" building those relationships with his student-athletes are in helping make him that first line of defense for anything that may come up in his athlete's lives. He said:

I think it all goes back to the most fundamental thing for me. Honestly, I would like to build a relationship with them before they even get injured, before they even have to come to the training room. Personally, I feel like I have a really strong relationship with all of my athletes to where I'm one of the first, if not the first person they reach out to if they need help.

Hailey added on to Edwards point by going incredibly in-depth into how she builds relationships with the athletes she is able to work with each day in two quotes:

Day-to-day I get the amazing opportunity to build relationships with student-athletes. As a faith-based person, I thank God every day for the opportunity to impact over 500 impressionable people. On top of that, I get a paycheck for it. I get to build relationships, so if we do face an emergency the conversation is easier, because they've already established that they are cared for. They know that I care for them and that our department cares for them.

'People want to know how much you care, before they care how much you know.' So, going off that premise and defining—I know I say it all the time, but it always goes back

to relationships and transparency. When you humanize yourself, you take away anything that puts you above or below someone else. So, appearing as normal humans, having the desire to build a relationship with these kids and to care about them for who they are and not for who they could be or what they could bring to the table is how we continue to break through those barriers and tackle the stigma.

Building relationships is essentially the backbone of being an AT, and when an AT is required to spend as much time with the athletes as they do, in the words of Frank, "...you're just bound to get to know people when you spend as much time with them as we do." To build on to this, two subthemes presented themselves that allow the ATs to further grow the relationships they have with their athletes.

Constant Presence

Constant presence refers to the notion that in order for the Athletic Trainers—and other members of the soon-to-be-mentioned holistic care team—to build relationships with student-athletes, they must be a constant presence around their athletes. This differs from direct contact in that this means being around often times at more than just practice or games, but finding small pockets in one's day or even life to be around in non-practice or game situations. Hailey once again went in-depth on this aspect of her own day-to-day schedule. She said:

We try to create an equality in our presence by using opportunities where we know there's going to be a diverse group. Like I mentioned, using the academic building. It's one of my favorites, because you run into any and everybody. Even if you walk in, walk past all of the tables and walk out, you never know who's going to be in there. We also use our Student Athlete Advisory Committee (SAAC) group and attend some of their meetings, or our other two leadership groups and we try to be a presence in there as well.

Frank went on to discuss that this time includes travel and meals and everything in between, on top of practices and in his case tennis matches. He also discussed that at times it may not even be he who gets closest to the athletes. He said:

I spend a lot of time with them. You're just bound to get to know people with the amount of time you spend with people. We spend as much time with them as a coach would, if not more depending on the situation. It just depends on personalities. Some people become closer with their support staff and others may not. When you're traveling, going to practices—I'm spending at least 8-10 hours a week with them pretty personably.

While multiple participants described the optimal situation being that the athletes get the closest with them as ATs, at the end of the day it was clear that the importance was on them becoming close to *someone*, so that should a situation arise, someone would be notified and the proper care could be utilized.

Becca went on to discuss the importance of not only herself constantly being around, but also those others who the athletes come in contact with that are a part of the care team. Again, while it may not always be her, it was about providing an outlet for the student-athletes to have someone to open up to. She said:

...In between counseling sessions, the counselors may be downstairs engaged in conversations with track athletes. They're as much a part of the athletic training world as we are. They are a part of the medical team

...So, if they've set up this relationship before, then it wouldn't be odd if the counselor comes by practice that day and started with a casual conversation with the athlete after practice. You kind of set it up. Part of their job is to just hang around and see what happens. Sometimes the conversation will start and sometimes it won't.

Edward mentioned how important it is for those other care team members to be around but gave a thorough example of how he is constantly trying to be around and stay around his athletes even when they're not practicing or competing. He said:

I think it goes back to being an individual. Everyone builds relationships a bit differently. A lot of it in this sense is just reaching out. Especially for freshmen, it's reaching out in that first semester quite a bit and seeing if they need anything, not even athletic related. We have the student-athlete cafeteria that's right in the middle of all of our athletic facilities, so I try to pop my head in there quite a bit and eat with my athletes to talk about things away from sport.

Another thing I think is really helpful, is we do what we call class dinners. Each coach will host a class three times for dinner. So, whatever night that dinner is, let's say the freshman class is eating with the head coach on Monday, then in two weeks they may eat with the assistant coach and I try to go to as many of those dinners as I can. Again, it's getting in and building that relationship outside, because I think if you really emphasize that you're a human too and are as imperfect as they are and make mistakes just as they do and learn every day, that helps them to realize that.

While not every participant brought up this aspect of their job, to these four it was evident that the relationship goes beyond the playing surface and intertwines itself into the daily lives of both the athlete and the AT. When this happens, the strongest relationships are formed, and the best care is able to be provided. It is also these relationships and this presence that helps to "humanize" both the athletes and the ATs that can eventually lead to conversations that have nothing to do with sport.

Non-Sport Conversations

Non-sport conversations are just what the subtheme says. They are conversations AT's have with their student-athletes that have nothing to do with their performance, practice, games, or injuries. They are normal everyday conversations that derive themselves from the constant presence the AT's are around their teams, the relationships they've built, and the pure amount of time the AT's spend with their athletes as mentioned above. Being a constant presence laid the foundation for the relationships, but these conversations began to build the frame of the house that many relationships eventually become. Becca described a number of these conversations and how they helped build a true bond with her student-athletes and made her more equipped to care for them as both athletes and human beings. She said:

So many conversations I would have with athletes in the athletic training room would have nothing to do with football. My approach had always been to spend the time to develop the rapport. That was probably my nature as a female athletic trainer. It's just more comfortable to have a casual conversation than to have awkward silence while doing treatment. So, I was always engaged with them in a way that maybe made them feel like more than just an athlete. I think by the nature of being physically or emotionally available to them, the conversations they trusted me with sometimes turned into heavier topics pretty quick.

She went on to further explain how these conversations helped her in case any major non-sport related mental health issues were to possibly come up, along with what her strategy was, in providing them a platform to share anything that may be going on:

My strategy was to let them talk. I would try to be conscious of my facial expressions and my body language, to make sure I wasn't sending them any mixed messages that said I

was either afraid of them, that they were strange, that this was awkward or anything like that. I really just tried to listen and not interrupt. As an athletic trainer I like to fix things and so, the idea of just letting them talk, is something I've gotten better with over time...I think a lot of those kids trusted me, because I would give them straight answers and I think I just felt more like the mother that wasn't going to be judging and wasn't going to be whipping up on them for their mistakes.

Christine similarly said:

I would say that I still consider myself a young professional, although the older I get, the younger they seem and the more it leans toward the fact that I don't really relate to these kids at all. But I do try to talk about things that I know interest them. I don't always try to talk about their sport, because I think we can often get too focused in on their performance and I think that can stress them out from coaches...But I'll talk about anything. I'll talk about movies, the news, different shows. I really feel like I try to promote an environment where my athletes feel like they can come and talk to me about anything.

Gertrude described a specific example with one of her football student-athletes that happened due in part to the relationship she had formed with this specific athlete:

I had one kid one day a few years ago who just looked down. Maybe he had a bad night's sleep or something, so I asked him if he was ok. He said "Yeah," then he went to the bathroom. I wrote up his sheet and everything, he came back, sat down and I asked him again, "Are you ok?" Then, he just started crying. I obviously did other things after that, but that's just an example of how conversations like that might arise. From there, if it's a situation like that, I took him into the conference room so we could be out of the way. I

took him in there and we just sat. He was a guy that I worked with a lot, so I felt comfortable asking him what was going on. One of the first things I said was, “Do you want to talk about it?”...I told him I would sit there all day long.

The situation arose and the conversation came up because of the relationship Gertrude and the athlete had previously established. Hailey proceeded to bring up multiple examples of these conversations and the strategies she uses to create an environment that is once again a safe space, but also helps foster these conversations. She said:

In terms of conversations, I’ve always been very big on person-first language and identifying how they like to carry a conversation. Are they the type that comes into treatment before practice and they don’t want to talk about anything at all, they just want to get their heat pack and head out to practice? Or, are they the ones who want me to ask them how their day was? Do they want me to ask about their mom and grandmother, or their child or sibling? Do they want me to ask about their academics? It’s just figuring out what it is they need and then trying to be consistent in that. Trying to figure out how we can grow together and build a bond. I’m really big on foundational relationships and so, how can we build a foundation that’s going to allow you to trust me? Because I can’t be with you 24/7, but I need you to feel comfortable being able to tell me anything that happens within that 24 hours a day. Whether it’s right then, or the next day when we see each other, but I need them to feel comfortable in doing that. I also believe in being transparent. If I’m not having a good day, then I’ll tell them, ‘You know I love you, but I’m having a crappy day and I’m just not here for it.’ And they’ll respect that, because you’re human.

She went on to describe how her strategy of having these conversations and building these relationships changes from athlete to athlete:

What changes sometimes is your approach to building that relationship. How I approach you may be different than how I approach Sony Michel from the deep southern part of Florida. One thing I enjoy and have always found common ground with my athletes on is shoes. I love shoes and when I tell you my shoe game is legit? That situation alone gives us common ground and gives us something to talk about. So, figuring out what that common ground is, with whomever you're talking to, regardless of the background is saying, "Where can we meet and find the commonality between the two of us, so we can build that relationship?"

It was clear that the conversations with subjects having nothing to do with sport help create a trust between athletes and their AT's. At times, as mentioned in constant presence, those relationships can form with those who may not be the athlete's primary AT as Daniel said, "I have athletes that are much more comfortable with one of my interns and that's fine." The formed relationships between AT's and student-athletes is what allows for the full integration of an institution's holistic care team to provide the proper care for the athletes they are serving.

Holistic Care Team

The holistic care team is the set of people and resources universities have in place for their student-athletes should any of those non-sport related conversations turn into a mental health related issue. These resources differ from institution to institution, with each participant describing how their place of work handles the mental care of its student-athletes. These processes begin from the second a student-athlete says that something is going on/is wrong,

through referral to either in-house or community-based services all the way through an athlete's return to competition. Daniel said:

I think with us, we have such a good mental health department. We have three full-time mental health professionals that work solely with our athletes. All three of their specialties are all very different. One has more of a social work background. One is more focused on sport performance/sport psychology, so more of a traditional sport psychology background. The third one is different from the other two.

This was just one example of many that came up from each participant about not only the people in place, but further, the strategies the institutions implemented in order to keep the care in-house, while normalizing its presence in their athletic departments.

Continuity of Care

Continuity of care is what the AT's described as their effort to keep as many aspects of mental care in-house as possible. This means hiring professionals from each corner of the mental wellness side of care, such as: social workers, counselors, psychiatrists, grief counselors, and at some institutions even more than this. This allows the entire care process to remain under the eyes of the university, while giving each professional the ability to build relationships and be a constant presence in much the same ways the AT's are able to do so. This in turn creates an environment where the student-athlete can form bonds with these people, so when things inevitably come up, they are able to trust the people they are talking to and eventually referred to.

Hailey described the multitude of people and resources they have at her institution and justified the ways in which they have modeled their care team. She said:

For eating disorders specifically, we have an eating disorder team and we have an off-campus therapist that works on that team who we refer out to for services. We do the same for substance abuse. We have a facility we use here in town for testing, hospitalizations and intensive outpatient services.

The other thing we separate is sport performance. We do that, because we want them to know the difference between a clinical mental health counselor and a sport psychologist and to keep the performance side separate, so they can keep their identity separate as well. We have a Licensed Professional Counselor and a Licensed Clinical Social Worker that are in-house and only work with our athletes. So, they see the full gamut of our mental health disorders and they're also substance abuse certified. That means when they're done seeing off-campus resources, off-campus resources may refer them back to our clinicians for what we call after care to help them through the recovery process. Then, our psychiatrist oversees every bit of that wheelhouse. We mirrored it like athletic training. We did it in that, if I'm an athletic trainer, if I'm doing rehab on your Achilles, there's still a physician that's signing off on that rehab and guiding it. So, we wanted to mimic the same thing with our behavioral medicine side.

She described how keeping everything in-house allows for the processes to be streamlined and similar no matter what type of care the athlete is receiving. Christine brought up the unique situation at her university where they are in a transition phase in terms of hiring a mental health coordinator, along with the fact that her and her colleagues are employed by the local hospital, not the athletic department. She said:

In the past, we've always had an in-house clinical psychologist and she was mostly on performance therapy and focused on performance-based things. She was also our

emergency contact should a student-athlete have suicidal thoughts, which I have had previously here. I have had athletes who have come to me and said these things and I've literally taken their hands and taken them directly to her office, dropped them off and waited. So, that was a huge blessing to have, but with that being said, she was overworked and overwhelmed. She was one person for over 300 athletes which is just asinine. My job is crazy, but that's just insane for the type of position she had. So, I think she was overworked, but she actually just took a new job and we're working on re-hiring someone. Right now, through the summer we don't really have many kids here, but we have a good relationship with our university counseling center. We have some contacts there, where if I had an athlete that was struggling, I would give them that info and they would talk to someone over there.

One other thing I should have mentioned that's unique about us is that we are employed by our university medical center, not our athletic department, but everything I do is for athletics. With that being said, we have a bunch of contacts at the medical center, which is great. So, I can just get a kids' medical records, send a note to a physician and ask if they have time to see one of our athletes. We also have a clinical psychiatrist that we keep in contact with and he does a lot of work and helps with medication management and stuff like that. He's great and we do send a lot of kids to him.

These are two different institutions that are both in the same conference, yet the type and scope of the resources they have at their disposal is vastly different. Gertrude spoke on her experience with attempting to add more to her university's mental health department following a dire situation that occurred with a track athlete at her institution. She said:

I am thankful to say that from that conversation, we have hired a full-time person in the athletic department who is a licensed social worker and she serves as our gateway. The job shifted as we were hiring it and it went out of my hands. I'm not saying it shouldn't have, I'm an athletic trainer, not a mental health professional, but it went into administration and when administration got a hold of it and got other opinions, it morphed into something a little bit different than what we were originally dreaming of. But, it's still great, because she's full-time, she creates programs for the teams, she does actual counseling and she is the gatekeeper for our other providers. We still have that psychiatrist, because we obviously have a lot of people who need to be prescribed medicine and we also have those two psychologists. She helps facilitate the buckets the athletes need to go in, depending on what their specific need/needs are. I am very thankful that we were able to do that.

This situation shows that the level of care her institution has now, didn't always exist, but now that it does, they are reaping the benefits of the care they are now able to provide.

Becca went on to further describe the benefits and advantages of having mental health professionals on staff and how it helped one of the programs at her institution through the early stages of the COVID-19 global pandemic. She said:

We just have to want these counselors to be present, and the coaches have to know that the counselors are the experts- the athletic trainers do the referral, but we are all on the same team. This means there are times where you're going to have to bring professionals in from the outside that may be different from who they're used to working with. But, the more you can incorporate the mental health professionals into your program, the better off you are. Our mental health professionals are doing mandated training sessions with

coaches as well. This is an annual training as well and once the counselors do their presentation; they too realize there's nothing weird about it. The coaches often realize that the counselors have a unique skill set, providing services like leadership training sessions within the group and team building activities that help create comradery. Once you get that far, you're good, because then the coaches actually like the counselor to travel with the team on the road. It's a great thing. A good case in point was when our men's basketball team was at March Madness. The counselor travelled with them and the team was told to leave the court during shoot-around. The NCAA had just cancelled the tournament as the world was in the early phases of the COVID-19 pandemic. Our counselor was there to help process the frustration and emotions in real time. The same counselor was there to help the team process the grief after one of our student-athletes was murdered. The counselor was already considered an extension of the team, so his guidance and support once again became clutch.

The ability for a university to have this continuity of care allows for an easier and more direct referral process from professional to professional, while providing the athletes with care from people they trust and are around every day.

Recognize, React, Refer

Recognize, react, refer is essentially the process AT's practice in order to recognize any and all mental health situations they may see, react to the things they are seeing, and referring the student-athletes to the best professional at the next level of care, no matter what or who that professional/level of care may be. Each institution had a different process for recognizing, reacting, and referring its student-athletes, but the general idea was very similar from participant to participant. Abner went into detail about how he reacts to the things he's seeing, along with the initial process his institution has in place for any and all mental health situations. He said:

Anyone in athletics that comes in contact with a student-athlete has the capability to make a referral. It's called (Our Way). It's a website that you can login to and either you can list your name, or do it anonymously and say "I would like behavioral medicine to check-in with Susie, because I noticed these things going on." Anyone in athletics can log on to the website and then all that does is trigger someone in behavioral medicine to reach out, "Hey, Susie, how's it going?" That sort of thing, it's very low level. Above that would be if a baseball player specifically or any student-athlete came to me directly and said, "I have X, Y, Z concerns and need to speak with behavioral medicine." I can reach out directly to behavioral medicine and sort of, again get them in contact with the people they need to be in contact with. Let's say a student-athlete walked in that was in crisis, our policy is that we keep them in vision, especially if they've voiced any self-harm issues or things like that. We keep them in our vision line, and then we have a specific athletic trainer that works specifically in behavioral medicine that we can reach out to. Then, that person helps us work through all of our options such as: does that need to be a 9-1-1 call? Does that need to be a "Hey, I will come to your office, keep that person there." "Hey, bring that person to behavioral medicine." Does that person need to do a telemedicine conference with a specific provider? They are kind of the gateway to get that person to the right person for treatment or whatever is going on.

This referral process shows that it doesn't at times even need to be an AT that recognizes a situation, reacts to it and refers from there. Hailey described this process at her school almost verbatim. She said:

One thing that we preach or promote here is Recognize, React, Refer. Recognize what you see. React to it in a calm manner, and then know the different people you can refer

them to... We try to push the same message over and over again in different ways.

Typically, it always goes back to recognize, react, refer. We just show different ways throughout the year and ask the same questions: “What are you recognizing?” “How are you reacting?” And, “Who are you referring to?”

While Hailey’s institution directly states the process, at other schools it may not be so up front and deliberately shared. Christine reiterated how the continuity of care in the past has helped her with this process in her own unique circumstances. She said:

I do think there’s a huge need and an advantage to having an in-house person. I’ve had athletes come to my office crying and saying they want to jump off a parking garage and I just took their hands, stayed with them and took them to her. So, there’s a huge need and an advantage to have that in athletics, because that’s the kind of care we can provide as athletic trainers, but we really need that resource in a crisis situation. We do have that. We have emergency personnel and we’re working to improve that aspect of our own department and I think we’re going to continue to get better.

For a number of the AT’s the process of recognizing and reacting to situations can occur from everyday conversations, because of the aforementioned relationships the ATs have already built with the athletes. Daniel said:

I also think the biggest piece of all of this is relationships. So, if you have a good relationship with an athlete then you know when something is wrong and you can tell, because you know what’s normal and what’s not normal for them. Then, you’re able to decipher that say Johnny came in today and he usually says ‘Hey!’ comes in and does his thing, but today he walked in, didn’t say anything to anyone and walked out. So, what’s

wrong with Johnny? You're in tune as long as you know what's normal for them and what's weird.

It all continues to feed on itself. The relationships are there, because they are around a lot, in turn those relationships allow for the recognition, reaction, and referral of any situation that may come up. That referral allows for the true chain of care to begin to take place.

Chain of Care

The chain of care is the actual concrete processes the schools have in place should a “regular” or emergency situation occur. This chain of care is once again slightly different in each athletic department depending on the fiscal resources available, along with the importance placed on mental health by each department. Frank discussed the referral process and chain of care at his institution by saying that there could be situations where he is never once involved. He said:

Here we have our own mental health and sport performance department. The athletes are welcome to reach out to them and they know how to reach out to them on their own.

Then, unless it does become a medical concern related to the issue, I may not even know.

...the way our referral process works, we have a really good and close working relationship with our mental health department. The three of them each have specific sports they are assigned to, so we have our primary contact should one of our athletes want to talk to someone. But we also communicate with all three of them, just depending on who would be a better counselor for the student-athletes needs.

Edward countered Frank, by discussing situations where he, as the AT is very much involved in both the initial interaction and the further referrals. He said:

...As far as chain of command goes, it's me, then it's our sport psychologist and if it's more in-depth—if there's more substance than just needing to talk things through and get

some techniques, I'll always talk to our assigned team physician about it. Then, any sort of medication the student-athlete may be on that involves our outside psychiatrist, they will work with them on that.

Basically, it goes from me to our sport psychologist on-campus, then they stop that conversation if I need to contact our psychiatrist while keeping everyone in the loop as confidentially as possible.

Gertrude discussed the unique chain of care at her institution, where availability at times is based on the time of day and who may or may not be available. She also described their emergency action plan in loose detail.

(Our social worker) is one of our main contact people. Football is a little bit different, obviously we're always different, so we work a lot with her, but we also work a lot with our Director of Wellness, our psychiatrist, and it all depends on the hour of the day, what the need is, etc. We know our psychiatrist may be making rounds at the hospital or she may be doing something else, so those are the routes for us with football. We also have a paired down emergency action plan when it comes to mental health, so people know directly who to call and who not to call. You don't call the coach, you call the sport administrator, you call us, you call the director of sport medicine and that sort of thing.

Daniel used an example to lay out the procedure for him and his colleagues. He said:

(In a mental health situation), we would find the athletic trainer for their sport, evaluate them and decide whether or not this is something that needs to be evaluated more by professionals who deal with this kind of thing. If it is, then we refer them to our director of mental health. She does an evaluation and quick interview with them and then she refers on depending on her findings from that evaluation. That can lead to referral to a

counselor that we have and use, we also have a sport psychologist that is available to every athlete. Let's just say we have an athlete that says, 'Hey, I'm struggling with doing x, y, and z in the pool, it's just a mental barrier for me and I just need someone to talk to.' All of our coaches can refer them to us and let us know that they want their athlete to see this sport psych doctor. There's two ways to see this sport psych doctor. You can get a referral from the coaches to us, or we can refer them to our director of mental health and she can refer them on to them. That really just works with how things are paid for. If the coach refers them, they pay for it and if we refer them, we pay for it. We also have a psychiatrist that we use in the event that there's medication that needs to be referred and that kind of thing.

While each of these four examples are slightly different, the basic premise is the same: help get the athlete to the right people for the right type of care and treatment, no matter what the situation may be. Whether it's a performance issue, or a mental care issue, the process is the same. In making the process the same for each level of care, the care the institutions provide begins to become normalized among the athletes and the athletic department as a whole. The participants also mentioned that while they do have resources at their disposal, at times it is clear that even the professionals they *do* have are over worked and the need for more manpower is evident.

Normalization of Care

Normalization of care is how each athletic department best utilizes its resources. It's one thing to have a multitude of facilities and professionals at one's disposal, but how the institution and sport medicine departments go about normalizing the presence of these individuals is

another. Each participant described the different ways in which their respective institution normalized this care and presence of every employed mental health professional.

Gertrude answered the question of if the social worker they hired is better able to complete their own job, because they have a better grasp of what the student-athletes are going through, thus making the athletes more comfortable around them. She said, “I don’t think they go see her any more than before, because she understands what they’re going through, but they might go to her more, because she is more visible than anyone we’ve ever had before.” She described not necessarily her ability, but her presence. Her presence is step one in normalizing the care and activity. As mentioned before, if this social worker is constantly around, relationships are better able to form, a level of trust is created between the athlete and the social worker, making them better equipped to provide the proper care. Daniel reiterated this point at his own institution when he said:

We are now at the point where we are placing such an emphasis on it, that we have a massive section in our football athletic training room that is solely responsible for mental health care, which means they are taking it seriously and they are making strides to make sure that student-athletes have the resources available to them.

Edward brought up this normal presence of these professionals at his university but took it a step farther by discussing his own practices with his athletes in treating each mental health diagnosis or situation just like any other injury. He said:

I always try to put it into terms of, ‘You’re running to second base and you rolled your ankle. It hurts you and you can’t do what you want to do, but you’re not coming to rehab and the training room? Then, it’s not going to get better.’ It’s the same thing with anxiety.

‘Ok, you know you’re anxious. You know you’re having trouble focusing on whatever it is. What are you doing for it?’ Nothing? ‘Ok, then you’re not really helping yourself.’

This aspect of normalizing care seemed to be its own subtheme as multiple participants discussed treating any mental health diagnosis as if it were any other injury that needed to be cared for. Abner described their similar protocol and program for this normalization of care, highlighting the shift from a medical model to a behavioral medicine model when he said:

I want to say five years ago we put in a behavioral medicine program. It’s housed within sports medicine, but it is its completely own department. What it has done is take the stigma out of mental health that other people talk about. Our athletes are used to talking about behavioral medicine and mental health. They’re really almost at the point now where they’ll talk to each other about it. They’ll talk to me about it and they’ll just openly talk about different things they’ve had going on. They know resources are available, so they’re a lot more open to coming out to ask questions.

We chose to move it to a little bit more of an athletic behavioral medicine model, because we want to treat behavioral medicine in the same way as if you have an ankle sprain, or a concussion, or an ACL tear. It’s just something you need to rehab. It’s an issue or an injury if you want to say it that way, and we just want to give you the resources you need to rehab and that’s it.

Hailey similarly said:

We’re constantly trying to promote (it all), so it’s routine. It’s normal and it’s easy as opposed to it being, ‘Now you all have deemed me unstable and I’m going to see *this* person.’ No, it’s not that you’re going to see *this* person. It’s, ‘Oh, I have an appointment with Charlotte today,’ or, ‘I have an appointment with Brad,’ and that’s ok to say.

Christine went on to say that one of the biggest pieces to normalizing the care, goes back to the foundational idea of these professionals being a constant presence around the athletes they work with. She said:

...Showing up to practice, games and traveling with the team and being a part of the team and having that mental health person really work alongside the AT, rather than us having to constantly reach out. I think that position has a very unique opportunity to provide without people asking—just being more physically available. Being present and showing the student-athletes that you're there and a part of the team is something that would make a huge difference.

This once again shows how each theme blends into the next. At the end of the day it's each member of a school's holistic care team being able to be a constant presence and build relationships with the athletes that will allow for each facet of a school's mental care protocol to move forward without a hitch. What Christine began discussing is where the next theme lies. It is not often within an ATs ability or scope of practice to be able to provide the proper mental health care for their student-athletes. That is why the constant presence and normalization of the holistic care team as mentioned by the participants is so important, because it allows the ATs to complete the job they were hired to do.

Scope of Practice

Scope of practice is what the participants identified as the bounds of an AT's role in the mental care of the student-athletes they work with each day. Multiple participants stated that they aren't mental health professionals, or even mental health care providers, but that they are athletic trainers whose job is to help the athletes reach the next stage or level of care. They described this

role as not necessarily knowing how to treat mental health but knowing the full extent of the resources that are available to them. Gertrude said:

At the end of the day, I'm not diagnosing someone with bi-polar disorder. I just need to know when I need to call somebody else. We need to spend less time on the signs and symptoms of these mental health issues, because I'm not going to school to be a mental health professional. I am going to school to be an athletic trainer. Yes, I need to know those things, but in reality, I need to know where to access these things in case I have a question about them. The next most important thing I need to know is what my resources are. I always tell the students in the class I teach that no matter what setting they're in, they need to know who they are going to call, what their community resources are, what their school resources are, and what the policies are at the place they're working. For an athletic trainer those things are more important than the bare bones signs and symptoms. It's more about knowing where we function in mental health care. When is referral needed? How do we refer? Where do we refer? Those things are going to be different for everyone, so it's about teaching those basic ways and strategies of how to find those things...In our education we need to train people of how to get those answers, not what those answers are.

It was a long answer that truly lays out what role AT's believe they play in the mental health care of student-athletes. Abner continued this theme when he said:

I am absolutely not a mental health expert. I am comfortable helping my student-athlete get to the next care level. I certainly would never counsel a student-athlete or tell them any recommendations. I literally just want to get them to the next level of care and the

appropriate level of care wherever that needs to be. Then, on the back end, once they've received care, I want to help them re-enter the sport.

While this is the role AT's see for themselves throughout the care process, the actual things that keep AT's from carrying out a large portion of this care are seen as the limitations they face within their profession.

Professional Limitations

Professional limitations are what keep AT's from being able to properly care for the mental health of the student-athletes they work with. The first and most prime example is the lack of mental health education that goes with majoring in athletic training as both an undergraduate and graduate student. Frank described his experience in college and how he continually tries to stay within the scope of his job as an AT. He said:

I mean, beyond the basic psychology class that was required for my athletic training undergrad degree, there wasn't anything that was specific to mental health. I took a regular psychology class and a sport psych class that was a bit more performance focused. It looked at disorders a little bit and other things to be concerned with as well. I think every athletic trainer should have some sort of mental health first-aid, or some sort of credential to go along with it to have something a bit more practical. I also think it's important to not overstep what our training is. I think some people try to take on too much and more than what they're capable of. For me, I just try to keep it as much within my scope as I can in terms of making those referrals, dotting those I's and crossing those T's as far as liability and making sure that not only is the student-athlete safe, but you're not missing anything in terms of major concerns.

Christine looked at this discussion from a bit of different lens. She said:

Believe it or not, my general psychology class has helped me a lot and I think it's something I pull from a lot more than I would like to admit. With that being said I would love it if we had some sort of general counseling course at my school. I most of the time end up being this counselor of sorts, because sometimes a kid just wants to come in and talk and hear from me. I've taken some continuing education courses and stuff like that but looking back I wish I had just had a general counseling class. It would better help me deal with someone who may not have general anxiety to the point where they need to see a therapist, but they still just need someone to talk to.

Edward added on to both points by siding in between Christine and Frank:

In college I took a sport psychology class and then we had what we called seminar classes. I took an athletic training seminar and a pretty large block of our second or third seminar covered mental health and psychology. To be honest with you, a lot of that was based off the really severe cases of how you're going to handle someone who is trying to end their own life or are self-injuring themselves or claiming they want to injure other people. Those things are really important to know, but they're not necessarily something you see every day.

He continued by discussing a class he took as part of continuing education. He said:

We had a class called 'Dismantling the Suicidal Athlete,' which was a course that looked at helping us to pick up on the fact that it's not the kid that's talking that's at the most risk, it's the kid that's not talking about it. It talked about different ways to pick up on different struggles people may be going through, stuff they may be saying, and even stuff they may be doing.

These are things the AT's are discussing long after their own collegiate experience is done. Hailey even said that most undergraduate programs across the country "(teach) you nothing in regard to the mental health side of the ball."

The other aspect of the limitations AT's face is not only the education they receive as undergraduate and graduate students, but also the training or at times the lack thereof at the institutions they work for. Some schools have better training programs than others. Daniel discussed this limitation at his own institution when he said:

We didn't have much training in terms of mental health, but we did meet to discuss the avenue for how to carry out your evaluation to decide if it's something you can handle as an athletic trainer, or if it requires a referral. So, we went through the chain of command in terms of where to go, where to send and who to refer to, but there wasn't any formal training in terms of telling us what to do in various situations.

Christine described her institutions "training" as a meeting that happens twice a year when she said:

As far as mental health, we do have a meeting twice a year. We have it once in the summer and once in January with all of our physicians, AT's, sport administrators, mental health professionals, and we have some fellows come as well. It's a big, big deal, so we have that along with emergency care training and other things along those lines. As far as actual mental health training and providing us with that info, it doesn't really happen. I will say that we do go over what resources we have available to provide athletes, so it's not like we're left in the dark, but it would also be difficult for a new staff member who is anxious to come in and get with their team, because we don't really have a training course for them. I don't know if a lot of schools have that. I think it's great and

is probably very needed. We don't really have it, but we do have protocols in place of what to do and who to go to. Then, in that meeting, if specific questions do come up, there are people on staff we're allowed to have detailed conversations with.

Frank described a similar type of training regimen at his institution:

Here, within our department we just have policies in place of how we do referrals, who needs to be aware of certain things and what things need to be maintained private unless the student-athlete signs an actual release. It's not a formal training, it's really just for us to read the policy and ask any questions that may come up to our senior staff members.

To counter these points, Hailey said:

Earlier today I did an on-boarding session with our interns. I started it off by just asking them what they knew about the mental wellness side. I asked them about what they had seen and what they had been told. Then, after that we defined their level of understanding. We defined the need when it comes to statistically that one-in-five students in the collegiate realm suffer from some sort of mental illness and recognize that within our department of athletics, we're spot-on with that. We're actually right above that at 32 percent. Then, I went through our behavioral medicine guidance packet that defines key terms, talks about what the stressors look like, and how to have conversations once you identify the need.

Becca promoted her institution's training regime when she said:

I think we do a pretty good job here. In our curriculum, our mental health counselors do a few lectures related to identification of mental health struggles and illness. It takes more than just taking a sport psychology class. Psychology class isn't going to cover it. So, having people that are boots on the ground managing these types of chronic stressors that

student-athletes experience and communicating and teaching basic skills to our student-athletic trainers as they're coming through is important. Having that same training for the staff and the graduate assistants is important too, because the student athletic trainers look to them and model how they respond to things.

The training and education needed is important, again not necessarily to help the AT's to treat student-athletes, but to allow them to be better equipped to mitigate some situations before they even happen or to get their athletes to the next level of care using the resources at their disposal.

Daniel looked at this from both sides of the coin. He said:

I think training is always the best, because I feel like if you can help the athletic trainers that are assigned to a specific sport to mitigate a situation before it has to get to that person, the I think you're looking at less stress for one person and to disperse that to each sport's athletic trainer...On the flip of that, we don't actually say this, but how much of a toll does this take on us as athletic trainers? Because, you're not just bringing your emotions to the situation, but you're holding on and addressing their emotions, which can really take a toll on a person depending on how serious it is.

AT's are ATs. They are not licensed mental health professionals and while they are often times in the best physical position to help and care for student-athletes, it is apparent that given their professional limitations and the scope of the positions they are in, it is not necessarily training or education on how to treat mental health, but training and education on what resources they have at their disposal to use and refer to.

Chapter V: Discussion

The purpose of this study was to discover where athletic trainers lie in the mental health care of SEC student-athletes. The experiences and roles of each participant differed and cannot be generalized among all NCAA Division I ATs. However, the discovered themes can help create a greater depth of understanding into what goes into the role of an AT at the Division I level, along with the necessary resources that are required to provide adequate care.

Connections

Each identifiable theme provides connections to previous literature that can be used to strengthen the literature on the experiences of both collegiate student-athletes and collegiate ATs. The findings can then be applied to those in positions of power and change inside collegiate athletic departments to help strengthen and support the needs of ATs and their respective athletes. The findings of this study provide a rationale for the implementation of a greater number of resources to assist current collegiate ATs and to assist with the mental health care of student-athletes.

First Line of Defense

First line of defense was a prominent theme throughout the study. It was the ATs way of expressing that they believe they will be the first individuals to know of or find out about any mental health problem or potential diagnosis with one of their student-athletes because of the amount of time they spend with them. This time spent with the athletes derives itself from the pure number of ATs most collegiate athletic departments hire for their athletic training rooms. According to Mazerolle (2010), most athletic departments have seven full-time staff members to cover anywhere from 20-28 sports. While this isn't generally the case in the SEC, the average

number of ATs per school in the SEC still does not fit in with the NATA guidelines and best practices (Courson, et. al, 2014).

The time these ATs spend with their athletes doesn't just extend through the normal in-season and out-of-season periods during the school year. In today's collegiate athletic climate, most athletic programs will require their student-athletes to stay on campus through the summer months. Mazzerole et. al (2016) stated:

It has already been reported that an "offseason" no longer exists, particularly as athletic training staffs at NCAA Division I schools are understaffed at ATs often balance multiple sport assignments (i.e. soccer in the Fall and lacrosse in the spring). This can increase the demands placed upon the AT. Role overload and hours worked are a sources of conflict in athletic training because ATs often have limited control over their work schedules and working greater than 40-hour work weeks creates problems with work-life balance (pp. 175-176).

This means that even though the large amounts of time ATs spend with their athletes allows them to eventually build foundational relationships and help them get to the next level of mental health care should they need it, the negative effects on the AT could oftentimes outweigh the positives.

Building Relationships

The second theme that presented itself was building relationships. Building relationships was what the participants stated was the result of the amount of time they spend with their athletes. They said that building lasting relationships was important to them, because it allowed them to provide the proper care to the athletes, while as an undertone the relationships made their

jobs as ATs more enjoyable, because they are able to get to know the athletes not just as athletes, but as people.

This ability to know their athletes as more than just athletes as the participants stated with regularity allows them to better care for the athletes in all aspects of their time as athletes, whether it's rehabs, daily treatment, or helping them get to a specialist for a specific injury. As multiple participants stated, knowing their athletes allows them to know what kind of care they need, even when the athlete may not explicitly state it. Bejar et. al (2019), stated in a study on how ATs impact the basic psychological needs of student-athletes during injury rehabilitation that ATs are often the main point of contact and the person student-athletes rely on the most when going through injury rehabilitation (p. 245). This statement, according to the study participants will bleed into both physical and mental rehabilitation.

Holistic Care Team

The holistic care team is the set of both human and other intangible resources at the disposal of the studies participants when it comes to the mental health care of their student-athletes. These resources differ from school to school, much like the pure number of ATs available to each athletic department. A number of the participants referred to their director of mental wellness or health positions. They discussed the presence of departments and offices known as “behavioral medicine.” In these behavioral medicine offices, there tended to be a mix of social workers, sport psychologists, psychiatrists and behavioral therapists. The participants also discussed the number of individuals involved in the care of a student-athlete’s mental health, should they face a negative situation or a mental health diagnosis.

For an institution’s care team to function properly it—much like the ATs—needs to be a constant presence around the athletes and the professionals that have been hired need to focus

much of their time and energy on building lasting relationships with the athletes they are around every day. These things help reduce the effects of the stigma that tends to surround the perception and treatment of mental health diagnoses. According to Corrigan (2004) the stigma of mental health derives itself from four social-cognitive processes: cues, stereotypes, prejudice, and discrimination (p. 615). It is these four processes that will inhibit a student-athletes help-seeking behavior for non-physical ailments. However, when the care and the professionals who are able to provide said care are constantly around as noted by Abner and Hailey specifically that stigma slowly becomes removed. Because, not only are the employees talking about it, but so are the athletes. It becomes normal behavior and normal interactions, thus creating a situation where the members of the aforementioned holistic care team are able to give the care they have been hired to provide.

Scope of Practice

The scope of practice was the final theme that rose to the surface during the coding process. The AT scope of practice described the limitations faced by the participants in the mental health care of student-athletes, because they were trained and educated to be athletic trainers, not mental health professionals. So, while they may have built strong relationships with their student-athletes, are around them for large periods of time, and have mental health resources at their disposal, there are still limitations to what they are able to do and provide for their athletes.

Burnout and poor work-life balance are already prevalent in the AT profession (Eberman et al., 2019; Eason et al., 2017; Mazerolle et al., 2010). These alone derive themselves from the prescribed roles of what being an AT is, which is a medical provider, not a mental health counselor. Eason, et. al (2018) completed a study that examined the uniqueness of the AT

profession in relation to the profession of being a mental health care counselor. The goal of the study was to evaluate the Professional Identity and Values Scale (PIVS) among professionals in the AT population (Eason, et. al, 2018). PIVS is an instrument that evaluates the attitudes, beliefs, and practices of professional counselors. This study used this scale to learn of the similarities and differences between ATs and the counselors that many Division I institutions employ.

Eason, et.al discovered that while ATs and mental health counselors have similar paths to the professional world and discovering their professional identities, the difference in education requirements, in-the-field hour differences, and supervisory requirements makes the professions wildly different in terms of scope of care (Eason, et. al, 2018). This discovery is what creates the delta in scope of practice for ATs in comparison to mental health counselors. Each profession is trained to do what they do, not the roles of the other.

Limitations

The main limitation of this study lies in its limited sample. Each participant works at a similar sized university with similar athletic budgets, all of whom are in the same conference. While the study provided an in-depth look into the resources that are available at those schools, it failed to look at how the resources and care differs from conference to conference at the division I level. A study of this size would do a better job of painting the full picture of what is currently available, what more needs to be done and what the role of an AT looks like at schools across the country, not just in the Southeastern Conference. While many of the participants discussed their past experiences, because those experiences were no longer current, it was difficult to even consider examining that information.

A second limitation were the effects of the COVID-19 global pandemic. It made setting up and carrying out the interviews more challenging. During numerous interviews there were problems with connectivity and audio quality through the Zoom platform. This in turn led to audio files that were difficult to transcribe, meaning that portions of interviews weren't able to be documented, because of these negative outcomes. The pandemic also may have prevented a number of potential participants from being able to participate, thus creating a smaller and slightly less diverse sample of participants and meaning that the study reached saturation much quicker than it would under more "normal" global conditions.

It can also be recognized that this study focused solely on the experiences of athletic trainers in the Southeastern Conference in the NCAA's Football Bowl Subdivision of college athletics. This means that the number of resources the ATs interviewed in this study have at their disposal is much different than those at schools in other conferences in division I, and especially those who are at schools at the division II and division III levels, and other collegiate athletic organizations outside of the NCAA. This perspective creates multiple limitations and recommendations for potential future research.

Recommendations for Future Research

The first recommendation for future research derives itself from the limitation of the study: pull from a larger sample. ATs are an integral part of every collegiate athletic department at all three divisions of the NCAA and at schools who participate in organizations outside of the NCAA. While the participants provided in-depth and worthwhile information regarding their own experiences, there was a lack of perspective in seeing what the experience of an AT would be at a university or institution with fewer mental health care resources and fewer athletic training resources as a whole.

A second recommendation would be to use unstructured interviews as opposed to semi-structured interviews. At times during this study, in an attempt to keep the interview on-track with the interview guide, the researcher would be required to abruptly end or cut off a participants' point to ask a predetermined question. Using an unstructured interview method could allow for these potential conversations to fully develop and provide the full picture of the ATs experiences currently, at any past institutions they may have worked at, and the full scope of the care they feel they should provide in their roles as ATs.

Practical Implications

The results of this study apply to the various stakeholders who have a vested interest in its results. For ATs, the results of this study and others provide evidence that helps to confirm the role of ATs not as a mental health caregiver, but as an AT. The day-to-day experience of an AT is one that is multidimensional (Mazerolle et al., 2016), that requires them to constantly be flexible in meeting the needs of their student-athletes. With this comes the potential to have to reach outside their professional limitations, resulting in compromised care for the student-athlete and a compromised life for the AT that could include burnout and/or poor family-life balance (Mazerolle et al., 2010).

For student-athletes, this study shows that the proper care they need is available and if implemented properly can provide a number of benefits as detailed by Becca and Hailey throughout the results section. For administrators implementing the proper care for athletes and assistance to ATs not only improves the experience of the ATs, but also allows the institution to provide the proper resources to allow its student-athletes to compete in accordance with the NCAA's mission statement, which states: "Our purpose is to govern competition in a fair, safe, equitable and sportsmanlike manner, and to integrate intercollegiate athletics into higher

education so that the educational experience of the student-athlete is paramount” (NCAA, n.d.). Doing so would allow for the student-athletes to obtain care that not only allows them to compete at a high level on the field, but holds the potential for them to compete at a higher level in the classroom in their pursuit of an education, both of which are highlighted in the NCAA’s mission statement.

To reiterate, the definition of health is one that encompasses all aspects of an individuals’ life, not just the absence of disease or sickness. This means that a person’s mental well-being often coincides with their physical well-being. When it comes to a student-athlete between the ages of 18 and 22, this couldn’t be more paramount. How they are able to handle stress in the classroom, their personal lives, and in all aspects of their off the playing surface experience will have a direct correlation to how they will compete and perform on the playing surface.

Thus, for administrators, the more resources available and the more normalized mental health care is, then conceivably the more wins the institutions programs will experience, greater levels of success will follow and in theory higher level athletes will continue to follow. As that cycle progresses the more resources these departments will have at their disposal and the more opportunities, they will be able to provide in the long term.

Conclusion

The purpose of this study was to evaluate the role of ATs in the mental health care of NCAA division I student-athletes. The goal was achieved, despite the limitations of COVID-19. Prior research discussed the uniqueness of the student-athlete population, the experience of collegiate ATs, and the multiple models of care collegiate athletic departments have implemented. The selected participants discussed the nature of their jobs on a daily basis, the roles they play in any situation regarding a student-athletes mental health, how they respond to

those situations, look into the resources they have at their disposal, along with what they would like to see change in the collegiate athletic training landscape.

The participants discussed the amount of time they spend with their athletes on a daily basis, how this time allows them to build strong and lasting relationships with said athletes, and how both of these factors assist ATs in caring for the athletes' mental health. Throughout the interview process, the researcher felt as if the conversations flowed naturally and that the participants carried out what they believed the role of an AT was, not because it was in their job description, but because they cared for and cared about their athletes. Multiple participants discussed their relationships and athletes as more than athletes and discussed their jobs as more than taping ankles and filling coolers.

Along with this, the participants also opened up about the true prevalence of mental health diagnoses among student-athletes and the real need for more resources to not only help the athletes, but to assist them to allow them to complete the jobs they were trained and educated to carry out. The interviews showcased the need not only for in-house professionals, but a removal of expectation from the ATs to always be that "first line of defense" for their athletes. Providing an NCAA mandated mental health department in every collegiate athletic department would help with these negative aspects of being an AT. While, not every school would be able to afford in-house professionals, at least having a mandated set of community resources could help create a stigma free environment, while providing the student-athletes *and* ATs the support and help they need.

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Appendix

Appendix A: IRB Approval



THE UNIVERSITY OF
TENNESSEE
KNOXVILLE

April 22, 2020

Dom Palumbo,
UTK - Athletics-Media Relations

Re: UTK IRB-20-05769-XP

Study Title: The Role of Athletic Trainers in the Mental Care of NCAA Student-Athletes

Dear Dom Palumbo:

The UTK Institutional Review Board (IRB) reviewed your application for **revision** of your previously approved project, referenced above.

The IRB determined that your application is eligible for **expedited** review under 45 CFR 46.110(b)(2). The following revisions were approved as complying with proper consideration of the rights and welfare of human subjects and the regulatory requirements for the protection of human subjects:

- Change in-person interviews to either phone or Zoom interviews
- Application version 1.2
- Participant Follow Up E-mail - Version 1.1
- Participant E-mail FINAL - Version 1.1

Approval does not alter the expiration date of this project, which is 04/08/2021.

In the event that subjects are to be recruited using solicitation materials, such as brochures, posters, web-based advertisements, etc., these materials must receive prior approval of the IRB. Any revisions in the approved application must also be submitted to and approved by the IRB prior to implementation. In addition, you are responsible for reporting any unanticipated serious adverse events or other problems involving risks to subjects or others in the manner required by the local IRB policy.

Institutional Review Board | Office of Research & Engagement
1534 White Avenue - Knoxville, TN 37996-1529
865-974-7697 | 865-974-7400 fax | irb@utk.edu

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Finally, **re-approval** of your project is required by the IRB in accord with the conditions specified above. You may not continue the research study beyond the time or other limits specified unless you obtain prior written approval of the IRB.

Sincerely,

Colleen P. Gilrane

Colleen P. Gilrane, Ph.D.
Chair

Institutional Review Board | Office of Research & Engagement
1534 White Avenue Knoxville, TN 37996-1529
865-974-7697 865-974-7400 fax irb.utk.edu

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Appendix B: Tables

Table 1 *Participant Demographics*

Participant	Sport Responsibilities
Abner	Baseball
Becca	Football
Christine	M/W Tennis and XC and Track & Field
Daniel	Swimming & Diving
Edward	Softball
Frank	M/W Tennis
Gertrude	Football
Hailey	No Primary Sport Responsibilities

Table 2 *Themes and Subthemes*

Theme	Subthemes	Definition
First Line of Defense	<ol style="list-style-type: none"> 1. Direct Contact 2. Safe Space 	<p>What the participants referred to ATs as if and when a student-athlete is struggling with their mental health. They will be the first to know, because of how much time they spend with the athletes, along with the general environment they create in their training rooms.</p>
Building Relationships	<ol style="list-style-type: none"> 1. Constant Presence 2. Non-Sport Conversations 	<p>What the ATs said was the most important part of their jobs in terms of student-athlete mental health care. These relationships allow them to be more in-tune with what the athletes need, while also making it easier to guide the athlete through the chain of care many schools have in place, should they be struggling.</p>
Holistic Care Team	<ol style="list-style-type: none"> 1. Recognize, React, Refer 2. Chain of Care 3. Normalization of Care 	<p>The holistic care team is the general term for the resources the ATs have at their disposal at their respective institutions. These resources are there to guide the student-athlete from one step to the next to improve and treat their situation. These resources also help to normalize the existence of mental health care in the collegiate setting.</p>
Scope of Practice	<ol style="list-style-type: none"> 1. Professional Limitations 	<p>The limitations faced by ATs when it comes to mental health care seeing that ATs were trained to be ATs, not mental health care professionals.</p>

Appendix C: Recruiting Materials

C.1 Initial Recruitment E-Mail

Hello:

My name is Dom Palumbo and I am currently a graduate student at the University of Tennessee Knoxville in the Sport Management Master's Program. As I enter my second year at UT, I am in the process of completing my Master's Thesis under the supervision of Dr. Rob Hardin. The topic of my thesis is looking at where Division I college athletic trainers lie on the chain of care when a student-athlete is struggling with their mental health.

I am e-mailing you because you are an athletic trainer at an SEC institution, and I was wondering if you would be interested in taking some time to do a phone interview with me to help me with my study. The interview should last between 30 minutes to one hour.

The interview can take place either over the phone or through Zoom depending on your preferences and available resources.

The purpose of this study is to find out your experiences with student-athlete mental health, what actions you take during the care process, and what resources your institution provides to its student-athletes.

This study will hopefully lead to insight into the athletic trainer's role in student-athlete care and contextualize mental health best practices in athletic departments.

I want to thank you in advance for taking the time to read my e-mail, and I hope you will be interested and willing to assist me in my efforts.

Sincerely,

Dom Palumbo



Dom Palumbo

Graduate Assistant – Media Relations (MBB, Feature Content)

University of Tennessee

1551 Lake Loudoun Blvd.

Knoxville, TN 37996

Email: dpalumb1@vols.utk.edu

Cell: 703-967-0776

Office: 865-974-5270

C.2 Follow-Up Recruitment E-Mail

Hello:

My name is Dom Palumbo and I am currently a graduate student at the University of Tennessee Knoxville in the Sport Management Master's Program. I recently reached out to you regarding potential participation in my study for my Master's Thesis under the supervision of Dr. Rob Hardin.

The topic of my thesis is looking at where Division I college athletic trainers lie on the chain of care when a student-athlete is struggling with their mental health.

I am contacting you because you are an athletic trainer at an SEC institution, and I was wondering if you would be interested in taking some time to do a phone interview with me to help me with my study. The interview should last between 30 minutes to one hour.

The phone call will take place either over the phone or through Zoom given your specific preferences or resources.

The purpose of this study is to find out your experiences with student-athlete mental health, what actions you take during the care process, and what resources your institution provides to its student-athletes.

This study will hopefully lead to insight into the athletic trainer's role in student-athlete care and contextualize mental health best practices in athletic departments.

I want to thank you in advance for taking the time to read my e-mail, and I hope you will consider taking the time to assist me in my efforts.

Sincerely,

Dom Palumbo



Dom Palumbo
Graduate Assistant – Media Relations (MBB, Feature Content)
University of Tennessee
1551 Lake Loudoun Blvd.
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Email: dpalumb1@vols.utk.edu

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Appendix D: Informed Consent Form

Consent for Research Participation

Research Study Title: The Role of Athletic Trainers in the Mental Care of NCAA Division I Student-Athletes.

Researcher(s): Dom Palumbo, University of Tennessee, Knoxville
Robin Hardin, University of Tennessee, Knoxville
Lauren Beasley, University of Tennessee, Knoxville

Why am I being asked to be in this research study?

We are asking you to be in this research study because you are registered athletic trainer working in a Division I athletic department.

What is this research study about?

The purpose of the research study is to gain a deeper understanding of the emerging role of athletic trainers in athletic departments as part of a larger effort to address well-being of student-athletes.

Who is conducting this research study?

This study is being conducted by researchers at the University of Tennessee, Knoxville.

How long will I be in the research study?

If you agree to be in the study, your participation will last for approximately 2 hours: a one-hour phone interview and review of your interview transcript for accuracy.

What will happen if I say “Yes, I want to be in this research study”?

If you agree to be in this study, we will ask you to complete an approximately one-hour phone interview that will be recorded. You will be asked questions about your career path, your role and job description, and your experiences as an athletic trainer in a collegiate athletic department. After the recording is transcribed, you will be asked to review your interview to ensure accuracy.

What if I don’t want to answer a question for fear of being identified (Deductive Disclosure)?

Answering any questions that are asked by a member of the research team is once again completely up to you. All of your personal and identifiable information will be held confidential and all demographic information will be withheld from the final study manuscript. If you at anytime feel uncomfortable answering a question you have every right to not answer it.

What happens if I say “No, I do not want to be in this research study”?

Being in this study is up to you. You can say no now or leave the study later. Either way, your decision won’t affect your employment at your institution.

What happens if I say “Yes” but change my mind later?

Even if you decide to be in the study now, you can change your mind and stop at any time.

If you decide to stop before the study is completed, contact either Dom Palumbo at dpalumb1@vols.utk.edu and, (703) 967-0776 or her advisor, Dr. Robin Hardin at robh@utk.edu and (865) 974-7697. If you withdraw from the study at any point, your data will be destroyed.

Are there any possible risks to me?

There are minimal risks involved with participating in this study. Participants may recall experiences in past that were negative in nature, and questions that are personal in nature may cause discomfort. There is a risk of breaching confidentiality of students in participants' answers, however the researchers will not ask about individuals, and participants can decline to answer any question. All participants' names and school affiliations will remain confidential to decrease the risk loss of confidentiality. However, due to the number of athletic trainers employed in athletic departments, there is a risk of identification. Participants will be assigned a pseudonym, and that will be used for any direct quotation used.

Are there any benefits to being in this research study?

You may not directly benefit from your participation in this research study. The primary benefit of this study is increased awareness and deeper understanding of the role of athletic trainers within the athletic context. Societal benefits include a deeper understanding of the role of athletic trainers in addressing the mental care needs of college athletes.

Who can see or use the information collected for this research study?

We will protect the confidentiality of your information by keeping data stored securely and only made available to persons conducting the study unless participants specifically give permission in writing to do otherwise. If information from this study is published or presented at scientific meetings, your name and other personal information will not be used.

We will make every effort to prevent anyone who is not on the research team from knowing that you gave us information or what information came from you. Although it is unlikely, there are times when others may need to see the information we collect about you. These include:

- People at the University of Tennessee, Knoxville who oversee research to make sure it is conducted properly.
- Government agencies (such as the Office for Human Research Protections in the U.S. Department of Health and Human Services), and others responsible for watching over the safety, effectiveness, and conduct of the research.
- If a law or court requires us to share the information, we would have to follow that law or final court ruling.

What will happen to my information after this study is over?

We will not keep your information to use for future research. Your name and other information that can directly identify you will be deleted from your research data collected as part of the study. We will not share your research data with other researchers.

What else do I need to know?

Due to the small number of participants in this study, it is possible that someone could identify you based on the information we collected from you. If we learn about any new information that may change your mind about being in the study, we will tell you. If that happens, you may be

asked to sign a new consent form. You can choose not to share information in the interview that you believe may help identify you.

Who can answer my questions about this research study?

If you have questions or concerns about this study, or have experienced a research related problem or injury, contact the researchers, either Dom Palumbo at dpalumb1@vols.utk.edu and (703) 967-0776 or her advisor, Dr. Robin Hardin at robh@utk.edu and (865) 974-7697.

For questions or concerns about your rights or to speak with someone other than the research team about the study, please contact:

Institutional Review Board
The University of Tennessee, Knoxville
1534 White Avenue
Blount Hall, Room 408
Knoxville, TN 37996-1529
Phone: 865-974-7697
Email: utkirb@utk.edu

STATEMENT OF CONSENT

I have read this form and the research study has been explained to me. I have been given the chance to ask questions and my questions have been answered. If I have more questions, I have been told who to contact. By signing this document, I am agreeing to be in this study. I will receive a copy of this document after I sign it.

Name of Adult Participant	Signature of Adult Participant	Date
---------------------------	--------------------------------	------

Researcher Signature (to be completed at time of informed consent)

I have explained the study to the participant and answered all of his/her questions. I believe that he/she understands the information described in this consent form and freely consents to be in the study.

Name of Research Team Member	Signature of Research Team Member	Date
------------------------------	-----------------------------------	------

Appendix E: Interview Guide

1. What is your name?
 - a. title?
 - b. institution?
 - c. sport that you work for?
2. How many years have you been in the position you're in at said school and with said sport?
 - a. What was your career path?
3. How many hours would you say you are with your sports student-athletes in an average week?
 - a. Both in season and out of season.
4. Generally, how do you begin your sessions with your student-athletes?
 - a. If an athlete ever endorses mental health issues, under what context do they come up?
 - b. How do you generally respond?
5. When a student-athlete approaches you with a mental health issue what is your immediate response?
 - a. Does this response change, depending on the athlete and/or situation?
6. What do you believe the role of an AT is when caring for the mental health of a student-athlete?
 - a. (If referral is brought up) Who do you generally refer your student-athletes to?
7. Does your institution have a care team or a chain of care process when a student-athlete is struggling with something like this?
 - a. If so, how does it work?
8. Does your institution have any training programs to help walk you through what to do in a situation like this?
9. When an athlete comes to you, or shares that they are struggling, where do your own ethics lie?
 - a. Do you feel compelled to act and help, or do you follow the prescribed protocol?
 - b. Does it change based on the athlete you're working with?
10. How does the background of the student-athlete affect how you would handle this type of situation?
 - a. Does the sport you're working with have an effect on your actions as well?
 - i. If so, are the differences noticeable?
11. There was the situation at Washington State with QB Tyler Helinski, that story made major headlines, how did your department react to his death?
 - a. Were any new processes put in place?
 - b. Did you complete any sort of training?
 - c. Or did nothing change?
12. Has your department taken any action since the passing of the new NCAA legislation regarding mental health care for student-athletes?

- a. If so, were there any new policies or legislations implemented by your department?
 - b. If yes, how have they been implemented, followed and enforced?
13. Did you take any relevant courses or complete any relevant coursework during your undergraduate or even graduate studies that could/would prepare you for how to handle a situation like this?
14. If you could implement one thing in your athletic department, whether it's in regard to the mental care of student-athletes, making your job easier or anything in between, what would it be and why?

Vita

Dom Palumbo is currently a graduate student at the University of Tennessee, Knoxville. He currently works as a graduate assistant in Tennessee's media relations office, where he acts as the primary sports information contact for UT's women's golf and men's tennis programs, while also assisting as a secondary contact for men's basketball and acting as the staff feature writer.

Dom is originally from Manassas, Virginia, where he lived his entire childhood and early adult years. As an undergraduate student, Dom attended James Madison University, where he graduated in May of 2019 with a Degree in Sport and Recreation Management, with a triple minor in Business, Sport Communication and Writing, Rhetoric and Technical Communication (WRTC). His professional interests include research, feature writing and sports public relations.