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**Title:** Experiences of Athletic Trainers in Tactical Athlete Settings When Managing Mental Health Conditions

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1 **Title:** Experiences of Athletic Trainers in Tactical Athlete Settings When Managing Mental  
2 Health Conditions

3 **Context:** Research demonstrates that job demands impair tactical athletes' mental health. Mental  
4 health stigma in this population and limited resources prevent individuals from receiving care.  
5 Athletic trainers (ATs) are often the first, and sometimes only, contact for mental health  
6 concerns. Previous literature indicates that ATs desire more psychosocial training and  
7 experience.

8 **Objective:** To investigate ATs' preparedness and experiences managing patients with mental  
9 health conditions in the tactical athlete setting.

10 **Design:** Consensual qualitative research.

11 **Setting:** One-on-one, semistructured interview.

12 **Patient or Other Participants:** 15 athletic trainers [males=7, females=8; age=36±10 years;  
13 experience in tactical athlete setting=4 years (range = 6 months-20 years); military=12, law  
14 enforcement=2; fire service=1].

15 **Main Outcome Measures:** Interviews followed a 9-question protocol focused on job setting  
16 preparation, mental health training, and perceived role managing mental health concerns.  
17 Interviews were audio recorded and transcribed verbatim. A 3-person coding team convened for  
18 data analysis using the consensual qualitative research tradition. Credibility and trustworthiness  
19 were established using a stability check, member checking, and multi-analyst triangulation.

20 **Results:** Four domains emerged surrounding ATs mental health management experiences in  
21 tactical athletes: 1) population norms, 2) provider preparation, 3) provider context, and 4)  
22 structure of job responsibilities. Most ATs felt their educational experiences lacked  
23 comprehensive mental health training. Some participants described formal employer resources

24 that were optional or mandatory for their job, while others engaged in self-education to feel  
25 prepared for this setting. Participants shared that unfamiliar experiences, such as divorce and  
26 deployment, influenced their context as providers. Most ATs had no policy related to mental  
27 healthcare and referral, indicating it was outside their responsibilities or were unsure of role  
28 delineation.

29 **Conclusion:** ATs working with tactical athletes suggested additional mental health education  
30 and training are necessary. The ATs also indicated improvement is needed in job structure  
31 regarding role delineation and establishment of policies regarding behavioral health.

32 **Abstract Word Count:** 300 words

33 **Key Words:** military, qualitative, behavioral health

34 **Key Points:**

- 35 1. Athletic trainers lack the educational background to evaluate, manage, and refer patients  
36 for mental health concerns in the tactical athlete setting.
- 37 2. Athletic trainers working in tactical athlete settings do not have policies to help manage  
38 patients with mental health conditions.
- 39 3. Athletic trainers are unsure of their role related to mental health management and the  
40 resources available to assist patients with these concerns.

Online First

## 41 INTRODUCTION

42 Mental wellbeing is a multifaceted state with many definitions depending on the point of  
43 reference. The American Psychological Association defines mental health as “*a state of mind*  
44 *characterized by emotional well-being, good behavioral adjustment, relative freedom from*  
45 *anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope*  
46 *with the ordinary demands and stresses of life.*”<sup>1</sup> However, many organizations are rethinking  
47 the definition including the European Psychiatric Association which in 2015 proposed a new  
48 definition for mental health as “*a dynamic state of internal equilibrium which enables*  
49 *individuals to use their abilities in harmony with universal values of society. Basic cognitive and*  
50 *social skills; ability to recognize, express and modulate one's own emotions, as well as*  
51 *empathize with others; flexibility and ability to cope with adverse life events and function in*  
52 *social roles; and harmonious relationship between body and mind represent important*  
53 *components of mental health which contribute, to varying degrees, to the state of internal*  
54 *equilibrium.*”<sup>2</sup> As mentioned in the two provided definitions, mental health can be viewed  
55 positively and/or negatively and is influenced by social, environmental, and personal factors.  
56 Since these factors effect individuals differently, it is critical to evaluate mental health effects  
57 amongst various populations.

58 Previous research has identified that shift work (e.g. bartending, chauffeuring,  
59 construction, tactical positions) with hours outside the typical 7am-6pm period drastically  
60 increases rates of poor mental health and mental health disorders (70.6% increase) compared to  
61 non-shift workers.<sup>3</sup> A tactical athlete (TA) is an individual employed in military, law  
62 enforcement, firefighting, and rescue occupation necessitating physical preparedness for high  
63 occupational demands as well as tactical and technical abilities in order to face both

64 environmental and human risks.<sup>4</sup> These individuals participate in rigorous physical training and  
65 extreme occupational demands, (e.g. two-mile run tests, standing power throws, sprint-drag-  
66 carry, aerobic interval tests, and stair climbs) utilizing equipment that is often heavy, with  
67 ladders weighing 55-130 pounds, hoses creating forces ranging 80-110 pounds, and load  
68 carriages (e.g. ruck sacks) carrying up to 100 pounds of supplies.<sup>5-7</sup> These physical demands  
69 place great stress on the body which may result in prolific injury rates and can impact the  
70 individual's mental health.<sup>8</sup> According to a study examining recovery in rescuers after a twenty-  
71 four hour work shift, significant measures of recovery were recorded after forty-eight to seventy-  
72 two hours of rest.<sup>9</sup> However, long working hours and abnormal shifts may impact the ability of  
73 the individual to get adequate rest from the physical and psychological stresses of work.<sup>3,9</sup>

74 Previous research indicates that 70% of military members develop a mental health  
75 disorder (e.g. depression, anxiety, post-traumatic stress disorder [PTSD]) following injury.<sup>10</sup>  
76 Apart from physical demands, TAs also experience tragic events throughout their careers that  
77 can further affect their psychological wellbeing. In a study investigating prevalence of traumatic  
78 occurrences in volunteer and career firefighters, 96% of participants had experienced a traumatic  
79 or critical event on the job, of which the most commonly reported were scenes with: multiple  
80 critical injuries (81%), direct exposure to blood and/or body fluids (80%), corpse removals  
81 (77%), protection by police required (67%), a seriously injured victim trapped for long durations  
82 (64%).<sup>8</sup> Furthermore, 34% of career firefighters reported experiencing a co-worker's death on  
83 the job,<sup>8</sup> and firefighters reported that continual traumatic exposures took a psychological toll  
84 that impacted their mental health, personal wellbeing, job operation, and family life.<sup>11</sup> Additional  
85 literature has demonstrated that ambulance services tend to be more mentally demanding than  
86 firefighting services, and that the density of incidents to which the firefighters responds can

87 influence the psychological cost it takes on individuals.<sup>9,12</sup> Moreover, in 2019, mental health  
88 conditions (MHCs), regardless of specific diagnoses, was named the second leading diagnoses  
89 among military training instructors (10.4%).<sup>13</sup> However, mental health and associated healthcare  
90 is continually stigmatized in TA settings therefore numerous barriers to receiving care have been  
91 reported: stereotypes, non-supportive leadership, judgement from peers, disclosures not  
92 remaining confidentiality, and adverse career impacts.<sup>14-16</sup> While the military has implemented  
93 intentional efforts to investigate and mitigate mental health stigma, obstacles still exist that need  
94 to be overcome relative to resources and experience with providers.<sup>17</sup> In a study examining  
95 mental healthcare barriers in firefighters and paramedics, all participants reported a need for  
96 improved mental health literacy.<sup>14</sup> This indicates that healthcare providers must be able to  
97 recognize, refer, and educate individuals regarding MHCs within TA settings.

98 Research examining facilitators and barriers to collegiate athletes' access to and  
99 interaction with mental health services identified that ATs did not have structured protocols for  
100 referring athletes to these services.<sup>18</sup> Moreover, some athletic departments did not have resources  
101 necessary to provide mental healthcare and some individuals providing these services may be  
102 inadequately educated to do so.<sup>18</sup> Additionally, newly certified ATs reported being inadequately  
103 prepared for psychosocial job aspects.<sup>19</sup> A recent study of ATs with current or previous  
104 experience in military settings identified that most were skeptical if their athletic training  
105 programs (ATP) prepared them to work in this setting.<sup>20</sup> Research has demonstrated that TAs are  
106 at risk of developing MHCs from occupational stresses, but has not investigated training,  
107 education, and comprehension of psychological interventions by ATs to effectively manage  
108 MHCs in TA settings. Therefore, the purpose of this study was to investigate ATs' preparedness  
109 and experiences managing patients with MHCs in the TA setting.

## 110 **METHODS**

### 111 **Study Design**

112 A phenomenological approach was used to perform this qualitative research study. The  
113 study investigated perceptions, beliefs, and experiences of ATs working in the TA setting  
114 regarding their abilities to identify, refer, and/or help patients with MHCs to assess AT  
115 preparedness to manage such conditions. This research study was approved by the XXX  
116 Institutional Review Board.

### 117 **Participants**

118 Participants for this study were individuals who were currently working as an AT in a  
119 TA job setting.<sup>20</sup> In total, 25 ATs expressed interest in the study. Data saturation was achieved  
120 after interviews were completed with 15 participants. Demographic data including participant  
121 pseudonyms are provided in Table 1.

### 122 **Interview Protocol**

123 As there are no existing protocols addressing the objectives of this study, a custom semi-  
124 structured interview protocol comprised of closed- and open-ended questions was created.<sup>20</sup> The  
125 protocol was initially developed by two of the researchers and sent to three authors for revision  
126 and external review. The semi-structured interview approach permitted data to be flexible and  
127 allow for follow-up questions to be presented to better capture the experiences and beliefs of the  
128 participants.<sup>21</sup> The participants were asked five demographic questions to collect background  
129 information followed by nine interview questions regarding their experiences and perceptions  
130 pertaining to management of MHCs in the TA setting. Table 2 demonstrates the complete  
131 interview protocol used for this research study.<sup>21</sup>

### 132 **Procedures**

133 Participants were recruited via e-mail. The e-mails of ATs actively working in the TA  
134 setting were obtained through the National Athletic Trainers' Association (NATA) research  
135 database. An initial e-mail was sent to all potential candidates (n = 274) with a description of the  
136 purpose of the research study and a link to an online survey where they could provide their  
137 contact information if interested. The primary investigator (PI) sent a follow-up e-mail to all who  
138 provided contact information to schedule their one-on-one interview via teleconferencing (Zoom  
139 Video Communications, San Jose, CA).

140 Data for the study was collected through semi-structured online interviews with the PI  
141 and participants following the custom interview protocol. Participants provided consent prior to  
142 beginning the interview.<sup>21</sup> Interviews were conducted at the participants' convenience and lasted  
143 20-30 minutes.<sup>22</sup> Each interview was audio-only recorded, transcribed verbatim using artificial  
144 intelligence transcription (Otter.ai, Los Altos, CA), and verified by the PI.<sup>22</sup> Each interview  
145 transcript was sent to the corresponding participant to review and confirm accuracy through a  
146 process called member checking.<sup>22</sup>

#### 147 **Data Analysis**

148 The research study utilized the consensual qualitative research (CQR) tradition, a  
149 practical and established process for analyzing participant responses in qualitative research.<sup>23</sup> As  
150 part of the CQR construct, three researchers (AAA, BBB, EEE) comprised the coding team to  
151 minimize biases.<sup>23</sup> Data analysis underwent four phases illustrated in Figure 1.<sup>23</sup> To identify  
152 initial domains, the coding team initiated the phase 1 process by individually reviewing 4  
153 participant interview transcripts to select key core ideas and then group like ideas together into  
154 domains to establish the preliminary codebook.<sup>23</sup> Next, the coding team read 2 previous  
155 transcripts from phase 1 and 2 new transcripts to confirm the consensus codebook during phase



156 2. In phase 3 of the process, the coding team then applied the codebook (domains and categories)  
157 to all transcripts using multi-analyst triangulation by which each person coded 5 transcripts  
158 individually and then swapped with the other members for an internal review process. After  
159 independent reviews were conducted of each other's coding, the research team met to discuss  
160 disagreements to reach consensus on these discrepancies. An AT on the research team (CCC),  
161 but not on the coding team, acted as the external auditor to confirm the work of the coding team  
162 by reviewing 3 transcripts. Finally, cross-analysis occurred to group like quotes from the  
163 categories together followed by calculating a frequency count for each category. For frequency  
164 counts, a category was considered general if it was reported in all or all but one (n=14)  
165 transcripts, typical when reported in 8-13 transcripts, variant when coded in 4-7 transcripts, or  
166 rare when reported in 3 or fewer transcripts.<sup>23</sup> Trustworthiness of the data collected was assured  
167 through verbatim transcription of interviews, transcript confirmation by participants, and  
168 multiple-researcher triangulation.

## 169 **RESULTS**

170 Four domains emerged through data analysis regarding ATs' perceptions, experiences,  
171 and preparedness related to MHCs among patients after the interviews: 1) population norms, 2)  
172 provider preparation, 3) provide context, and 4) structure of job. Categories emerged to support  
173 the domains in illustrating the participants' thoughts and feelings more clearly from their  
174 interview responses. Table 3 presents the frequency counts of each category which identified we  
175 had a homogenous sample of participants with generally or typically similar experiences. Table 4  
176 provides supplemental quotes for each category that emerged from each domain.

### 177 **Population Norms**

178 Participants described cultural and organizational aspects of TA settings related to mental  
179 health. Two categories emerged in support of the domain: (1) stigma, and (2) mental health  
180 concerns.

### 181 *Stigma*

182 Twelve ATs reported stigma within the TA setting that affects mental health and mental  
183 healthcare among patients. Participants explained that TAs tend to be less open to discussing and  
184 seeking care for MHCs due to perceptions of weakness and judgement. Additionally, participants  
185 described concerns patients have regarding how disclosure of psychological struggles may affect  
186 their careers. Elizabeth illustrated stigma within this setting explaining, “[TAs] also seem less  
187 likely to seek care and associate it with weakness.” Fang shared their feelings surrounding  
188 societal views on mental health, “It is just a societal dogma. ...I think there is still a dark,  
189 condescending view if you need mental health assistance. ...That is on society as a whole.” Pat  
190 addressed mental health within TAs:

191 *I think that overall, at least in the Marine Corps, it used to be seen and is still seen as a*  
192 *weakness. For example, we are moving our resource team to a place where the command*  
193 *deck does not see them so Marines who think there is a stigma do not miss their*  
194 *appointments because they think they are going to be judged.*

### 195 *Mental Health Concerns*

196 Participants expressed that cultural factors, including work hours and job demands,  
197 impact patients’ mental health. Additionally, ATs described outdated concepts of handling  
198 MHCs within the population, expressing that TAs try to be mentally tough and hide  
199 psychological concerns. Participants felt mental health and associated care should be brought  
200 into a more common and positive light within TA settings. Bobby mentioned:

201 *As much as the Armed Forces has put resources towards dealing with [mental health], it*  
202 *honestly has not been enough, because these are systemic cultural problems that require*  
203 *more than just a class or a certification or a behavioral health referral.*

204 Mikey expressed career-related fears within the setting stating:

205 *[TAs] have a paranoia about their careers – it is very competitive, and they can very*  
206 *easily lose their spot on the squadron. When I first started, I had a few people say I could*  
207 *ruin their lives with anything that I do or say or write down.*

208

209 Brooke depicted pandemic effects on mental health in TAs noting:

210 *The thing with TAs and mental health is that you are always going to face it in some way.*  
211 *COVID-19 was a huge struggle for TAs. The stresses... of not knowing - are they*  
212 *deploying? If not, when are they coming home? Are they not going home? When are they*  
213 *going to get to see their families again because they have to quarantine? So, mental*  
214 *health was a very big issue this last year within our population. It is something that needs*  
215 *to be brought to more normalcy. I think ATs are going to be great assets in the coming*  
216 *years for helping with mental health because... we are the melting pot [in healthcare].*

## 217 **Provider Preparation**

218 Participants explained their educational experiences including optional sessions and  
219 elective courses. Participants described resources available at their current TA job site and  
220 proposed ideas for future professional development. Four categories emerged to support the  
221 domain: (1) educational experiences, (2) formal employer resources, (3) self-education, and (4)  
222 suggested professional development.

### 223 *Educational Experiences*

224 Three participants felt they had in-depth education related to mental health from their  
225 educational programs, which was mostly obtained in post-professional programs. The other  
226 twelve ATs felt their mental health education was minimal to none, being overall brief and  
227 general in nature. Drew added to this by stating, “we did not have mental health training back  
228 then [20 years ago].” Pat illustrated their mental health education: “I got a little bit with my  
229 master’s, but I would not say that it was extensive. I do not have a ton of mental health training.”

230 Bambi described the mental health training throughout their ATPs:

231 *In my professional education there was not much. And I would say the same about my*  
232 *master's program. My doctorate program is what provided me the most educational*  
233 *experience with mental health. We had coursework, clinical experiences, and simulations*  
234 *where mental health was involved. So, I think that is where I really got my feet wet in*  
235 *dealing with mental health and being educated on how to even go about asking those*  
236 *questions to a patient or how to incorporate holistic healthcare into my evaluative*  
237 *process – it definitely came from my Doctor of Athletic Training program.*

### 238 *Formal Employer Resources*

239 Participants reported varying levels of psychological resources available at their clinical  
240 sites which ranged from no knowledge of available resources to few accessible as the AT.  
241 Additionally, 66% of participants did not have any formal on-the-job education or training  
242 relative to MHCs, resources accessible for patients and staff, or referral for such conditions.

243 Lily outlined their mental health resources accessible stating, “We have a clinical  
244 psychologist working within our program, which I do a lot of referrals to, even if there are no red  
245 flags per se.” Carrie depicts their lack of resources regarding a patient case explaining:

246 *I realized that I did not have a whole lot of resources listed or have a good understanding*  
247 *of what those referral points looked like. I did not feel like I knew the resources that were*  
248 *available, who to send them to, and did not have really any preparation to have a good*  
249 *idea of how to help.*

250  
251 Grace described different trainings at various job sites:

252  
253 *In the Army, we were given quarterly training in mental health and factors to recognize.*  
254 *Working for the Air Force, it was a lot heavier - we had to do 2-3 classes every quarter in*  
255 *recognition of [mental health]. And in the Navy, they brought in a mental health*  
256 *professional who sat down twice a year so you could understand why certain individuals*  
257 *would not be allowed into Special Warfare based on their mentality issue that may have*  
258 *popped up.*

### 259 *Self-Education*

260 Most participants expressed they had invested in self-education prior to or during their  
261 employment in the TA setting. Several opted to make connections with providers at their clinical  
262 site independently, while others invested in additional trainings, conferences, and literature

263 regarding MHCs. Brooke reflected: “Everything that I chose to do is optional.” Mateo described  
264 their self-education to prepare for transitioning into this setting acknowledging:

265  
266 *There is no specific preparation and there is going to be a variety... depending on what*  
267 *assets are available locally - whether it is embedded assets or relying on base or medical*  
268 *group assets. So, learning what is available. A lot of that was self-directed and just*  
269 *working through situations as they present.*  
270

271 Bambi depicted their experiences with self-education:

272  
273 *Once I got here, I went to the wellness unit. I did that on my own - it was not a required*  
274 *element. I also have taken the Behavioral Health First Aid course for young adults. I did*  
275 *that before I was in the TA setting. So, I did get some information there that was outside*  
276 *of school and work. But it was not specific to TAs.*  
277

278 *Suggested Professional Development*

279 Fourteen participants felt additional psychological training should be integrated into  
280 ATPs to better prepare future ATs, specifically to reduce stigma and how to approach patients  
281 with MHCs. Theod construed the importance of additional training expressing, “I think any type  
282 of training geared towards helping clinicians understand mental health would be good to just feel  
283 comfortable having open conversations with your patient.” Grace further described the need for  
284 additional training and education:

285 *No matter what setting you are in, [it is important] being able to recognize when*  
286 *someone needs help or when someone is in trouble and how to approach that person as a*  
287 *medical provider. I have been out of school for 15 years, but the training that I received*  
288 *did not prepare me for people that were uncomfortable being touched because of*  
289 *traumatic experiences or mental disorders and it certainly did not prepare me for the*  
290 *types of experiences among the patients that I work with [in the TA setting].*  
291

292  
293 Danni discussed suggestions for future professional development within ATPs:

294  
295 *We are usually the first people that have a trusting relationship with [the TA] so they do*  
296 *come to us. I think that [mental health education] should be a core piece of the*  
297 *curriculum because we need to be able to recognize it. But we should also have a basic*

298 *understanding for encompassing all the different settings and how it can affect*  
299 *individuals and what we should be looking for.*

300  
301 **Provider Context**

302 Participants noted differences between traditional and TA settings, and how unique  
303 features of the TA setting impacted them as clinicians. Two categories developed in support of  
304 this domain: 1) unfamiliar experiences, and 2) comparative competency.

305 *Unfamiliar Experiences*

306 Thirteen participants (86%) described unfamiliar experiences that impact their clinical  
307 context in the TA setting, many (n = 9) reporting those experiences related to the population's  
308 culture, job demands, and deployments. Drew detailed the uniqueness of the TA setting  
309 recognizing they may find themselves, "dealing with a person who is trained and has access to a  
310 firearm." Theod spoke about TAs' career and family aspects mentioning, "The biggest part is  
311 understanding their work stresses, a lot of that being their schedule, as well as understanding  
312 their family dynamic." Elizabeth described the load of psychological concerns they see in TAs:

313 *Since I see a much higher number of soldiers compared to collegiate athletes, the volume*  
314 *I have seen with mental health in the setting took some getting used to. I was not*  
315 *prepared to have as many soldiers as I did have suicidal thoughts or anxiety issues.*

316 *Comparative Competency*

317 Participants had varying responses when comparing their experiences in the TA setting to  
318 the traditional setting. Bobby recognized that TA settings contrast the traditional settings in  
319 schedule acknowledging:

320 *It is like being on a sports team that they do not have an offseason - there is always the*  
321 *chance that they [will] need to go. So, there is this attitude of 'yes, we will get you...help.*  
322 *However, the mission comes first. So, if you [TA] get pulled on mission, then put those*

323 *issues in your back pocket and we will come around to those when there is time.’ And*  
324 *sometimes that can result in their care being delayed for years.*

325 Grace voiced distinctions between traditional athletes and TAs:

326 *There is a very big difference in... active duty versus the students coming straight from*  
327 *Basic Military Training (BMT). Active duty has seen combat, have seen team members*  
328 *die or been on missions with the utmost of secrecy. I honestly think the biggest difference*  
329 *is recognizing that a TA is always putting their life on the line, every time they deploy. In*  
330 *athletics, it is the mentality of focus and drive and doing the best that you can and being*  
331 *the best that you can and winning.*

332 Lily spoke to differing demographics stating, “I do not think there is a huge difference with  
333 athletes versus TAs per se, but definitely within age groups.”

### 334 **Structure of Job**

335 Participants shared experiences working with other healthcare providers, job duties  
336 related to MHCs, and policies associated with mental health referral and care. Three categories  
337 emerged in support of this domain: 1) lack of policy, 2) role delineation, and 3) collaboration.

#### 338 *Lack of Policy*

339 One participant reported having established policies regarding recognition, management,  
340 and referral for MHCs. It appears there was overall uncertainty or conflict surrounding the AT’s  
341 role in mental healthcare management within TA settings. When asked their role in managing a  
342 patient with psychological concerns, Mikey responded, “I have to be honest, I do not really  
343 know.” Many ATs, when asked about policies in place, responded similarly to Andrew who  
344 stated, “I do not have a written policy.” Carrie shared their thoughts on barriers related to  
345 policies:

346 *As far as it being an actual policy, the likelihood of that is low because of the contract*  
347 *standpoint. So, a lot of the processes that I create are not reviewed through the Air*  
348 *Force. It is more of a personal policy as a contractor.*

#### 349 *Role Delineation*

350 Fourteen participants discussed role delineation within the TA setting. Several specified  
351 that mental health management is not within the AT scope of practice, clearly identifying the  
352 need for mental health resources to utilize. Bobby spoke to role delineation regarding mental  
353 health stating, “As an AT, it is not within my scope to make that diagnosis or to be the primary  
354 caretaker for that.” Fang mentioned difficulty caring for patients with MHCs explaining, “[It]  
355 just depends on if the patient got orders to see the person. I do not have the ability to set up  
356 orders to see a mental health provider.” Andrew discussed practicing within AT training voicing:

357 *I think the biggest thing is we are not mental health specialists. My [spouse] is a mental*  
358 *health clinician that works with kids suffering from anxiety disorders. I do not think we*  
359 *should do that. We find them the appropriate means to help themselves, which I think*  
360 *would be to refer to a mental health clinician that has been trained years to be qualified*  
361 *and help that person through that situation.*

#### 362 Collaboration

363 Eleven participants (73%) discussed collaboration within the tactical setting, in which  
364 three subcategories developed: 1) formal, 2) informal, and 3) limited. Elizabeth voiced thoughts  
365 regarding collaboration within the TA setting:

366 *I think that if procedures were put in place so communication is improved between the*  
367 *provider and AT, we can help the TAs succeed a little bit more quickly than they are with*  
368 *the current practices in place. Because when there is not communication between the*  
369 *healthcare providers, within reason to the rehabilitation process, I think it makes it hard*  
370 *to manage certain cases.*

371 Bambi added:

372 *We have the wellness unit, so I have utilized that resource numerous times. I have*  
373 *handled numerous patients at different phases of their mental health. Sometimes I am the*  
374 *first person having that conversation that they are showing signs and symptoms of*  
375 *potential mental health impairments or struggles that they need to maybe have addressed*  
376 *if they would like to. Having that initial conversation and being the first person in their*  
377 *life who has told them that is extremely challenging, and so we are networking and using*  
378 *collaboration with the wellness unit.*  
379



380 Overall, the participants had varied experiences when collaborating with others. Danni  
381 described the minimal and unclear resources at their clinical site by stating, “If I did not seek it  
382 out as a medical provider, I do not know that I would have known what resources are available to  
383 the athletes.” The lack of formal job structure for interprofessional collaboration was a concern  
384 for participants.

## 385 **DISCUSSION**

386 By occupational nature, ATs’ frequent interactions with patients facilitate strong  
387 relationships, placing them in an optimal position to recognize signs and symptoms of MHCs  
388 and expedite referrals and/or psychosocial interventions for desirable patient outcomes.<sup>24-29</sup>  
389 However, our findings indicate that many ATs employed in the TA setting do not feel confident  
390 in their ability to recognize, refer, and manage patients with MHCs. This is similar to other  
391 research which indicated that, while over 90% of ATs believe facilitating referral for mental  
392 healthcare and recognizing signs and symptoms of MHCs is part of their occupational duties,  
393 they struggled to select proper care strategies for patients experiencing psychological distress.<sup>30</sup>  
394 Participants demonstrated several concerns specific to TA settings that influence the mental  
395 healthcare patients receive. Specifically, four domains were identified related to mental  
396 healthcare within the TA setting: 1) population norms, 2) provider preparation, 3) provider  
397 context, and 4) structure of job.

### 398 **Population Norms**

399 Mental health is a popular topic globally.<sup>31</sup> The abnormal work hours, career  
400 requirements, and occupational experiences put TAs at increased risk of developing  
401 MHCs.<sup>3,8,10,11,13</sup> Our research found that cultural stigma surrounding mental health impacted  
402 patients’ willingness to acknowledge and discuss psychological concerns. Previous research

403 exhibited similar results and barriers to receiving mental healthcare among TAs: perceived  
404 ridicule from peers, lack of appropriate resources, associations with weakness, and concerns of  
405 negative career impacts.<sup>14-16,32</sup> Stigma among TAs may relate to limited mental health literacy  
406 within the population, which research has indicated plays an important role in patients pursuing  
407 mental healthcare.<sup>33</sup> The United States military has taken initiative through research and  
408 interventions to reduce mental health stigma and improve access to and use of mental health  
409 resources. Their research demonstrated that a reduction in mental health stigma occurred when  
410 individuals believed that the organization supported and cared for their wellbeing.<sup>17</sup>  
411 Additionally, increased perceptions of organizational support were associated with a forecast of  
412 lessened PTSD at all phases of deployment (prior to, during, and after). Mental health self-  
413 stigmatization was significantly minimized when individuals participated in an intervention  
414 program, which typically targeted cognitive methods to educate individuals how to gain  
415 increased control of their emotions.<sup>17</sup> While these efforts and interventions have shown promise  
416 for lessening mental health stigma within the military, further research is necessary to identify  
417 beneficial program structures and policies that ATs can implement.

418 Our participants expressed unique aspects of TA populations that influence behavioral  
419 health, including elevated stress levels, low quality sleep, and lack of mental health resources,  
420 which coincides with previous literature.<sup>14,16</sup> Furthermore, preceding literature has indicated  
421 collegiate athletics demands impacted athletes' mental health as compared to nonathletes.<sup>18</sup>  
422 Additionally, one participant mentioned the COVID-19 pandemic further impacted their  
423 patients' mental health. It is important to note that most of our participants had been employed in  
424 the TA setting for less than five years, many for only 1-2 years. Therefore, these ATs'  
425 experiences managing MHCs may have been influenced by COVID-19 and may not reflect

426 typical experiences within the population. However, the pandemic may have shed additional  
427 light in healthcare gaps and cultural issues within the TA setting, as it has increased the  
428 prevalence of MHCs among adults revealing where issues in pursuing and receiving care lie.<sup>34</sup>

### 429 **Preparation and Context of the Provider**

430 While the Commission on Accreditation of Athletic Training Education (CAATE)  
431 dictates that psychology is required in ATPs, it does not define the amount or detail this  
432 education must reach resulting in disparities among AT preparedness to address psychological  
433 concerns.<sup>30</sup> Although most participants had completed a Master's degree, they indicated varying  
434 levels of training related to mental health recognition, care, and referral. As was true in a  
435 previous studies, our participants overall noted they had vague or little psychological education  
436 in their ATP and therefore, felt inadequately prepared to manage MHCs.<sup>19,20,28-30</sup> This suggests  
437 education specific to identification of concerning behavior, referral processes, and incorporating  
438 psychosocial strategies into clinical practice is critical to implement into ATPs to facilitate  
439 holistic and exemplary care for patients struggling with MHCs.

440 As previously mentioned, the CAATE standards do not clearly define psychological  
441 education within ATPs which leaves individual programs to dictate the extent of education  
442 students receive.<sup>30</sup> Our participants noted completing non-mandated training to improve their  
443 competency and confidence managing patients with MHCs, comparable to prior literature that  
444 suggests ATs may not obtain proficiency in psychological recognition, psychosocial  
445 interventions, and appropriate referral in their ATPs.<sup>18-20,28,29</sup> Yet, research has demonstrated that  
446 ATs express desire to gain thorough education pertaining to MHCs and management, many of  
447 whom elect self-education to do so.<sup>29</sup>

448 Psychological conditions are widely prevalent in various populations which indicates the  
449 need for healthcare providers to understand signs, management, and referral processes for  
450 patients with such conditions.<sup>3,10,11,13,18</sup> The educational outcomes received from a single  
451 psychology course and occasional continuing education programs within athletic training are not  
452 sufficient for clinicians to be adequately disciplined to implement psychosocial interventions into  
453 patient care.<sup>29</sup> Our participants reinforced this mentioning a need for additional mental health  
454 training, provided formally in ATPs and pursued individually, to effectively integrate  
455 psychosocial interventions into clinical practice. A potential solution to improving psychosocial  
456 education within ATPs is to facilitate collaboration between the primary organizational systems  
457 of athletic training and psychology. We recommend that the CAATE and the American  
458 Psychological Association Commission on Accreditation partner to allow ATs to become  
459 proficient and confident in psychosocial strategies during either their professional or residency  
460 program. This will in return allow for networking with psychology students who can become  
461 multi-disciplinary assets in future patient care for TAs.<sup>29</sup>

#### 462 **Structure of Job Responsibilities**

463 Literature has demonstrated that education, early detection, and appropriate referral are  
464 critical in caring for patients exhibiting psychological concerns.<sup>35</sup> It is further noted that  
465 structured protocols regarding the management of MHCs is necessary to not only improve  
466 recognition and referral of such concerns, but also improve overall patient care.<sup>35</sup> As was true in  
467 a preceding study, our results demonstrated that very few ATs employed in TA settings have  
468 these structured policies in place to assist in orchestrating appropriate and successful care for  
469 patients with MHCs.<sup>18</sup> This may be in part due to many athletic training jobs in tactical athlete  
470 settings, specifically within the military, being offered through contracts with independent

471 companies instead of directly from the site of employment, which may limit the athletic trainer's  
472 scope of practice and responsibilities.<sup>20</sup> Traditional settings, like colleges/universities, typically  
473 report having a written mental health policy in place.<sup>28</sup> Though college athletics deems updating  
474 policies regularly as best practice, many institutions do not consistently review these documents,  
475 implying that athletic training overall needs organizational improvement for mental health  
476 management.<sup>28</sup> This implies the lack of policies or outdated policies can inhibit effective patient  
477 care. System-based factors also complicate collaboration between mental health providers and  
478 ATs, as providers tend to use different documentation programs to record care provided to the  
479 same patients.<sup>27</sup> This suggests that interprofessional collaboration may be limited in this setting  
480 and advancements should be made.

481 Various methods exist, including electronic, and can be used as resources for MHCs  
482 allowing access at work, school, or home, which could be particularly useful in TA settings.<sup>27,36</sup>  
483 Our participants mentioned minimal resources available at their clinical site to care for and  
484 support patients with MHCs, and felt they needed to seek out resources or find options outside of  
485 their employer to utilize for patients in need of specialty services. Research shows that ATs  
486 believe the availability of easily accessible mental health providers is a critical factor for  
487 providing better care to patients.<sup>27</sup> Moreover, the most successful work place interventions to  
488 improve employee mental health were those aiming to reduce harassment, manage work load,  
489 and define roles.<sup>36</sup> Further, interventions targeting improvement in communication and  
490 collaboration, return-to-work protocols, and psychotherapy are universally suggested.<sup>36</sup>  
491 Therefore, action should be taken to elevate the resources provided in TA settings and improve  
492 organizational structure for more efficient and effective patient care.

### 493 **Limitations and Future Research**

494           Limitations regarding generalizability and recall bias exist in this research study. The  
495 NATA Research Database had 274 participants from all tactical athlete job settings which  
496 included military, law enforcement & government, police, fire, and public safety. Our participant  
497 sample was mostly employed in the military setting which limits the generalizability of their job  
498 experiences across other sectors of tactical athletes. Additionally, the COVID-19 pandemic may  
499 have impacted ATs experiences working in TA settings, with potential increases in patients with  
500 MHCs, and therefore influenced the results as several of the participants had only recently began  
501 working in this job setting. Finally, research volunteer bias may also be of concern as the ATs  
502 that responded to participate may be the most open to discussing mental health and healthcare  
503 which may not be the same introspective experience for all professionals working in tactical  
504 athlete settings.

505           Intentional efforts focused on implementation research must be prioritized in the law  
506 enforcement, military, and public safety setting. This may include the integration of ATs that  
507 have completed residency training and are board certified specialist in behavioral health.  
508 Additional research should explore mechanisms to have ATs assist and lead policy development  
509 related to mental health for the TA settings to achieve optimal patient outcomes and provide  
510 guidance to providers in these jobs.

## 511 **CONCLUSION**

512           Currently, ATs employed in TA settings do not feel completely proficient in  
513 implementing psychosocial techniques into healthcare plans for patients with psychological  
514 distress and concerns, and there are not sufficient and accessible resources to utilize for these  
515 patients. Because of this, ATs in TA settings require additional and advanced training in

516 behavioral health management to apply to their clinical practice in collaboration with  
517 psychological healthcare providers.

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Table 1. Demographic Information

Pseudonym	Age	Gender	Job Setting	Years of Certified Experience	Highest Degree Earned
Andrew	33	Man	Law Enforcement	2	Masters
Bambi	28	Woman	Public Service	2	Doctorate
Drew	60	Man	Law Enforcement	20	Bachelors
Bobby	35	Man	Military	2	Bachelors
Brooke	33	Woman	Military	2	Bachelors
Carrie	30	Woman	Military	1	Masters
Danni	37	Woman	Military	3	Masters
Elizabeth	28	Woman	Military	1.5	Masters
Fang	60	Man	Military	1	Specialist*
Grace	38	Woman	Military	9	Masters
Lily	28	Woman	Military	4	Masters
Mateo	35	Man	Military	1.5	Masters
Mikey	41	Woman	Military	1	Masters
Pat	33	Man	Military	1	Masters
Theod	28	Man	Military	0.5	Masters

\*Participant identified as having a specialist degree but did not provide additional information.

Table 2. Interview Protocol

Demographic Questions	<ol style="list-style-type: none"><li>1. What is your age?</li><li>2. What is your gender?</li><li>3. What job setting do you work in?<ol style="list-style-type: none"><li>a. Military, Police, Fire, Public Safety, Other</li></ol></li><li>4. How long have you worked in the tactical athlete sector?</li><li>5. What is your highest degree earned?</li></ol>
Experience Questions	<ol style="list-style-type: none"><li>1. Overall, why did you choose to enter this job setting?<ol style="list-style-type: none"><li>a. Describe your preparation working in the tactical athlete sector as you transitioned into this job setting.</li></ol></li><li>2. Tell me about your education and training relative to mental health from your professional or post-professional education.</li><li>3. Specifically, tell me about your preparation managing mental health aspects as you started in the tactical athlete settings.<ol style="list-style-type: none"><li>a. Has this changed over time? If so, how?</li></ol></li><li>4. Describe what on-the-job training you were provided specific to recognizing or referring mental health conditions in the tactical athlete setting.<ol style="list-style-type: none"><li>a. Do you believe these trainings or any other specific training you have done should be integrated into athletic training programs to better prepare future athletic trainers entering the tactical athlete setting?</li></ol></li><li>5. In your current role, have you managed a patient with a mental health condition?<ol style="list-style-type: none"><li>a. If yes<ol style="list-style-type: none"><li>i. Describe your role.</li><li>ii. Did you feel prepared to help the patient(s)?</li><li>iii. What other providers did you interact with in your setting to help the patient(s)?</li><li>iv. What resources were available and/or provided to these patient(s) at your clinical site?</li><li>v. Was there a policy in place to help guide your decision making?</li></ol></li><li>b. If no<ol style="list-style-type: none"><li>i. If a patient were to present, what do you think your role would be?</li><li>ii. Do you feel prepared to help future patient(s)?</li><li>iii. What other providers do you believe you would interact with in your setting to help these patient(s)?</li><li>iv. What resources do you believe are available to these patient(s) at your clinical site?</li><li>v. Do you have a policy in place to help guide your future decision making?</li></ol></li></ol></li><li>6. What do you believe is the main difference in addressing mental health issues for traditional athletes when compared to tactical athletes?</li><li>7. Tell me what you believe is the area you were least prepared to do relative to mental health specific to tactical athletes.</li><li>8. What advice would you give future athletic trainers wanting to work with tactical athletes relative to mental health?</li></ol>
Conclusion	<ol style="list-style-type: none"><li>1. Is there anything else you feel I should know about either your current job working with tactical athletes or the role of the athletic trainer specific to mental health that we have not covered?</li></ol>

Table 3. Frequency Counts by Domain and Category

Domain	Category	Count (n=15)	Label
Population Norms	Stigma	12	Typical
	Mental Health Concerns	11	Typical
Provider Preparation	Educational Experiences	15	General
	Formal Employer Resources	15	General
	Self-Education	13	Typical
	Suggest Professional Development	15	General
Provider Context	Unfamiliar Experiences	13	Typical
	Comparative Competency	15	General
Structure of Job	Lack of Policy	14	General
	Role Delineation	14	General
	Collaboration	13	Typical

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Table 4. Supplemental Quotes

Domain	Category	Participant Pseudonym	Quote
Population Norms	Stigma	Lily	“Yes, I think there is a little bit more of a stigma, and something that can affect the stigma is that it can affect their careers. It is not just being able to be physically active.”
		Mateo	“I think there is an element of having to tough through things and not admit weakness. I would say that it is enhanced in the tactical population compared to your athletic population. The hesitancy to seek care again, having to be tough, and get through situations.”
	Mental Health Concerns	Bambi	“We know from the research that there is very specific mental health ailments or issues that tactical athletes tend to deal with on at a higher rate than a different population...anxiety, depression, PTSD, alcoholism.”
		Bobby	“There is a cultural problem – very high levels of stress, poor sleep, and dietary habits. There is an off-tempo battle rhythm for them, so there is a lack of consistency. They are also expected to be very high performers. There is the normal anxiety that goes along with that.”
Provider Preparation	Educational Experiences	Mikey	“The mental health preparation when I was a student way back when was very minimal. It was a chapter in a book and that is not true to life.”
		Theod	“In my bachelor’s degree, I would say mental health was not really ever discussed in terms of provider healthcare. We were told to be aware of it, but never went in depth on what that means. Then, with my master’s program, there was never really any direct education on it either. It was more discussed in bits and pieces in other classes, where we were talking about understanding patient demographics and how that affects you working as a provider. It was never really directly discussed.”
	Formal Employer Resources	Pat	“[The tactical athletes] get full spectrum as far as athletic training. They get general medical type stuff and they get mental health.”
		Danni	“I do not think I was really provided with any training here. When I was at West Point, we went through a suicide prevention course which we did annually there, but as far as being [at my current job], I was not provided with any resources.”
	Self-Education	Carrie	“A lot of my preparation was mostly personal relationships and communicating with individual people about the setting.”
		Danni	“When I got to base, no one talked me through it. It is all research that I needed to do on my own.”
Suggested	Lily	“Be prepared. Be open to still learning and keep	

	Professional Development		up to date with the steps that need to be taken or red flags that are indicators. Then, building rapport with your tactical athletes and knowing all the resources that can possible help.”
		Mateo	“I do not think mental health training specific to the tactical setting would be appropriate for athletic training programs as a whole. I think keeping it to more general populations would be good. But the unique demands of the tactical setting changes a lot from what most athletic trainers are going to see. So, I think specific mental health training should fall more within the military or possibly even the contracting companies to prepare you for that.”
Provider Context	Unfamiliar Experiences	Grace	“You are hearing them talk about self-harm, you are hearing about alcoholism and how they are coping, whether it be drugs, or alcohol, or guns, or tattoos, or multiple sexual encounters, and it is just so far out of the wheelhouse and is just uncomfortable talking about it because I do not know how to help them.”
		Drew	“As far as the tactical setting, they are older. This is going to be career related and could be life threatening.”
	Comparative Competency	Andrew	“Tactical athletes can possibly kill people. Athletes, in most normal situations, unless it is something crazy, they do not. With athletes, it is more accidental death, like a football player lowers his head and has a cervical spine fracture that can result in paralysis or death. Tactical athletes are put in situations where they have to rely on their training, their instincts, and they have more of a possibility to experiences PTSD because they might have to shoot someone or tase someone.”
		Fang	“I would never have to ask a coach to have the athlete go see the sports psychologist. Whereas here, you would have to ask and inform the Sergeant Major that this guy needs to go see a mental health provider.”
Structure of Job	Lack of Policy	Pat	“I think if we got together and had a set plan, ‘if I see this or I see that, how do I report that to you or hot do I get that to you’, it would be pretty beneficial.”
	Role Delineation	Brooke	“It is recognizing the signs that someone is in mental distress, and trying to quickly decide whether it is life threatening mental distress, or if it is just something that we can hit that was just smaller, and then locating who is the best person to get a hold of.”
		Elizabeth	“Yes, just referral out and [the patient] works with

			their provided counselor. Then, I would do check-ins with [the patient] with certain questions to ask how they are doing in regard to their injury. But other than that, there is really not that much of a crossover between us and the counseling practices we have in place, which I would really like to see there be more communication.”
	Collaboration	Andrew	“I think a department of athletic training should actually have on staff counselors that have been taught the three-year degree that you get in a master’s program and then you graduate, and you have to take your boards and get licensed. I do think they should have two or three of those people.”
		Brooke	“I always work within a team, I never try to take something on like that by myself.”

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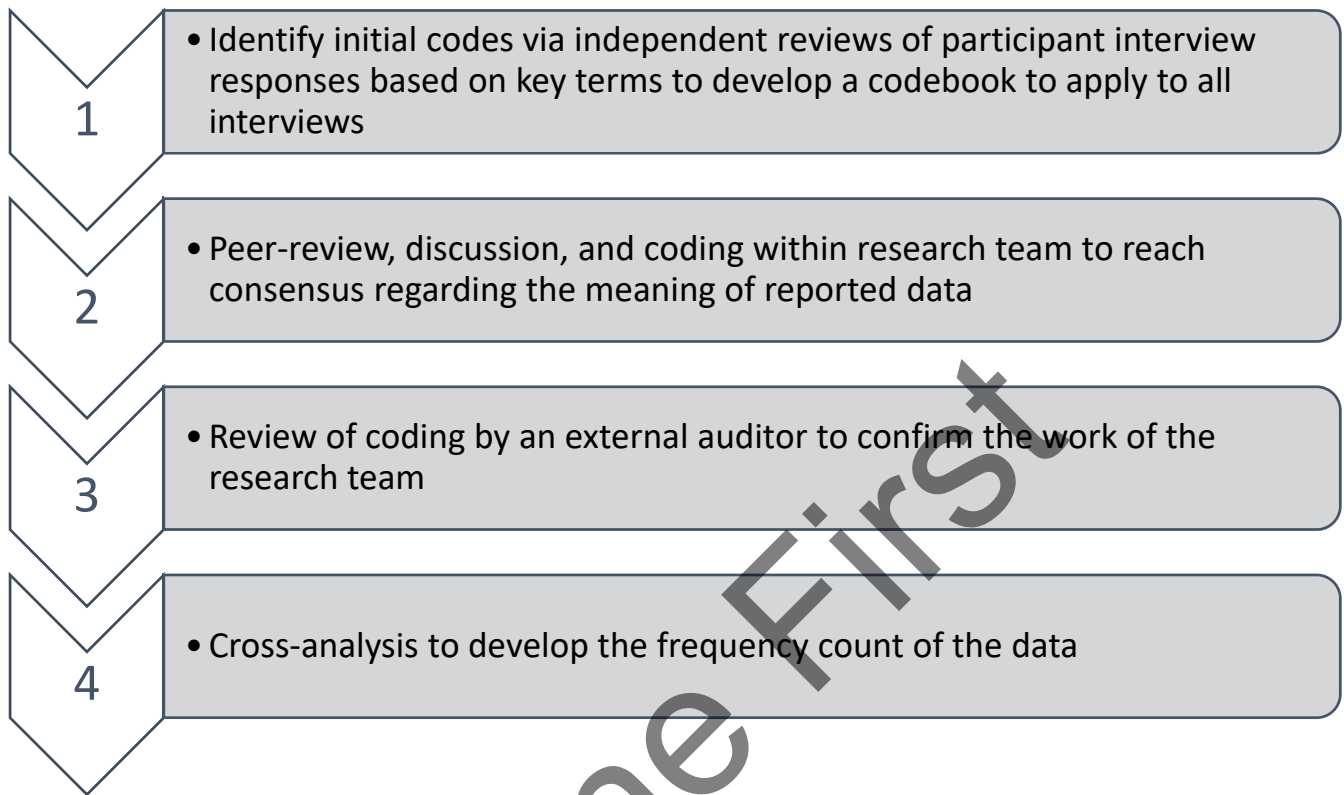


Figure 1. Consensual Qualitative Research Process

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