Effect of Stigma and Advocacy on our State of Mental Health: A Scientific and Personal Approach

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EFFECT OF STIGMA AND ADVOCACY ON OUR STATE OF MENTAL HEALTH: A SCIENTIFIC AND PERSONAL APPROACH

By

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Submitted in Partial Fulfillment of the Requirements for Graduation with Honors from the South Carolina Honors College

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Abstract

The prevalence of mental health disorders amongst college students, especially student-athletes and honors students, has reached dangerously high levels. Furthermore, the stigma associated with mental disorders has been proven to prevent the struggling population from seeking help for themselves through mental health services. This study examined the relationship between mental health and college students (i.e. undergraduates, student-athletes, and honors students), as well as the effects of mental health advocacy on the speaker and the listener. Study participants consisted primarily of NCAA Division I undergraduate student-athletes at the University of South Carolina, with a sample size of 116. Results indicated that there was, in fact, a large prevalence of mental health disorders amongst student-athletes; furthermore, stigma seemed to be a limiting factor in receiving help through mental health services. However, the strongest limiting factor was the perception that personal struggles with mental health aren’t “that big of a deal.” This perception may have been a result of stigma. That being said, mental health advocacy did evoke a reaction in student-athletes, encouraging some to receive help. From this researcher’s perspective, advocacy proved to be both a therapeutic and effective technique in treating personal struggles with mental health.
Summary

As a full-time undergraduate\textsuperscript{10}, student-athlete\textsuperscript{27}, and honors student\textsuperscript{11} at the University of South Carolina (USC), I have come to witness the common trend of mental health\textsuperscript{13} struggles amongst my peers. Furthermore, the stresses placed upon me while participating in these three spheres (i.e. undergraduate\textsuperscript{30} study, athletics, and honors coursework) have played a key role in my personal journey with mental disorders.

The observations made about myself and my social setting disturbed me at first but, over time, began to inspire me: I started to question whether the issues I had seen at the University of South Carolina were true on the national—and even international—sphere.

In the spring of 2016, my inspiration was spurred into action when I agreed to participate in the USC Office of Mental Health Initiatives’ Mental Health Matters Campaign\textsuperscript{31} launch video, which is now viewed campus-wide. This video was the first time I had ever spoken of my previous struggles with an eating disorder\textsuperscript{9} in a public sphere. In just five minutes, I spoke of both the cause of my mental disorder as well as the effects of mental health services\textsuperscript{15} on my recovery. The video concluded with a message from students at the university that aimed to alleviate the devastating effects created by the stigma behind mental health\textsuperscript{16}. A link to the launch video can be found in Appendix (4).

This message was one of the first times that I had ever considered the effects of stigma\textsuperscript{26} on preventing those who are dealing with mental disorders from seeking the help that they need. Furthermore, the empowerment that I felt both during and after sharing my story—as well as the positive events that resulted amongst my peers—further spiked my interest in the role stigma plays in seeking help.
With so many questions on the prevalence of mental disorders amongst college students in a variety of social settings, as well as the effects of stigma and mental health advocacy\textsuperscript{14}, I decided to embark on a study in which I: (1) researched the state of mental health and its treatment at the local, national, and international setting, and (2) conducted my own study on the state of mental health and the effects of mental health advocacy at USC.

The findings of my research are detailed in the \textbf{Literature Review}, while I attempt to share my personal story as it pertains to mental health in the \textbf{Introduction}. The data compiled from my personal study appears in the \textbf{Results}, and their indications and limitations are elaborated upon in the \textbf{Conclusions}. For ease of understanding, all phrases followed by a numeric superscript appear in the \textbf{Defined Terms}; the superscript’s number corresponds to a specific entry in the \textbf{Defined Terms}. 
Introduction

I have been a student since the age of two, an athlete since the age of four, and an honors student since the age of seven. By the time I was a teenager, my sports and my studies had become so predominant in my life that they began to shape the way that I identified myself, as well as the way I perceived how others identified me. This method of self-identification proved to be unhealthy; any bump in the road that posed a threat to my identity triggered a negative response within my heart and my mind. This line of thought eventually became the foundation for what has become years of struggles with mental health.

My struggles with food began when I was thirteen years old. Around this time, I was told by important figures in my life that I needed to “eat right” and “watch my weight” in order to be the best athlete I could be. While these statements were (and are) true, they were not fully explained to me. I was not told that eating right meant giving my body the extra food that it needed after a day full of exercise. I was not told how food is my fuel and how there is no such thing as “bad” food. I was not told that watching my weight not only meant eating so as to not become overweight, but also to not become underweight. Therefore, I blew these seemingly simple statements out of proportion, internalizing them in such a way as to develop a full-blown eating disorder.

Besides restricting my caloric intake and completely avoiding certain food groups, I exercised excessively in order to “burn as many calories as possible.” I thought that this was the best approach to becoming an elite athlete. Even the chance of “getting fat” threatened my identity as an athlete, so I trained to “get skinny.” Nobody told me that athletes should not train to be skinny; instead, they should train to be strong, and “strong” is not defined by a number on the scale but, rather, by physical health and, more importantly, a healthy state of mind.
Despite my eating disorder, I managed to have a successful senior year in high school as a cross country and track and field athlete. I placed seventh and third at the state championship for cross country and track and field, respectively, and signed to compete as a NCAA\textsuperscript{17} Division I\textsuperscript{18} athlete at the University of South Carolina. My success continued into my first year of college as I raced my way into the top-ten lists for the 5K and 10K at the University of South Carolina, and placed seventh in the nation at a junior national track meet. However, by the time I had my breakthrough national race, I was more than thirty pounds underweight (pictured below).

That being said, my outward appearance was just one consequence that ensued from the vicious storm brewing within my mind. My obsessions with food were so powerful that I began to withdraw from my social sphere, in order avoid being surrounded with “unhealthy options” or—even worse—being put in a situation where I could not control what I ate. When travelling to track meets, I would spend hours packing a suitcase full of food in order to avoid eating out. While all my friends were enjoying themselves at restaurants, I was eating alone in the hotel. I truly wanted to join them but I just couldn’t. I was too afraid of what I couldn’t control. I was too afraid of becoming overweight. Even though my teammates (who ate normally) were not, I thought that I was somehow at a higher risk for becoming overweight; and, furthermore, by eating “extremely healthy,” I could surpass my competition.
A pivotal moment in my life occurred following a sudden and harsh break-up. The overwhelming loneliness that I experienced following the break-up caused me to realize how warped my life had truly become. I was distant from my friends, I was hiding my condition from my family, and I had absolutely no respect for myself. I decided to change this right then and there: I would no longer allow my eating disorder to define my life. I called my athletic trainer in July of 2015 and I was put on the schedule with both a psychiatrist and a registered dietitian immediately.

My treatment for my eating disorder began in August of 2015. My psychiatrist helped me attack the mental aspects of my eating disorder, while my registered dietitian gave me the tools I needed to get myself back to a healthy weight. Because these health services were through the University of South Carolina, they were absolutely free-of-charge. By May of 2016, I was thirty pounds heavier and, more importantly, free from an eating disorder. I owe this achievement largely to my psychiatrist, dietitian, and sports medicine team. But, in retrospect, I now realize how much of this achievement I owe to myself. If I had not swallowed my pride and reached out
for help, I would still have an eating disorder to this day, and who knows what physical ailments 
would have ensued as a result.

But the story does not end here: just when I thought things were finally going to get 
better, my competitive running took a turn for the worse in the months following the onset of 
treatment for my eating disorder. Despite the hard work I was putting in at practice, my times at 
cross country meets were getting slower as the weeks progressed. I managed to compete for the 
remainder of the season, but I was now at the back of the pack instead of the front. I know now 
that this was a result of how poorly I had treated my body in the years prior: my body was beaten 
to a pulp by the time I decided it was time to get help for my eating disorder.

This sudden decline in my performance threatened my identity as an athlete in a way that 
I had never experienced. When I had an eating disorder, I feared a possible future (i.e. becoming 
“fat and slow”); but now, I stood face-to-face with the actual present: my body just couldn’t do 
what it used to do. By the time track season rolled around in the spring of 2016, I received a 
devastating injury, pulling my hamstring in the middle of practice. Not only did this injury put 
me out of an entire season of track, it slashed my identity as an athlete right down the middle.

To make matters worse, my struggles with running were coupled with an extremely 
stressful situation with my studies. At this point in my collegiate career, I was taking 
challenging upper-level classes. My coursework demanded hours of my time and, despite my 
efforts, my grades just weren’t what they used to be. I had grown up as a 4.0 student but now 
that I was in classes such as Physics II, Organic Chemistry, and demanding honors courses, a 4.0 
GPA just wasn’t going to happen no matter how hard I tried. I felt like a failure when I got my 
first B. This sounds so silly now but, at the time, this was absolutely devastating to me because 
my identity as the “perfect student” was no more. My life was a whirlwind: I was “failing” as an
athlete and a student. My stress increased while my sleep decreased and, by the spring of 2016 (right around the time I pulled my hamstring), I began to have panic attacks and crying spells. I did not know it at the time, but this began a long and difficult journey with anxiety and depression.

It wasn’t long before I realized the severity of the issue: I began to be treated for anxiety and depression in the fall of 2016 and started meeting regularly with a psychologist as well as a psychiatrist. I talked through my identity crisis with my psychologist while my psychiatrist and I made the decision to begin medication. I had never taken medication for a mental disorder before as I felt that anything could be overcome with sheer will and determination, but my psychiatrist felt differently so I—reluctantly—took the medication. I soon learned how helpful of a tool medication could be when used properly and my willingness to partake of treatment grew further when I discovered that a mental disorder is actually a disease characterized by a chemical imbalance in the brain. In other words, mental disorders sometimes require medication to fix this chemical imbalance—they can’t always be cured by will.

My depression and anxiety started getting better in the weeks after taking the medication, but I soon reached a plateau that I just couldn’t seem to overcome. At this point in my treatment I was in my third season of cross country. I was at the very back of every practice and was running so poorly that I was no longer eligible to compete. This devastated me. Finally, I had a break-through session with my psychologist: when discussing my situation with running and my decision to stop my participation as a Division I athlete, she pointed out how it sounded like I was grieving. She was right. I was mourning the loss of a loved-one: myself.

As I said earlier, my identity was largely created by my life as an athlete. While my perspective towards school had reached a much healthier level and I no longer stressed over the
“small stuff,” I had still clutched on to my identity as an athlete with everything that I had. With my running going downhill, I felt that my career as an athlete had been so cruelly ripped out of my hands. I felt that I had lost my self. I felt that a part of me had died and I mourned my loss.

It was at this moment that I realized I needed to make a change. I could no longer identify myself by my activities, no longer identify myself by my success. My psychologist and I embarked on a journey to “find myself.” I began to identify myself by what really mattered: I was a daughter, a friend, a sister, a girlfriend, etc. I love writing, eating peanut butter, and learning about the human body as it relates to nutrition. I am good at helping people, giving hugs, and doing stupid things to make others laugh. These are all what make me me and none of these things can be taken away from me. Once I began identifying myself in this way, my depression and anxiety started improving immensely. To this day, I still have my moments with anxiety and depression, but I am able to come back strong when these moments do occur.

As a result of my struggles with mental health, I developed an intense passion for helping my companions who also struggled. I looked around me and I saw my academic and athletic peers stressed beyond comprehension. I knew in my heart that at least some of them had to be struggling too and I wanted them to reach out for help the same way that I did. It was at this time that I was given the opportunity to speak in the University of South Carolina’s Mental Health Matters Campaign launch video.

In this video, I spoke about my struggles with mental health and how crucial seeking help was to my recovery. Once it was published, I shared the video with my friends and it evoked an interesting response: I was told of my bravery and thanked for sharing my story. Furthermore, when I began working on my thesis project and speaking to athletes at the university (see Methodology), the same thing occurred: I was thanked for being “so brave.” This confused me.
I had never thought of talking about mental health as “brave.” I was just speaking to encourage people to get help and make them aware of available services. This really bothered me and prompted the social media post below:

“Within the past few months of working with the Office of Mental Health Services here at UofSC, I have been astounded with the enormous amount of people who have come up to me telling me how amazed they are that I was brave enough to seek help and how amazing it is that I am so willing to share my story with my friends and people I don't know. I know these comments mean well and I am so thankful for the support, but what they imply is that most people think that I would most likely feel ashamed of my struggles with mental health and that I would be embarrassed to get any form of help. Now, this does not offend me, but it makes me so sad. What these comments cause me to assume is that the majority of people would NOT seek help if they had problems because they ARE embarrassed and ashamed of their state of mind. Why is that?!

No, I am not ashamed of my struggles in the past, nor am I ashamed of the struggles I face in the present. I do not have problems with food anymore, but there are some days where the insane amount of demands placed on my shoulders can leave me feeling very anxious and sometimes very scared. I am not embarrassed by that... it is a problem I have and I am getting help and working through it. Why? Because I believe we ALL have problems--the world is far too imperfect for any single person to have a perfect life. It is OKAY to not be okay. What is NOT okay is knowing you are not okay and not doing anything about it. What is NOT okay is having reason to believe one of your loved ones is struggling and not addressing them about it because it is "none of your business." What is NOT okay is the way society treats mental health as some sort of "hush-hush" topic that should not be discussed or talked about in an open setting.

Just because I have a weakness does not make me weak. Just like just because you did
badly on a test does not make you stupid, just because you had a bad game does not make you a bad athlete, and just because you made a bad decision does not make you a bad person. It makes you a HUMAN. When I see a teammate who is injured, I do not think to myself, "what a failure". I think, "OK, she's injured, she's working on it, and she will be back on the track soon." Why can't we view mental health in the same light?

I do not go around campus making videos and giving speeches to be applauded. I do not seek anyone's pity nor want it in any way, shape, or form. I could care less if people remember my name or if this makes me "popular." My dream is that, by doing what I'm doing, I can help remove the stigma that goes along with mental health and that I can convince people to do something about their struggles. Everyone deserves to be happy and free. If you are reading this post and are struggling in any way--big or small--I pray with all my heart that you reach out to your loved ones and, if need be, a professional and get help. Take it from me, it works wonders. You are not weak. You are human. If you can't do it for yourself, do what I did and do it for all the dozens and dozens of people who love you and want to see you smiling from the inside out.”

~Posted on Facebook on October 4, 2016

As I wrote this post, I realized how powerful and evil of an enemy stigma was (and still is) in regards to mental health. Stigma plants fear into the struggling person’s heart. Stigma prevents the sick from getting the help they need. Stigma keeps society from talking about the white elephant in the room. Stigma needs to be stopped. Therefore, I made it one of the main focus-points of my thesis project.

Back when I was at my lowest point with depression, I began digging through the internet, seeking to find some sort of blog on recovery. I wanted to find hope. There was nothing out there that was personal; all that existed were scientific projections. The only
personal blogs I could find were of how awful and horrible mental disorders truly are. But the struggling already know that. They need hope. They need positivity. But I did not lose hope. I did not lose positivity. After my failed search, I told my boyfriend that I was going to beat my disease and then I was going to write a blog about it. I wanted this blog to do what nobody else seemed to do: combine science, personality, and hope. Once I embarked on the road to recovery in January of 2017, I was finally able to put my promise into action. But, because I can never just leave things plain and simple, I took my oath a step further and turned it into a thesis. I hope you enjoy.
Literature Review

Mental Health at the University of South Carolina

The overall state of mental health amongst students at the University of South Carolina (Columbia) was assessed in 2016 with two surveys: (1) Healthy Minds (Healthy Minds Survey 2016-2017, 2016) and (2) the National College Health Assessment (National College Health Assessment—University of South Carolina, 2015). The primary focus group of both surveys consisted of full-time undergraduate students at the University. The highlights of these surveys are elaborated on below.

Healthy Minds

On November 22, 2016, the Healthy Minds survey received responses from 610 students at the University of South Carolina. The students at the university were very successful—79.7% of them having a B average or above. That being said, 73.65% of the respondents said that they experienced one or more days in which emotional/mental difficulties impacted their academic performance within the four weeks prior to taking the survey. Of the overall sample, 16.05% reported experiencing these difficulties for six or more days. Despite this reported stress, 86.03% of students agreed that they will be able to finish their degree despite emotional challenges. (Healthy Minds Survey 2016-2017, 2016)

When reflecting on the two weeks prior to the survey, 41.67% of respondents reported several days of feeling down, depressed, and hopeless; 34.43% felt bad about themselves and that they were “a failure”; and 11.98% had thoughts of self-harm/suicide. Furthermore, 24.69% of students said that they feel they need to be very thin to feel good about themselves and 13.43% make themselves sick when they eat too much. When reflecting on the year prior to
completing the survey, 18.06% of respondents reported inflicting harm upon themselves and 10.52% had seriously thought of committing suicide under this same time frame. (*Healthy Minds Survey 2016-2017, 2016*)

In terms of the prevalence of mental health disorders at the University of South Carolina, 39.67% of respondents reported that they were diagnosed with some sort of psychological disorder. Among these, 20.11% experienced depression, 22.83% had anxiety, and 3.8% dealt with an eating disorder. (*Healthy Minds Survey 2016-2017, 2016*)

Regardless of the individual’s condition of mental health, it was found that students were more likely to talk to friends and family (56%) than a psychiatrist, psychologist, or counselor (37%). For those students who did choose to seek help through counseling, 82.4% of them received it through USC campus resources, with 57.6% finding the services helpful. Additionally, 27.89% of students dealing with mental health were on medication, and 72.48% found this treatment method helpful. (*Healthy Minds Survey 2016-2017, 2016*)

Students reported that their biggest barrier to not receiving services from counselors, psychiatrists, and psychologists was their lack of time. Because of this, 63.9% of respondents chose a more convenient route and received counseling from friends and family; 76.66% found it helpful. There did seem to be some resistance to talking with campus employees about mental health, as 38.1% of respondents said they wouldn’t talk to anyone on campus about their struggles. However, those who did talk to academic personnel (i.e. instructors, advisors, and academic staff) found this method to be extremely successful: 95.16% of students who reached out to USC academic personnel found the personnel supportive and helpful. (*Healthy Minds Survey 2016-2017, 2016*)
In general, 89.26% of the survey’s respondents considered themselves knowledgeable about mental health and its treatment. The interesting fact is that 92.38% of participants had never received training in mental health and 48.05% of them are unaware of mental health outreach programs at USC, indicating that they may not be as knowledgeable as they think. (*Healthy Minds Survey 2016-2017, 2016*)

While lack of time was reported to be the biggest barrier to a student’s receiving treatment for emotional disorders, the data indicated that stigma alone may play a huge role in preventing students from seeking help. To elaborate, 42.39% of struggling students were ashamed of their mental illness and 59.79% of those students were keeping it a secret. However, the most shocking point presented in the data was that this stigma may just be a personal construct. Of respondents, 59.49% thought that others believe that receiving help for mental health is a sign of weakness and failure. That being said, 88.06% of students who took the survey did not personally see receiving help as a sign of failure. Also, 45.41% of participants think most people would think less of a person struggling with mental health. However, an overwhelming 92.69% of students personally did not think any less of a person going through these struggles, indicating that the perceived stigma is essentially false. (*Healthy Minds Survey 2016-2017, 2016*)

**National College Health Assessment**

Based on the *National College Health Assessment* survey conducted in 2015, there was found to be a significant drop-off in the prevalence of on-campus mental health education compared to the other topics taught to students in outreach programs. For instance, 81.7% of survey respondents reported receiving information about drugs and alcohol while only 59.8%, 30.7%, and 49.9% had received information about depression and anxiety, eating disorders, and
how to help others in distress, respectively. (*National College Health Assessment—University of South Carolina, 2015*)

These statistics are quite tragic in light of the vast amount of emotional distress experienced among students in just the two weeks prior to completing the survey. Of students surveyed, 51.4% reported feeling overwhelmed with all that they had to do, 23.1% were very sad, 7.8% felt so depressed it was difficult to function, 21.2% experienced overwhelming anxiety. Furthermore, 5.5% of respondents reported that they had seriously considered suicide within the 12 months prior to completing the survey. 16.2% of survey participants were diagnosed with anxiety, and 11.7% with depression. Eating disorders were far more rare, with a little over 1% of respondents diagnosed with anorexia, and a similar amount with bulimia. That being said, 2.5% of students had vomited or taken laxatives to lose weight within the 30 days prior to the survey. Additionally, 8.2% of respondents said they had panic attacks. Academically related, 42.2% said academics were “traumatic” and very difficult to handle, and 52.2% of students experienced more than average stress within the last year (8.7% of them classified it as tremendous stress). Only 26.7% of participants reported getting enough sleep five or more days out of the week, with 38.8% not having more than two days of adequate sleep. (*National College Health Assessment—University of South Carolina, 2015*)

All this considered, only 35.4% of respondents have received help from a counselor, therapist, or psychologist, and 15.4% from a psychiatrist. Furthermore, only 18.3% of survey participants had taken advantage of USC’s mental health services even though 52.2% experienced more than average stress within last year (8.7% classified as tremendous stress). The lack of treatment being received an apparently troubled student population is concerning and raises questions about the mechanisms behind students’ emotional distress, as well as the reasons
behind why students seem to be avoiding treatment despite their struggles. Attempts to answer these questions are provided in the studies presented below. (*National College Health Assessment—University of South Carolina, 2015*)

**Mental Health in Honors Students**

A study was conducted by scientists in Australia aiming to assess mental health in students within what the researchers considered to be an “educational bottleneck”: a university-level honors college (the scientists used the term “bottleneck” because an honors college essentially “filters out” high-achieving students). Subjects’ mental health was measured twice during the study: once when they submitted their research theses and a second time a month after their theses had been submitted. At the time of thesis submission, honors students were found to have significantly higher levels of psychological distress than non-honors students and 49% of these subjects were on the clinical spectrum for depression. An inverse relationship was also found in that the highest-achieving students had the lowest well-being at the time of thesis submission. When the second round of data was collected one month later, the students’ well-being was found to have improved significantly. That being said, this was not the case for students who received a poor grade on their thesis. Overall, it was found that honors students at the highest risk for mental health-related issues were those who felt that they lacked control over their academics, had little social interaction, and possessed a high-achieving personality. (*Cruwys, et. al., 2015*)

Back in 2006, a similar study was conducted at the University of Florida in which researchers surveyed 600 students within the school’s honors program (*Rice, et. al., 2006*). The study targeted honors students because it has been argued that perfectionism is a significant risk factor for psychological distress in high-achieving students, such as those within a
university’s honors college (Delisle, 1986; Dixon & Scheckel, 1996; Pfeiffer & Stocking, 2000). Students first completed a self-reported test that classified them on the Almost Perfect Scale-Revised. This classification was used to distinguish perfectionists from non-perfectionists. It was found that there was a positive correlation between perfectionism and perceived stress ($r^2 = 0.57$). A positive correlation also existed between perfectionism and hopelessness ($r^2 = 0.45$), as well as perfectionism and depression ($r^2 = 0.50$). Conversely, a negative correlation was found between perfectionism and social connection ($r^2 = -0.45$) (Rice, et. al., 2006).

**Mental Health in Student-Athletes**

*Athletes vs. Non-Athletes*

In a study comparing athletes and non-athletes, it was found that athletes have a higher prevalence of depression, anxiety, and psychological stress. Using the Manual for the Depression Anxiety Stress Scales, point values were assigned for depression, anxiety, and psychological stress among subjects (higher point values indicate greater severity and/or frequency of negative emotional symptoms (Raad, 2013)). Athletes averaged a score of 16.24, 17.18, and 19.04 for depression, anxiety, and psychological stress, respectively. Conversely, non-athletes averaged a score of 9.84, 9.69, and 15.62 for depression, anxiety, and psychological stress, respectively. In terms of statistical significance, athletes therefore experienced an increased amount of psychological disorders as compared to non-athletes (Demirel, 2016). This phenomenon is attributed to the overtraining, injury, and failure in competition that can be faced in high-caliber sports (Nixdorf, Frank, & Beckmann, 2016).

*Concussions and Depression*

The Journal of Athletic Training presented a study in which previously concussed NCAA student-athletes were compared to a control group who had never been concussed. The purpose
was to determine whether a concussion was a risk factor for depression. It was found that 20% of the concussed athletes displayed a statistically significant rise in depression by the end of the study. Conversely, only 5% of the control group experienced an increase in depression. (Vargas, et. al., 2015)

Likewise, a similar study was conducted in 2012 with the same goal in mind. It was found that college athletes who were concussed experienced a significant increase in depression at 2, 7, and 14 days post-concussion. Furthermore, collegiate athletes had noticeably higher levels of depression 14 days post-concussion as compared to high school athletes who had also experienced a concussion. (Kontos, et. al, 2012)

A study presented in Developmental Neuropsychology took the research of the above experiments one step further—with the aim to ascertain if collegiate athletes who experienced mild levels of depression prior to a concussion would display a greater increase in depression post-concussion. Of concussed athletes, 19.8% reported that they were feeling depressed following their concussion. Furthermore, athletes who had a history of depression were 4.59 times more likely to experience depression post-concussion than athletes with no history of depression. (Yang, et. al., 2015)

**Eating Disorders**

A study aimed at determining the prevalence of eating disorders among 151 female collegiate athletes found that 6.6% and 10.6% of subjects were experiencing an eating disorder according to the Eating Attitudes Test-26 and the Minnesota Eating Behavior Survey, respectively. There were no differences found between sports (Shriver, et. al, 2016). Recall that, according to the National College Health Assessment at the University of South Carolina, only 1% of undergraduates in general were said to have an eating disorder, therefore indicating that
female student-athletes are more likely to experience eating disorders (National College Health Assessment—University of South Carolina, 2015).

A similar study was conducted using the 50-item Questionnaire for Eating Disorder Diagnosis among a population of 732 male collegiate athletes. While only 1.1% of the subjects had an eating disorder, 16% were classified as symptomatic. (Chatterton & Petrie, 2013)

**The Current State of Mental Health Services**

**Services for all Undergraduates**

In 2014, a study was conducted to examine the therapeutic effectiveness of mental health services. Undergraduates enrolled in a general psychology class at a private Midwestern university were asked to report their perceptions on the effectiveness of a range of Mental Health Service Providers (MHSPs). After undergoing sessions with each of the MHSPs, the students were to classify effectiveness in terms of “positive”, “neutral”, “negative”, and “don’t know”. From most to least effective, the results were as follows: 66% of students found counselors to be “positive”, 59% thought this for psychologists, 50% for psychiatrists, 45% for marriage and family therapists, 44% for social workers, and 43% for psychiatric nurses. With positive results only seen in about half of the students, it seems that work needs to be done in regards to mental health services. (Ackerman, et. al., 2014)

That being said, it was found in multiple studies that students who receive counseling are more likely to graduate from college than those who avoid this service. (Kharas, 2014; Lee, et. al., 2009; Moss, 2015; Turner & Berry, 2000; Wilson, et. al., 1997)

**Services for Student-Athletes**

A study was conducted by the Journal of Athletic Training to determine whether or not collegiate members of the National College Athletic Association (NCAA) provided their athletes
with proper and effective mental health screenings\textsuperscript{24} and services. It was found that only 39% of the schools’ sports medicine departments had a written plan for pinpointing their athletes with mental health issues. Furthermore, less than half of these programs had neither written nor verbal screenings in place—only 44.5%, 32.3%, and 30.7% tested for disordered eating\textsuperscript{8}, depression, and anxiety, respectively. A rather important observation was made in regards to the fact that NCAA Division I institutions and programs with a higher athletic trainer-to-athlete ratios were more likely to have proper and effective mental health screenings and services in place. (Kroshus, 2016)

**The Stigma behind Mental Health**

**On the College Campus**

At a large Canadian public university, students struggling with mental health were studied by a team of researchers. The experiment focused on what was termed “the self (individual factors), the social (interpersonal factors) and the school (environmental factors)” and how each of these three spheres were related. In terms of stigma, struggling students reported that the message they received from their peers was that mental illness is not “real”. Students were therefore hesitant to disclose their issues with friends, family, and university employees. Furthermore, interviewed students said that they felt that physical illnesses and injuries are treated with far more compassion and support than mental illnesses. Therefore, students felt that they needed to “prove” the fact that they were ill so that their professors would believe them. Some students internalized the stigma and began to blame themselves and feel ashamed of their condition. When students did overcome the fear of the stigma and seek help for themselves, they found the on-campus mental health services to be inadequate, difficult to access, unreliable, and
of poor quality. The study therefore concluded that social stigma and poor services were actually preventing struggling students from overcoming their diseases. (Kirsh, et. al., 2016)

**In Athletics**

In a study focusing on mental health in student-athletes, it was found that although there was an overwhelming positive outlook and acceptance of mental health and counseling, athletes were hesitant to get help for themselves because they felt there was a social stigma associated with it. However, after an extensive outreach program, the same athletes were interviewed again. Following the second interview, student-athletes indicated that their views on the stigma behind mental health changed positively and they felt that the program alleviated their insecurities in regards to society’s views towards mental health. The outreach program’s main focus was what it termed the “Five Cardinal Mental Skills”: relaxation, imagery, routines, self-talk, and concentration. Based on the positive reviews in the interviews, it was concluded that this specific outreach program was, indeed, effective in treating student-athletes and raising awareness about mental health. (Beauchemin, 2014)

**Mental Health Advocates: Impact on the Speaker and the Listener**

A study in 2016 interviewed 35 individuals who chose to disclose their stories regarding their struggles with mental health and how they overcame them. The interviewed participants felt that, because they had personal struggles with mental illness, they were among the best-equipped to help those who were still struggling. Their personal stories were also able to break down the barrier that was created by the stigma behind mental illness. People who were still struggling found that they were able to forge strong relationships with these advocates because the advocates were understanding. That being said, willingness to share past struggles with
mental health was completely dependent on social context and perceived hostility or acceptance of the environment. (Marino, et. al., 2016)

It has also been found that the advocates themselves have experienced therapeutic benefits from sharing their stories: improvements were made in terms of self-esteem, empowerment, and increased personal insight. (Barnes, et. al., 2006; Walters, et. al., 2003)

Furthermore, one study found that advocates who shared their stories on the public sphere experienced boosted self-confidence and a sense of achievement. They found the process to be “enjoyable” and said that it allowed them to come to terms with their problems. From the listeners’ perspectives, they were able to learn from the advocates’ shared experiences and felt a vast reduction in the stigma surrounding mental health. (Rani & Byrne, 2014)

Recommendations and Attempts to Improve

On the College Campus

A qualitative study was conducted on a college campus to determine the strengths and limitations of on-campus mental health services. A widely-reported strength was the sheer fact that colleges offered mental health services to their students in the first place. That being said, students indicated that the services available needed far more advertisement, as many students were unaware of their existence. Students also indicated that faculty members needed to be better educated in the sphere of mental illnesses. From this study, it was concluded that the state of mental health would improve on college campuses if students and faculty were better educated in regards to mental health. Furthermore, students must be constantly reminded of services on campus through mass emails, social media, etc. (Welch, 2016)
In Athletics

The Journal of Athletic Training developed an informative entry detailing the extensive list of “triggers” faced almost exclusively by NCAA athletes. Among these triggers are burnout and overtraining, anticipated end of athletic career, injury, conflict with coaches or teammates, concussion, poor performance or perceived poor performance, balancing sports and schoolwork, and lack of playing time. Along with these triggers, it was noted that NCAA athletes have been found to define themselves by their sport: therefore, these triggers become major issues in that they threaten these athletes’ personal identities and self-worth. It was found that the more rigidly the athlete tied his or herself to the sport, the more at-risk he or she was for mental health concerns such as depression, anxiety, and disordered eating. (Neal, et.al, 2015)

After discussing the key points related to mental health among NCAA athletes, it was recommended that behavioral monitoring should be instilled both on the teams and within the sports medicine programs of these undergraduate institutions. Among behaviors to monitor were changes in eating and sleeping habits, unexplainable changes in weight, substance abuse, lying and irresponsibility, lack of social contact, negative self-talk, frequent injury, mood swings, and feelings of lacking control. (Neal, et.al, 2015)

For treatment, it was found that a team approach was most effective—i.e. a mental health team consisting of athletic trainers, team physicians, school nurses and counselors, and community-based clinical psychologists and psychiatrists. In addition, it was also recommended that a pre-participation mental health screening would be implemented at the beginning of every sporting season in order to have a comparative baseline if an athlete were to have an issue down the road. (Neal, et.al, 2015)
According to the *Journal of Clinical Sport Psychology*, researchers noticed that student-athletes were not getting proper help with their mental health due to a lack of knowledge of services as well as the stigma associated with mental health. Therefore, they conducted a study in which they created a website (www.SupportForSport.org) designed to educate student-athletes on mental health as well as to boost their confidence to get help if issues were to arise. After the website was determined to function properly and was approved by coaches and athletic directors, a controlled field trial was conducted among 153 student-athletes from all parts of the United States. It was found that athletes that viewed www.SupportForSport.org developed greater knowledge in terms of mental health referral and efficacy than athletes who did not view the site. (Van Raalte, et. al., 2015)
Defined Terms

1. **Academic Personnel**: all faculty members and unclassified academic staff positions affiliated with the University of South Carolina. These include professors, librarians, assistant professors, lecturers, instructors, research associates, teaching assistants, university affiliates, master’s teachers, etc. A full list of University of South Carolina’s academic titles and their definitions are listed in the university’s list of policies. (Executive Vice President for Academic Affairs, & Vice President for System Planning, 2016)

2. **Anorexia**: type of eating disorder in which individuals perceive themselves as overweight although, in reality, they are extremely (and often dangerously) underweight. It is common for an individual struggling with anorexia to perform frequent weigh-ins, severely limit food intake, and—when they do eat—eat very small amounts of very specific foods. Anorexics also live with an overwhelming fear of gaining weight, thus causing their extreme food restrictions. This mental illness is very dangerous, as it causes more deaths per year than any other mental disease. (What are Eating Disorders, 2016)

3. **Anxiety**: the body’s normal reaction to events that are perceived as stressful, unfamiliar, or unsafe. Healthy anxiety (such as being nervous about an upcoming interview) is completely normal and considered to be helpful, as it helps the individual to focus and prepare. That being said, unhealthy anxiety can interfere with daily life by impeding the individual’s ability to function. An individual is said to have an anxiety disorder when the experienced anxiety is irrational, reoccurring, and overwhelming. Psychological symptoms of Anxiety Disorder include feelings of lacking control over thoughts and emotions, trouble concentrating, obsessive
thoughts, and extreme perceived stress. Physical symptoms include headaches, trembling, heavy breathing/hyperventilation, and lack of sleep. (Bystritsky, et. al., 1999)

4. **Bulimia**: type of eating disorder in which individuals go through repetitive cycles of binging and purging. During a binge episode, a bulimic individual will eat an abnormally large quantity of food, often uncontrollably. This large food intake is followed by feelings of guilt, which causes the individual to purge in order to compensate for the binge. The individual can use a variety of tactics to purge: forcing his or herself to vomit, taking laxatives, not eating for a long period of time following the binge, exercising excessively, and so on. It is harder to pinpoint individuals suffering with bulimia due to the fact that they are at what is considered to be a healthy weight. (What are Eating Disorders, 2016)

5. **Burnout**: state of complete exhaustion (emotionally, mentally, and/or physically) due to extreme and prolonged stressors placed on the body. These stressors can range from excessive exercise to a rigorous work schedule. (Smith, et. al., 2016)

6. **Counselor**: professional whose duty it is to talk their patients through problems, diagnose mental illnesses, and refer their patients to other professionals (e.g. psychologists and psychiatrists) when necessary, such as when the patients’ situations become severe. (Counselor-License: A State by State Counselor Guide, 2011)

7. **Depression**: medical illness characterized by a range of emotional, mental, and physical symptoms, including feelings of sadness, loss of interest in once-enjoyable activities, changes in
appetite, suicidal thoughts, lack of energy, and changes in sleeping habits. It differs from general sadness, grief, and bereavement in one key way: sadness, grief, and bereavement are emotions while depression is a state of being. For example, if an individual’s mother were to pass away, the individual would, naturally, experience feelings of sadness and withdrawal for a given period of time. With depression, feelings of sadness are often irrational and persist for longer periods of time. Furthermore, a depressed individual often experiences a lack of self-esteem and feelings of worthlessness, while these symptoms do not appear in the individual grieving the loss of his or her mother. (Parekh, 2017)

8. **Disordered Eating**: "a wide range of irregular eating behaviors that do not warrant a diagnosis of a specific eating disorder." An individual with disordered eating is, therefore, experiencing some of the symptoms characterized by eating disorders but to a lesser extent. “Disordered eating” describes the abnormal way in which an individual eats, but it does not diagnose that individual with an actual disease like being diagnosed with an eating disorder would. If an individual’s abnormal eating patterns and symptoms don’t fully meet the American Psychiatric Association’s criteria for an eating disorder, the individual is said to experience disordered eating. That being said, individuals who display disordered eating are at risk for developing full-blown eating disorders, so it is important that they are monitored, educated, and treated accordingly. (Anderson, 2015)

9. **Eating Disorder**: mental illness characterized by extreme disruptions in an individual’s normal eating habits. Often, the individual experiencing an eating disorder also deals with obsessions with food and his or her weight (National Institute of Mental Health, 2016).
mental illness is most likely caused by a combination of genetic, psychological, social, and cultural factors. (What are Eating Disorders?, 2016)

10. **Full-time Undergraduate**: an undergraduate student who is enrolled at least 12 credit hours per semester.

11. **Honors Students**: students enrolled in advanced classes who have met certain requirements to participate in said classes (i.e. passed placement exams, received a minimum score on standardized tests, etc.). Honors programs are considered to be more rigorous than standard programs and, therefore, consist of a greater work-load.

12. **Marriage and Family Therapist**: mental health professionals capable of diagnosing patients with mental illnesses and treating said patients for these illnesses while also focusing on the family and marriage unit. A marriage and family therapist therefore attempts to determine how an individual’s relationships may be impacting his or her state of mental health. (American Association for Marriage and Family Therapy, 2002)

13. **Mental Health**: “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.” (Mental health: a state of well-being, 2014)
14. **Mental Health Advocates**: individuals who choose to share their personal stories and struggles with mental health in order to educate the general public in the field of mental disorders.

15. **Mental Health Services**: services put in place to treat diseases that fall within the mental health spectrum.

16. **Mental Health Stigma**: the negative connotations associated with mental disorders. These include the thought that mental illness is not actually an illness but instead a choice, a sign of weakness, and a condition that makes one “less-of-a-person.” The stigma also includes the belief that receiving help through mental health services is both a sign of weakness and of an inability to cope.

17. **National Collegiate Athletic Association (NCAA)**: collegiate athletic association including college presidents, athletic directors, compliance officers, conference staff, academic support staff, coaches, health and safety personnel, sports information directors, and faculty athletics representatives. The NCAA aims to prioritize “academics, well-being, and fairness so college athletes can succeed on the field, in the classroom, and [in their lives].” (What is the NCAA?, n.d.)

18. **NCAA Division I Institutions**: collegiate institutions of the NCAA\(^1\) that hold a minimum of seven sports for each gender (men and women). Division I institutions must offer a minimum amount of financial aid to their athletics programs each year (Divisional Differences and the
History of Multidivision Classification, n.d.). There are 335 institutions classified as Division I (Scottsdale Soccer, 2017).

19. Perfectionism: character trait in which the individual feels a need to be perfect and, according to Psychology Today, sees life as an “endless report card on accomplishments or looks”. Perfectionism is accompanied by a fear of failure and, therefore, a risk factor for mental disorders such as depression and eating disorders when the individual perceives his or herself as imperfect. (Psychology Today, 1991)

20. Psychiatric Nurse: mental health specialists who are both classified as registered nurses and have obtained a master’s or doctoral degree in psychiatric-mental health nursing. These nurses analyze their patients’ mental health conditions and diagnose them with mental health diseases, if necessary. They also serve to identify any risk factors that their patients may have for mental illnesses and work to develop a plan of treatment for their struggling patients. Psychiatric nurses offer counseling to patients and are capable of writing prescriptions for mental health medications. (American Psychiatric Nurses Association, 2017)

21. Psychiatrist: type of medical doctor that is specialized in treating patients with mental health disorders. These medical professionals are capable of assessing the range of symptoms associated with mental illnesses, especially the mental and physical symptoms. Psychiatrists diagnose patients with specific mental disorders, evaluate medical and psychological data, and develop treatment plans tailored specifically to each patient. Because psychiatrists are doctors,
they are capable of prescribing medication to their patients when necessary. (American Psychiatric Association, 2017)

22. Psychological Distress: mental discomfort that can be felt in a variety of ways. The cause of the discomfort is often extreme stress placed upon the individual, while the effect of the discomfort is a decline in mental health. (Durvasula, 2016)

23. Psychologist: mental health professional who has obtained a doctoral degree in psychology and performs similar tasks to those performed by a psychiatrist. However, unlike psychiatrists, psychologists do not attend medical school and, therefore, are not capable of prescribing their patients with medication. (European Foundation for Psychologists and Analysts, n.d.)

24. Screenings: tests that attempt to determine if the tested individual has a specific disease before the disease becomes symptomatic. By finding the disease early (i.e. before the diseased individual begins to display symptoms), subsequent treatment becomes much easier (MedlinePlus, 2017). In terms of mental health, screenings are used to determine individuals who are at risk for developing full-blown mental health disorders, and pinpointing these individuals who require further attention and possible treatment.

25. Social Workers: professionals who help individuals learn to cope with problems and better their lives. Social workers focus on teaching coping skills and practices that patients can put into place as they deal with their daily lives. This profession is often part of a mental health team consisting of other professionals such as psychiatrists, psychologists, etc. (Fanning, n.d.)
26. **Stigma**: “a perceived negative attribute that causes someone to devalue or think less of the whole person”. (Salters-Pedneault & Gluck, 2016)

27. **Student-Athletes**: individuals receiving an education (e.g. high school or college level) while simultaneously participating in sports affiliated with their schools. Student-athletes are often required to meet certain educational standards in order participate in competition. For example, according to the NCAA\(^7\), a collegiate student-athlete must maintain a GPA of 2.0 or above and be enrolled in at least 12 credit hours per semester to remain eligible to compete. (Staying on Track to Graduate, n.d.)

28. **Therapist**: an “umbrella term” for professionals who provide their patients with treatment and rehabilitation for mental health disorders. Therapists include psychologists, psychiatrists, counselors, social workers, and so on. A therapist’s education-level can range anywhere from a certificate to a PhD. (All Psychology Schools, 2002)

29. **Trigger**: an event, action, or statement that sets off a disturbing memory or flashback for an individual. A trigger will cause a negative reaction, often causing the individual to display the same emotions that he or she displayed when the traumatic event took place. A trigger can also be an event, action, or statement that sets off an individual’s anxiety, depression, or other symptomatic mental disorders. (Sexual Assault Centre, 2016)

30. **Undergraduate**: student pursuing either a bachelor’s degree or associate’s degree at an accredited institution. (Miner, 2016)
31. **University of South Carolina Mental Health Matters Campaign**: mental health campaign launched in the spring of 2016 by the University of South Carolina’s Mental Health Initiatives area of Student Health Services. The campaign is designed to educate students at the University of South Carolina about mental health and, most importantly, to remove the stigma associated with mental health and to encourage those struggling to seek help.

32. **University of South Carolina On-Campus Mental Health Services**: services available to University of South Carolina students upon payment of their student health fee. These services include counseling (individual, group, and couples counseling), psychiatric services, preventative health screenings, stress and time management services, and online educational tools. (University of South Carolina, n.d.)
Methodology

In August of 2016 (the beginning of the 2016-2017 school year), Student Health Services’ Mental Health Initiatives program received approval from curriculum coordinators at the University of South Carolina’s student-athlete center (The Dodie Anderson Academic Enrichment Center) to conduct a number of mental health outreach presentations tailored towards student-athletes. Once approval was received from the student-athlete center, coaches of all USC Division-I teams were contacted and, consequently, a total of three teams elected to attend said presentations: Women’s Sand Volleyball, Men’s Track & Field, and Women’s Track & Field.

The outreach Power Point presentation was developed and approved by the Office of Mental Health Initiatives in September of 2016 (see Appendix (1)). During the months of September and October 2016, all three teams of student-athletes were presented to separately, attending a one-time presentation in a room consisting only of the athletes and the presenters (coaches and curriculum coordinators were absent). Among the presenters was a representative from USC’s Office of Mental Health Initiatives, Jennifer Meyers, and a mental health advocate, myself: Hannah Giangaspro. Meyers served to educate the student-athletes on mental disorders, on-campus mental health services,32 and coping strategies that student-athletes can put in place. I shared my personal story with a mental disorder and encouraged the attendants to obtain help. All three teams received the same presentation from the same presenters (see Appendix (1)).

Approximately five months later (March of 2017), I created an anonymous seven-question follow-up survey (see Appendix (2)). It was approved by the Office of Mental Health Initiatives, as well as the study directors from the University of South Carolina Honors College.
Once approval had been obtained from said groups, the survey was sent out via email to the three teams that had attended the presentation in the fall of 2016. The survey did not require International Review Board (IRB) approval (see Appendix (3)).

To maximize respondents, the survey was emailed to the teams on three separate occasions: March 17, 2017; March 21, 2017; and March 28, 2017. The survey was created on Google Forms with the aim to determine the following:

1) Attendance at the mental health outreach presentation

2) Prevalence of mental health disorders amongst University of South Carolina student-athletes

3) Specific mental health disorders amongst University of South Carolina student-athletes

4) Whether USC student-athletes began to receive mental health services as a result of the mental health outreach presentation

5) Whether USC student-athletes felt confident seeking help for their mental health as a result of the mental health outreach presentation

6) Specific items that stuck out to USC student-athletes as a result of the mental health outreach presentation

7) Specific barriers that prevent USC student-athletes from seeking help for their mental health

The survey was closed on March 29, 2017 and data was pulled for analysis (see Results).
## Results

All data was obtained from the Mental Health Presentation Follow-Up Survey (see Appendix (2)). A total of 41 respondents completed the survey.

### Table 1: Surveyed Population Statistics

<table>
<thead>
<tr>
<th>Team</th>
<th>Roster-Count</th>
<th>Total Undergraduate Student-Athletes</th>
<th>Total Graduate Student-Athletes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women’s Sand Volleyball</td>
<td>20</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Men’s Track &amp; Field</td>
<td>35</td>
<td>35</td>
<td>0</td>
</tr>
<tr>
<td>Women’s Track &amp; Field</td>
<td>61</td>
<td>60</td>
<td>1</td>
</tr>
<tr>
<td>Totals:</td>
<td>116</td>
<td>112</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 1: Details the surveyed population, i.e. the three teams that chose to receive the presentation. “Roster-Count” indicates the total number of student-athletes that comprise each team. The population consisted of primarily undergraduate student-athletes (112 undergraduate student-athletes compared to 4 student-athletes pursuing a graduate degree, most likely a master’s degree). It is unknown exactly how many of these athletes attended the mental health presentation.

### Table 2: Response-Rate Among the Surveyed Population

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey Respondents</td>
<td>41</td>
</tr>
<tr>
<td>Surveyed Population</td>
<td>116</td>
</tr>
<tr>
<td>Response-Rate</td>
<td>35.34%</td>
</tr>
</tbody>
</table>

Table 2: Compares the total number of student-athletes who responded to the survey (“Survey Respondents”) to the total number of student-athletes who received the survey via email (“Surveyed Population). The total surveyed population of 116 comes from the total “Roster Count” in Table 1. The response rate was calculated by dividing the total number of survey respondents by the total survey population.
Figure 1: Shows the percentage of survey respondents who attended the mental health presentation in the fall of 2016. This graph corresponds to “Question 1” of the Mental Health Presentation Follow-Up Survey (see Appendix (2)). “Yes” (in blue) indicates that the respondent attended the presentation while “No” (in red) indicates that the respondent did not attend the presentation. This was a mandatory question and therefore received answers from all 41 survey participants. The graph was created by Google Forms.
Figure 2: Prevalence of Mental Disorders

The figure shows the prevalence of mental disorders (in the form of percentages) among the survey respondents. This graph corresponds to “Question 2” of the Mental Health Presentation Follow-Up Survey (see Appendix (2)). “Yes” (in blue) indicates that the respondent suffered from some form of mental disorder at the time of the survey while “No” (in red) indicates that the respondent did not suffer from some form of mental disorder at the time of the survey. This was a mandatory question and therefore received answers from all 41 survey participants. The graph was created by Google Forms.
**Figure 3: Incidence of Specific Mental Disorders**

<table>
<thead>
<tr>
<th>Disorder</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety, depression</td>
</tr>
<tr>
<td>Anxiety, depression</td>
</tr>
<tr>
<td>Stress from being a student athlete with a job</td>
</tr>
<tr>
<td>I can be very anxious, not to an extreme extent but it does effect me</td>
</tr>
<tr>
<td>hey up if you need direct quotes or an interview or whatever oox. and on</td>
</tr>
<tr>
<td>the next question I was already in therapy when I attended the presentation so &lt;3</td>
</tr>
<tr>
<td>Anxiety</td>
</tr>
<tr>
<td>Anxiety (mild)</td>
</tr>
<tr>
<td>Depression, anxiety</td>
</tr>
<tr>
<td>Anxiety, depression, self-harm, disordered eating</td>
</tr>
<tr>
<td>N/A</td>
</tr>
<tr>
<td>anxiety</td>
</tr>
<tr>
<td>Moderate Anxiety</td>
</tr>
</tbody>
</table>

**Figure 3**: Displays direct responses from survey participants detailing their specific mental disorders. All responses were anonymous. This figure corresponds to “Question 3” of the Mental Health Presentation Follow-Up Survey (see Appendix (2)). This was an optional question and therefore received answers from only 12 of 41 survey participants. Certain content has been censored for the sake of privacy. The figure was created by Google Forms.
Figure 4: Mental Health Services Received as a Result of the Presentation

Figure 4: Shows the percentage of survey respondents who chose to receive mental health services as a result of the mental health presentation in the fall of 2016. This graph corresponds to “Question 4” of the Mental Health Presentation Follow-Up Survey (see Appendix (2)). “I did not attend the presentation” (in blue) indicates that the respondent did not attend the presentation. “Yes” (in red) indicates that the respondent chose to receive mental health services as a result of the presentation. “No, I still did not seek help” (in orange) indicates that the respondent struggled with mental health at the time of the presentation but chose not to receive mental health services following the presentation. “No, I do not struggle with mental health” (in green) indicates that the respondent does not struggle with mental health and, therefore, did not receive mental health services as a result of the presentation. This was a mandatory question and therefore received answers from all 41 survey participants. The graph was created by Google Forms.
Figure 5: Shows the percentage of survey respondents who report feeling comfortable about receiving mental health services as a result of the presentation. This graph corresponds to “Question 5” of the Mental Health Presentation Follow-Up Survey (see Appendix (2)). “Yes” (in red) indicates that the respondent felt comfortable with seeking help through mental health services as a result of the presentation while “No” (in orange) indicates that the respondent did not feel comfortable with seeking help through mental health services following the presentation. “I did not attend the presentation” (in blue) indicates that the respondent did not attend the presentation. This was a mandatory question and therefore received answers from all 41 survey participants. The graph was created by Google Forms.
**Figure 6: Qualitative Reactions to the Presentation**

<table>
<thead>
<tr>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>You made mental health something approachable and important. Your words felt very genuine and honest.</td>
</tr>
<tr>
<td>you are amazing hannah and such a wonderful human being and I love you so much and am so honored to be your teammate. keep being you girlie!</td>
</tr>
<tr>
<td>That having a mental illness doesn't make you abnormal, and asking for help isn't a sign of weakness</td>
</tr>
<tr>
<td>How many options there are when seeking help. People care</td>
</tr>
<tr>
<td>N/A</td>
</tr>
<tr>
<td>You did an amazing job!!!</td>
</tr>
</tbody>
</table>

*Figure 6: Displays direct responses from survey participants detailing what parts of the presentation stood out to them. All responses were anonymous. This figure corresponds to “Question 6” of the Mental Health Presentation Follow-Up Survey (see Appendix (2)). This was an optional question and therefore received answers from only 6 of 41 survey participants. The figure was created by Google Forms.*
Figure 7: Perceived Constraints on Receiving Mental Health Services

Figure 7: Indicates what survey respondents felt prevents them from receiving help for their mental health via mental health services. This figure corresponds to “Question 7” of the Mental Health Presentation Follow-Up Survey (see Appendix (2)). From top to bottom on the y-axis, choices are as follows: “Time,” “Fear,” “Embarrassment,” “It is a sign of weakness,” “It’s not that big of a deal,” “People would think less of me,” and “Other.” Respondents were able to choose all options that applied. This was a mandatory question and therefore received answers from all 41 survey participants. The graph was created by Google Forms.
Conclusions

As seen in the **Results**, the findings of my study have some alarming implications. First and foremost, *Figure 2* reveals that 36.6% of surveyed student-athletes experience some degree of psychological distress. While the survey did only produce 41 responses, the fact that over one-third of responding athletes struggle with mental health is quite startling. Furthermore, this disturbing percentage does not veer far from the findings presented in the **Literature Review** (see *Mental Health in Student-Athletes*). It would be interesting to see how this data would appear if all sports at the University of South Carolina were represented rather than just Track & Field and Sand Volleyball. Also, conducting the same study at other universities and comparing the findings would allow researchers to better determine whether this problem is restricted to just the University of South Carolina or if it is representative of a nationwide epidemic. Based on the research I have personally conducted, I would not be surprised if this hypothetical epidemic did, in fact, exist. Similar analysis of Honors students as well as general full-time undergraduates would also be of interest, for reasons stated in the **Literature Review** (see *Mental Health in Honors Students* and *Mental Health at the University of South Carolina*).

The qualitative data in *Figure 3* reveal that depression, anxiety, general stress, disordered eating, and self-harm were among the mental disorders that the struggling 36.6% of respondents reported experiencing. Above all, according to *Figure 3*, anxiety was the most prevalent mental disorder in University of South Carolina student-athletes. However, the survey question that comprised this table (see **Appendix (2) Question 3**) received only 12 responses from the 41 survey participants, so this result may be skewed. To explain, respondents may feel more comfortable sharing that they experience anxiety due to the fact all people experience anxiety to some extent. Therefore, a disease such as an anxiety disorder may not be as difficult for a
struggling individual to talk about, as it is more publicly acknowledged and thus perceived as more socially acceptable. On the other hand, individuals who deal with self-harm and depression may feel less inclined to share the fact that they live with these diseases due to the stigma that surrounds these particular disorders. Consequently, this phenomenon created by the mental health stigma serves as a considerable limitation in this study.

The next figure that struck me at a very personal level. Figure 4 displays the percentage of student-athletes who chose to receive help for their mental disorders through mental health services as a result of my mental health advocacy, i.e. my presentation (see Appendix (1)). To some, 17.1% may seem like a small number. But to me, it brings me to tears every time I glance at it. If you do the math, 17.1% of 41 is 7. In other words, my mental health advocacy caused seven human beings to get help for themselves. That is absolutely amazing to me, as my presentation lasted less than an hour. This further proves my personal belief that in order to defeat the horrific stigma that surrounds mental health, we have to do what it prevents: we have to talk about mental health on a personal level.

That being said, reality must be faced: 14.6% of survey respondents struggled with mental health at the time of my presentation but still chose not to get help (see Figure 4). An answer to why student-athletes choose not to receive mental health services may be explained in Figure 7. According to this figure, it appears that time itself serves as a major limiting factor in regards to receiving help. I expected this to be true for athletes. As a former student-athlete myself, I know what a demand practicing multiple times a day on top of travelling most weekends, all while trying to keep up with studies, can drain one’s time rather severely. Even today, though I am no longer an athlete, it can be hard for me to find a time that works to meet with my psychiatrist. That being said, I know mental health is a priority, so I choose to make
time. It is therefore important that future interventions, especially by mental health advocates, really hit this point hard: mental health is worth making time for.

However, to my amazement, the greatest limiting factor preventing student-athletes from receiving mental health services was found to be the perception that their mental health struggles are “not that big of a deal” (see Figure 7). This result shocked me. As a lifelong athlete, I know the importance of the “mental aspect” of the game. Furthermore, even just as a general, functioning human being, I use my brain. All the time. Every day. This perception that mental health is “not that big of a deal” is therefore alarming and absolutely devastating, and is, no doubt, a direct result of the mental health stigma. For some reason, the stigma leads us to believe that our mental health isn’t important and that we shouldn’t address it like we would any other disturbance in our health. This is wrong for obvious reasons. Mental health advocates therefore need to work to convince their listeners of the opposite. They need to make them realize how painful of an experience a mental disorder can be and how important it is to get help and nip it in the bud as soon as symptoms arise, not after they have developed into a full-blown mental disorder.

Moving forward, I would love to give the same survey (see Appendix (2)) to a group of individuals who have attended a “typical” mental health presentation: a presentation where a person knowledgeable in the field of mental health merely presents some statistics and reasons why a struggling individual should get help. While this form of presentation means well, I believe that it fails to convince the struggling to receive help; its lack of personality and relatability maintains the stigma behind receiving help.

When an individual speaks from a personal level about mental health, the listeners who struggle with mental health are able to form an impenetrable bond with the speaker due to their
commonalities. As shown in the Literature Review (Mental Health Advocates: Impact on the Speaker and the Listener) this serves to “break down” the barrier created by the enemy that is stigma. It puts a name with a face, as individuals discover the fact that their peers have struggled as well. They are not alone. Their peers have received help and have bettered their lives; they are not without resources, not without hope.

From the perspective of the speaker, i.e. the mental health advocate, I can personally say that the benefit of mental health advocacy does not reside with the listener alone. From the moment I spoke for the Mental Health Matters campaign launch video (see Appendix (4)), I began to feel a strong and powerful therapeutic effect. My story was out there to be seen and heard. My name and face were now associated with an eating disorder but, more importantly, with hope of recovery. It was the first time I outwardly admitted to having an eating disorder; it was the first time I had looked at my disease as something I had, not something that had me. By saying it out loud, the weight of the words not only left my mouth, it left my shoulders. I felt the feeling of liberation I had been dreaming of. It was the first time I had truly thought of myself as “recovered.”

Once the video was made live, the feeling became even more incredible as I received message after message of thanks. This marked the first time in which I had felt that all my struggles were suffered for a purpose. This was the first time I viewed my pain as a blessing rather than a curse. This feeling was what inspired me to continue my advocacy by speaking in-person to my athletic peers. The responses of Figure 5 and Figure 6 inspire me to keep going even further. The fact that only 2.4% of respondents felt uncomfortable seeking help through mental health services (see Figure 5) as a result of my in-person presentation brings immense joy to my heart. Once again, I would like to see what this result would be following the “typical”
mental health presentation described in the paragraphs above. The qualitative data presented in Figure 6, once again, brought tears to my eyes.

Although I did not speak of it in my presentation or in the Mental Health Matters campaign launch video, I have shared my story as it relates to anxiety and depression over social media (one post is presented in the Introduction) and in this particular thesis. The impact that my story has had on social media is, once again, absolutely incredible. People who I would have never guessed to experience mental disorders opened up to me both privately and publically about their struggles. Some of my friends began sharing their own stories over social media and received very similar responses to the ones I received from their own friends and family. Consequently, I believe that social media is a very powerful tool. So powerful, in fact, that I believe we can start a movement; we can start sharing our stories with mental health on the public sphere, destroying the stigma one story at a time. Not only does the advocacy destroy the stigma, it encourages the audience and both liberates and heals the speaker.

Speaking about my eating disorder, a disease that I have recovered from, was one thing; talking about diseases that I still deal with, i.e. anxiety and depression, was another. It was a lot harder for me to talk about the struggles I still faced, because I was afraid that my peers would look at me differently and, more importantly, that I would be too unstable to talk about my diseases. This did not prove to be the case. If anything, I became far more respected for the same reasons I discussed above: I had the diseases, but the diseases did not have me. By opening up to the world and putting my thoughts into words, I was able to make sense of my disorders. For anyone who has struggled with mental health, you know how big of a deal just making sense of it all as well as labeling it can be. Furthermore, opening up has caused others to open up to me, thus forging a beautiful network of supportive and understanding individuals in my life, all
tied together by one common problem and, most importantly, by one common goal: to be freed. Once again, for anyone who has struggled with mental health, you know how big of a deal just being understood can be.

It is my hope that this thesis will have an even larger impact than my discussion with my peers both in-person and over social media due to the fact that it combines my personal story with science and fact. People are suffering. Everywhere. Over one-third of my peers deal with mental disorders. It is not uncommon. Stigma has been winning. It is time to destroy it. After much deliberation, the results of my mental health advocacy and the findings of this thesis have convinced me to make this document public. I want everyone to have access to my story and my research. I want this document to go beyond the spheres of my personal life. I want it to start a movement, to change the world. I do not want this to cause my name to be associated with an eating disorder, with depression, with anxiety, because these disorders do not define me. I want this to cause my name to be associated with hope, with love for oneself, with acceptance of the cards one has been dealt. As I endure this long and difficult journey with mental health, I will continue to share my story with the world and I will continue to pray that we can one day overcome the stigma behind mental health, thus allowing ourselves to obtain the help we truly deserve, no longer suffering in silence. I hope for a Tomorrow in which my peers and I are free. But, for Today, I thank God for my struggles and for allowing me to serve my life’s purpose.

Thank you for reading.

~Hannah Giangaspro
References


Appendix

(1) Mental Health Power Point Presentation

*Slide 1:* I elaborated on a serious injury I received due to thinking my soreness was “not a big deal.” I spoke about how getting proper treatment helped me get back to full-health in no-time.
Slide 2: I spoke about my past struggles with an eating disorder and how it related to my athletics.

ALSO JUNE 2015 (SAME DAY)
Slide 3: I elaborated on how I got help for my eating disorder and related it to my recovery story from Slide 1. I also spoke to how getting help does not make you any less of the person.
Mental Health Presentation Follow-Up

Hello everyone! Please take a few minutes to fill out this anonymous, SUPER quick survey. It is for my senior thesis... I need it to graduate... help a fellow Gamecock out (;

* Required

Question 1. Did you attend the mental health presentation given by me (Hannah Giangaspro) and Jennifer Meyers from the Office of Mental Health last semester? (If you don't remember, it was a mandatory event according to the coaching staff. I shared my story over a Powerpoint while Jennifer talked to you all about mindfulness and did a meditation practice). *

- Yes
- No

Question 2. Do you struggle with mental health disorders (anxiety, depression, substance abuse, OCD, self-harm, disordered eating/eating disorder, etc.)? *

- Yes
- No

Question 3. If you wish to elaborate on the above question, you may do so here. (**OPTIONAL**)
**Question 4.** Did you begin seeking help for your mental health (even if it was just for general stress) following the presentation given by me and Jennifer? *

- I did not attend the presentation
- Yes
- No, I still did not seek help
- No, I do not struggle with mental health

**Question 5.** Do you feel confident seeking help for your mental health following the presentation? *

- I did not attend the presentation
- Yes
- No

**Question 6.** If anything from the presentation stuck with you, please elaborate here. (**OPTIONAL**)
Question 7. What do you feel prevents you from seeking help/talking about your mental health? (**CHECK ALL THAT APPLY**) *

- [ ] Time
- [ ] Fear
- [ ] Embarrassment
- [ ] It is a sign of weakness
- [ ] It's not that big of a deal
- [ ] People won't understand
- [ ] Other:  

SUBMIT

Never submit passwords through Google Forms.
(3) International Review Board Email
This response was received from the International Review Board (IRB) in regards to the Mental Health Presentation Follow-Up Survey. The IRB manager’s name and phone number are omitted for the sake of privacy.

IRB review and approval are not required for this activity.

Thank you,

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(4) University of South Carolina Mental Health Matters Campaign Launch Video Link
Follow the link below to watch the video in which I first appeared as a mental health ambassador.

https://youtu.be/Pi_9QTyGQoQ