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Original Research

Barriers to and Facilitators of Collegiate Athletes Seeking Mental Health Services

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Context: Approximately 1 in 5 student-athletes experience some type of mental health concern. However, fewer than half of student-athletes who report mental health concerns seek mental health treatment (ie, psychotherapy or medication). Data concerning barriers to student-athletes seeking mental health care are limited but suggest that stigma is the primary reason. Further, whether having shared identities with their sport psychologists (eg, race and gender) encourages student-athletes to seek help has been minimally explored.

Objectives: To determine the frequency of internal and external barriers to athletes seeking mental health care and examine the importance of athletes and sport psychologists sharing identities as a facilitator of seeking help.

Design: Cross-sectional study.

Setting: Collegiate athletics.

Patients or Other Participants: A total of 266 student-athletes (53.8% women, 42.5% White) from a National Collegiate Athletic Association Division I university.

Main Outcome Measures: Student-athletes responded to 9 binary (*yes* or *no*) prompts related to internal barriers (eg, beliefs and attitudes about mental health) and 7 reflecting external barriers (ie, different stakeholders, such as the head coach). Regarding facilitators of mental health help-seeking, student-athletes rated how important it was for them to share each of 10 identities with their sport psychologist from 1 (*not at all important*) to 5 (*extremely important*). All identified barriers and facilitators were derived from existing research.

Results: Differences were found in athletes' ratings of internal and external barriers. For example, a belief in one's own reliance and not having enough time were significant barriers, as was their head coach having a negative attitude about the importance of mental health. Female student-athletes rated sharing a gender identity with their sport psychologist as more important than did male student-athletes.

Conclusions: Despite efforts by the National Collegiate Athletic Association to reduce the stigma surrounding mental health, persisting barriers within collegiate sports may keep athletes from seeking help.

Key Words: psychological well-being, mental health stigma, matching hypothesis

Key Points

- Student-athletes experienced barriers to mental health care, such as a belief in one's own self-reliance and a lack of confidence that mental health treatment would be effective.
- Regardless of sex or race, student-athletes perceived head coaches' negative attitudes toward mental health as a barrier.
- Overall, matching identities with their sport psychologists was not thought to be as important when student-athletes sought assistance, although they wanted their sport psychologists to talk about their similarities and differences.

The prevalence of mental illness among the general population is high and increasing. In the United States, an estimated 51 million (20.6%) adults reported suffering from mental health concerns (eg, major depressive disorder, generalized anxiety) in 2019; the highest prevalence rates were among young adults aged 18 to 25 years (29.4%).[1] Young adults experience developmental stressors, such as working part or full time, becoming financially independent, navigating new friendships and romantic relationships, and being continuously exposed to social media messages, which often contribute to their risk of experiencing psychological distress.[2] College students also may have moved away from home for the first time, had to share their living space with roommates who hold different identities and beliefs, and faced high expectations of their academic performances, all of which may add to their risk.[2] Further, the novel coronavirus disease 2019 (COVID-19) pandemic brought about additional (and new) health, financial, and societal stressors that have exacerbated already high levels of mental health concerns among college students.[3,4]

As a subset of college students, athletes experience unique stressors that have been suggested to contribute to their psychological distress, despite their generally high levels of physical fitness, activity, and wellness, all of which may lessen the risk.[5] For example, between their academic and sports responsibilities, student-athletes have full schedules that leave them little time for rest, recuperation, and relaxation. They also face high expectations related to their sports, academic standards to remain athletically eligible, the possible loss of sport scholarships, potentially negative interactions with or demands from coaches, and the ever-present reality that they might experience a

career-ending injury.[5] Since 2010, researchers[5–10] have been documenting collegiate athletes' mental health concerns (eg, depression, anxiety), often finding rates that were similar to nonathlete peers. Noting these high and increasing levels of psychological distress among collegiate athletes, professional organizations, such as the National Athletic Trainers' Association[11] and National Collegiate Athletic Association (NCAA),[12] published consensus statements regarding best practices for understanding and supporting mental health and wellness. Since COVID-19, prevalence rates of mental health concerns have remained high, even exceeding pre-COVID-19 levels for some conditions, which has only heightened the need for research and programming to assist athletes in this area.[4]

Although substantive numbers of collegiate student-athletes experience mental health concerns and despite recommendations that collegiate athletic departments (1) have mental health professionals on staff, (2) have procedures for identifying and referring athletes for mental health care, (3) conduct preparticipation mental health screening, and (4) promote and support athletes' mental health through education and programming,[12] approximately 60% of student-athletes did not seek any form of psychological treatment.[9] In documenting help-seeking before and just after the onset of COVID-19, Slavin et al[4] found that collegiate athletes' use of counseling services decreased from 17.1% (pre-COVID-19 onset) to just 2.3% (post-COVID-19 onset). This decline may have been due, in part, to student-athletes moving off campuses and the subsequent challenges of accessing telehealth opportunities, yet even pre-COVID-19 use was low and substantially below the rates at which collegiate athletes were experiencing mental health concerns.[4,6,9]

Given this discrepancy between reported concerns and help-seeking behaviors, investigators[13–15] have focused on identifying the factors that may serve as barriers to or facilitators of athletes using the mental health services available to them. Although the most frequently cited barrier is mental health stigma, different internal (eg, beliefs and characteristics) and external (eg, stakeholder attitudes) factors underlie the stigma and thus prevent athletes from seeking out and using the available psychological services.[16,17] For instance, internal factors include the fear of being perceived as weak, a lack of knowledge about mental health, a lack of time, and a belief in their own self-reliance (ie, dealing with the concerns on their own); all are considered aspects of stigma that inhibit help-seeking.[17,18] Student-athletes also have indicated that external factors, particularly the attitudes of stakeholders within the sport environment (eg, coaches and athletic trainers), play a role in how they view and respond to mental health concerns.[19] That is, when stakeholders hold negative views about the importance of mental health or make pejorative comments about seeking help, athletes may become increasingly reticent to acknowledge, share, and seek help for their own psychological distress.

Compared with barriers, research on potential facilitators of health help-seeking has been scant.[15,17] However, one of the more robust areas of investigation of facilitators of mental health care addresses the "matching hypothesis."[20] Grounded in an altruistic motivation to provide culturally sensitive care to clients who have been historically marginalized in the mental health field,[20] the matching hypothesis argues that when clients are matched to mental health providers with salient identities, such as race, they become more open to seeking and receiving psychological care and subsequently perceive their therapy experiences more positively.[20] Although the matching hypothesis makes intuitive sense, and the authors of 1 study[21] have documented a preference for shared racial or cultural identities between student-athletes and sport psychologists, the actual effectiveness of this approach regarding clinical outcomes (ie, symptom reduction) has not been well supported.[22,23] One limitation of this line of research, in particular as it relates to athletes' experiences, has been an almost exclusive focus on the identities of race and culture.[21,24] Thus, additional exploration is needed to examine the importance of, or athletes' preferences for, other salient identities, such as gender, sexual orientation, or athletic status, in relation to the psychological services they might receive.

Given (1) the high prevalence of mental health concerns that exist among college student-athletes[5–10] and (2) the discrepancy between the rates of such concerns and the frequency with which student-athletes seek mental health care,[4,6,9] we examined student-athletes' perceptions of potential barriers to or facilitators of seeking mental health care and considered the extent to which their perceptions varied based on their own gender and racial identities.[4,6,8] We explored the strength of the athletes' perceptions of internal factors but hypothesized that those who identified as a racial minority and male would endorse barriers more often than those who identified as White or female. Regarding external factors (ie, stakeholders' attitudes), we proposed that student-athletes would most frequently identify head coaches as the primary barrier. Regarding potential facilitators, we evaluated the relative importance of the athletes sharing identities with their sport psychologists and hypothesized that having shared experiences in sports would be the most salient.

METHODS

Participants

Participants consisted of 266 student-athletes (women = 53.8%, White = 42.5%) who represented an entire NCAA Division I athletic department. Recruits were drawn from 11 sports. Detailed demographic information is provided in Table 1.

Instruments

Barriers to Seeking Mental Health Services. After an extensive review of the literature,[13,14,17,18] we identified 9 internal factors (ie, beliefs, knowledge, and attitudes) that have been supported as possible barriers to athletes seeking mental health care. Each of the 9 factors, written as statements, was presented to the student-athletes with the following prompt: "Which of the following would keep you from using the mental health services that are available to you as a student-athlete?" Each factor as presented to the student-athletes is listed in Table 2. For each factor, participants selected *yes* or *no* to indicate if they thought the belief or attitude would keep them from using available mental health services. The response to each belief or situation served as its own outcome.

Also extending from our literature review,[17–19] we identified the 7 key stakeholders who surround and influence

Table 1. Participant Demographics

Characteristic	No. (%)
Gender	
Man	123 (46.2)
Woman	143 (53.8)
Race or ethnicity	
Asian or Asian American	8 (3.0)
Biracial or multiracial	16 (6.0)
Black or African American	93 (35.0)
Hispanic or Latinx	27 (10.2)
Native American	3 (1.1)
Native Hawaiian or Pacific Islander	4 (1.5)
Prefer not to share	1 (0.4)
Prefer to self-identify	1 (0.4)
White	113 (42.5)
Sport	
Men's basketball	11 (4.1)
Women's basketball	16 (6.0)
Cross-country or track and field	67 (25.2)
Football	72 (27.1)
Men's golf	3 (1.1)
Women's golf	7 (2.6)
Soccer	28 (10.5)
Softball	22 (8.3)
Swimming and diving	24 (9.0)
Tennis	6 (2.3)
Volleyball	10 (3.8)

college student-athletes. Each stakeholder was presented independently to the student-athletes with the following question: "For each person listed below, if they had a *negative attitude* about seeking help for psychological concerns, would that keep you from using the mental health services that are available to you as a student-athlete?" The 7 stakeholders are listed in Table 3. The response to each stakeholder (ie, *yes* or *no*) served as its own outcome.

Importance of Shared Identities With Sport Psychologists. Consistent with the matching hypothesis[20] and based on our review of the pertinent research, we categorized 10 key identities (eg, race, sex, and athlete status). Each identity was presented independently in the following prompt: "If you were going to seek mental health care from a sport psychologist, how important would it be for your sport psychologist to. . ." Then, for each identity, such as ". . .be of the same race/ethnicity" or ". . .share your sexual identity," athletes responded from 1 (*not at all important*) to 5 (*extremely important*). The identities are listed in Table 4, and the response to each identity served as its own outcome.

Although the term *sport psychologist* may suggest a sport, performance, or mental skills focus to some, in this university's athletic department, all the sport psychology staff were part of an American Psychological Association–accredited counseling psychology doctoral program that had an integrated specialization in sport psychology. The doctoral program had been providing the sport psychology or mental health services for this athletic department for the last 25 years; all services were overseen or supervised by licensed psychologists (who were also trained in sport or performance). Further, mental health screening and education had been ongoing in this athletic department for 10 years, and the athletes, coaches, and staff were aware that the sport psychology staff provided both mental health care and more traditional sport psychology services. Therefore, for this sample of collegiate athletes, responses reflected how important they believed each identity was in relation to seeking help from someone they understood to provide mental health care.

Table 2. Athletes' Perceptions of Potential Barriers to Seeking Mental Health Services[a]

Potential Barrier	Mean ± SE
A lack of knowledge about mental health disorders and symptoms	0.420 ± 0.032[a,b]
If you had a negative attitude toward seeking help, such as feeling ashamed or embarrassed if you did	0.383 ± 0.031[a,b]
A lack of confidence that mental health treatment will be effective and help you get better	0.391 ± 0.031[a,b]
A belief in your own self-reliance (ie, believing that you can handle everything yourself)	0.490 ± 0.031[a]
A concern that the information you share will NOT be kept confidential	0.319 ± 0.029[b,e,d]
Not enough time in your schedule	0.487 ± 0.031[a]
A lack of awareness of the mental health resources available to you	0.321 ± 0.030[c,d]
Previous negative or poor experiences with a mental health or sport psychology professional	0.255 ± 0.028[d]
A lack of support from your family for seeking mental health treatment	0.198 ± 0.026[e,d]

Note: Items are presented in their original format.
[a] Mean scores that do not share a common superscript (eg, [a] or [b]) were different at the .01 level.

Table 3. Athletes' Perceptions of Stakeholders' Negative Attitudes Being a Barrier to Seeking Help[a]

Stakeholder	Mean ± SE
Head coach	0.323 ± 0.030[a]
Assistant coach	0.267 ± 0.028[b]
Academic staff or counselors	0.226 ± 0.027[b]
Teammates	0.210 ± 0.026[b]
Strength and conditioning staff	0.241 ± 0.028[b]
Athletic trainers	0.232 ± 0.027[b]
Other athletic department staff (eg, compliance staff, athletic director)	0.221 ± 0.027[b]

[a] Mean scores that do not share a common superscript (eg, [a] or [b]) were different at the .01 level.

Procedures

Our university's institutional review board approved the study. As part of their 2020 to 2021 mandatory annual mental health screening, student-athletes completed the items in this study (a copy of the full mental health screening survey is available upon request). Review of the research items was performed by 12 doctoral-level counseling or sport psychology students and their professor. Student-athletes were sent the online survey link, which was hosted on Qualtrics, and then voluntarily consented for their data to be used in this research project (84.2% consented). The review focused on item clarity, adherence to what had been identified in past research, and ease of completion. The entire survey took approximately 10 minutes to complete; as part of the screening process, student-athletes were informed that their data would not be shared with their coaches and would be part of their confidential medical record. Although

Table 4. Athletes' Ratings of the Importance of Sport Psychologists Sharing Identities or Characteristics With Them[a,b]

Shared Identity or Characteristic	Mean ± SE		
	Total, n = 250	Men, n = 113	Women, n = 137
To be of the same race or ethnicity	1.41 ± 0.056[a,d]	1.50 ± 0.085[a]	1.32 ± 0.074[a]
To be similar in terms of age	1.60 ± 0.063[a,b,d,f]	1.59 ± 0.094[a]	1.62 ± 0.082[a]
To share your gender identity	1.64 ± 0.071[a,b,e]	1.45 ± 0.108[b]	1.82 ± 0.094[b]
To share your sexual identity	1.50 ± 0.067[a,d,f]	1.54 ± 0.10[a]	1.47 ± 0.088[a]
To be from the same country of origin	1.40 ± 0.058[a,c,d]	1.46 ± 0.09[a]	1.33 ± 0.09[a]
To be from a similar socioeconomic status	1.36 ± 0.056[c,d]	1.45 ± 0.08[a]	1.28 ± 0.073[a]
To be similar in terms of physical ability status	1.37 ± 0.057[d]	1.40 ± 0.09[a]	1.34 ± 0.075[a]
To openly discuss similarities and differences in shared identities	2.25 ± 0.087[g]	2.11 ± 0.13[a]	2.38 ± 0.114[a]
To have been an athlete at the collegiate level or higher	1.92 ± 0.073[e]	1.86 ± 0.11[a]	1.99 ± 0.096[a]
To have played your sport	1.77 ± 0.071[e,f]	1.83 ± 0.10[a]	1.71 ± 0.094[a]

[a] Mean scores that do not share a common superscript (eg, [a] or [b]) were different at the .01 level. Mean comparisons were made within the total category and separately for each gender comparison (men versus women).
[b] Mean scores for each identity or characteristic can range from 1 (*not at all important*) to 5 (*extremely important*).

student-athletes provided their names and contact information as part of the mental health screening to facilitate treatment follow-up as needed, this identifying information was removed from the research dataset. The student-athletes received no compensation for their participation.

Data Analysis

Statistical analyses were conducted using SPSS (version 25.0; IBM Corp). For each set of barriers, internal (eg, beliefs and attitudes) and external (eg, perceptions of stakeholders), we computed how frequently the athletes endorsed each item (ie, responded *yes*). To examine differences in the athletes' endorsement of each item within the set of barriers (eg, among all 9 internal factors), we conducted a repeated-measures analysis of variance, with each set of barriers (eg, the 7 stakeholders) serving as the within-subject factor and gender (men versus women; no athlete selected any other gender identity) and race (due to the numbers of the racial identities selected by the student-athletes [see Table 1], they were grouped as White or Athletcs of Color) as the between-subjects factors. Thus, we conducted this analysis separately for the ratings of the stakeholders and for the athletes' internally held beliefs or attitudes. We were specifically interested in the within-subject main effect as well as its possible interaction with either of the between-subjects variables. For significant within-subject effects, we conducted least significant difference pairwise comparisons to differentiate the student-athletes' ratings across each set of items.

For the identity items, we first computed the mean and SD for each; all items were normally distributed based on skewness, kurtosis, and outliers. Similar to the barrier analyses, we used a repeated-measures analysis of variance, with the identity items as the within-subject variable and gender and race as the between-subjects variables. Among the sample of 266, some athletes did not provide data for each set of barriers and identities. Because of the nature of the data (ie, each question serving as its own outcome), we could not use traditional procedures to replace the missing values. Therefore, the number of participants in each analysis differed slightly and is stated in each section of the results. We set α at .01 for all analyses to control the family-wise error rate.

RESULTS

Internal Barriers: Athlete Beliefs and Attitudes

The interactions of the student-athletes' perceptions of their beliefs or attitudes by their gender and race ($F_{6.91,1719.99} = 19.942$, $P = .096$, $\eta^2_p = .007$), their perceptions by gender ($F_{6.91,1719.99} = 2.179$, $P = .034$, $\eta^2_p = .009$), and their perceptions by race ($F_{6.91,1719.99} = 1.930$, $P = .052$, $\eta^2_p = .008$) were not significant. However, the main effect for the student-athletes' perceptions of the internal barriers was significant ($F_{6.91,1719.99} = 2.72$, $P < .001$, $\eta^2_p = .074$), suggesting that they viewed the items differently as potential barriers to seeking help.

From the post hoc least significant difference analysis, we found that, regardless of the athletes' gender or race, a lack of knowledge about mental health disorders and symptoms (mean ± SE = 0.420 ± 0.032), having a negative attitude toward seeking help (0.383 ± 0.031), a lack of confidence that mental health treatment will be effective (0.391 ± 0.031), a belief in your own self-reliance (0.490 ± 0.031), and not enough time in your schedule (0.487 ± 0.031) were the most frequently endorsed internal barriers. Although their ratings of these 5 barriers did not differ from one another, all were perceived as barriers by more athletes than was having had a previous negative experience with a sport psychology provider (0.255 ± 0.028) and lacking support from family members for seeking mental health care (0.198 ± 0.026; Table 2).

External Barriers: Stakeholders' Attitudes About Mental Health

The interactions of athletes' perceptions of each stakeholder by their gender and race ($F_{4.65,1177.45} = 0.620$, $P = .673$, $\eta^2_p = .002$), stakeholder perceptions by gender ($F_{4.65,1177.45} = 1.005$, $P = .410$, $\eta^2_p = .004$), and stakeholder perceptions by race ($F_{4.65,1177.45} = 0.443$, $P = .806$, $\eta^2_p = .002$) were not significant. However, a significant main effect was evident in the student-athletes' perceptions of the stakeholders as barriers to mental health help-seeking ($F_{4.65,1177.45} = 9.461$, $P < .001$, $\eta^2_p = .036$). The post hoc analysis indicated that the student-athletes, regardless of gender and race, were more likely to endorse their head coaches (0.323 ± 0.030) as a barrier to their help-seeking

than any other stakeholder; the next closest stakeholder was assistant coaches (0.267 ± 0.028; Table 3).

The Importance of Shared Identities

The interaction of the importance of sharing identities or characteristics by athlete gender and race ($F_{6.69,1646.07} = 1.857$, $P = .037$, $\eta^2_p = .009$) and the importance of sharing identities or characteristics by race ($F_{6.69,1646.07} = 2.339$, $P = .024$, $\eta^2_p = .009$) were not significant. However, the importance of sharing identities or characteristics by gender interaction ($F_{6.69,1646.07} = 3.354$, $P = .002$, $\eta^2_p = .013$) and the importance of sharing identities or characteristics main effect ($F_{6.69,1646.07} = 30.792$, $P < .001$, $\eta^2_p = .111$) were significant.

Although the athletes' mean ratings of the importance of each identity were below the midpoint of the scale (ie, 3), suggesting that they did not believe it was important that a sport psychology consultant hold any of the stated identities, significant differences were present even among their lower ratings. Through the post hoc analyses, we found that the most important identities or characteristics were being able to discuss similarities and differences in identities (2.25 ± 0.09) and having been at least a collegiate-level athlete (1.92 ± 0.07). Student-athletes also rated having played the same sport (1.77 ± 0.07) as more important than many of the other identities or characteristics. Of the demographic identities (eg, gender, race, age, socioeconomic status), gender was rated as the most important identity (1.63 ± 0.07; Table 4).

Regarding the gender-by-importance interaction, only 1 effect was significant. Male and female athletes differed when rating the importance of a sport psychology consultant matching their gender identity. Specifically, women (1.816 ± 0.09) indicated that sharing the same gender identity was more important than it was for men (1.454 ± 0.11).

DISCUSSION

We investigated student-athletes' perceptions of potential barriers (internal and external) and facilitators of seeking mental health care. Regarding internal barriers (ie, the athletes' own beliefs or attitudes), regardless of the student-athletes' gender or race, they most frequently endorsed a belief in their own self-reliance and a perceived lack of time to seek care as barriers, which is consistent with previous research assessing the realities of athletes' personalities and the demands they are under.[24] For example, collegiate sports environments may contribute to self-reliance by rewarding athletes who push through adversity and demonstrate mental toughness.[24] Other significant internal barriers were a lack of knowledge about mental health disorders, a negative attitude toward seeking help, such as feeling ashamed or embarrassed, and being concerned that mental health information would not be kept confidential. These findings suggest that, despite efforts athletic departments may already be making, there is a continuing need to provide mental health education to help student-athletes feel less stigma (eg, shame) about mental health, understand how the process of counseling works and how it can help them alleviate their concerns, and assure them that mental health information is kept confidential in their medical records; such efforts would be consistent with best practices for supporting student-athlete mental health.[12]

Regarding the 7 stakeholders we identified in the literature,[18] student-athletes generally perceived them as not being strong barriers to seeking help, although they did identify their head coaches as being most important or influential as a barrier. No other differences in how the athletes perceived the remaining stakeholders were seen. Head coaches possess high levels of control over their athletes (eg, schedules, scholarships, and playing time), especially in collegiate sports.[25] Thus, if student-athletes believe that their coaches have a negative attitude about mental health and seeking help, they may defer needed care out of fear of their coaches seeing them as weak or thinking less of them and losing playing time.[25] Similar to student-athletes, and again consistent with best practices,[12] head coaches should undergo mental health education that reduces their own stigma and increases their mental health literacy and knowledge, which can increase their comfort in talking about mental health with athletes and making sensitive and supportive referrals for psychological care.[26] Unfortunately, a recent study[27] indicated that coaches' mental health literacy remained only moderate.

As for athletes sharing identities with a sport psychologist, their lower ratings suggested that they did not view any identity or characteristic as being particularly important in relation to their seeking mental health care from that person. However, 3 identities or characteristics were rated as more important than all the others, including being able to openly discuss similarities and differences in identities, having played sports at an elite level (eg, college or higher), and having played the same sport as the athlete. Individuals who believe their clinicians are not sensitive to cultural factors may feel mistrust, leading to potential premature termination of services.[28] Thus, it is important for sport psychologists to broach the subject of identities in sessions, especially as discussions of gender, race, sex, and sexuality have become more frequent and salient in sport and among athletes. Consistent with this perspective, Lubker et al[21] determined that unchangeable attributes of sport psychologists, such as gender and race, were less important to athlete clients than changeable ones, such as the level of training and interpersonal skills. Similarly, Horst et al demonstrated that counselors with cultural awareness and understanding of differences were more important to clients than sharing an identity, such as gender or race.[29] Sport-related identities may serve as a proxy for how well sport psychologists understand and are comfortable in sport environments. Knowing that their sport psychologists had their own high-level sport experiences would likely make it easier for athletes to feel comfortable in the counseling relationship and trust the sport psychologist and for the provider to be able to appropriately understand and contextualize the athlete's concerns and not make recommendations that are misaligned with the athlete's goals and realities, such as dropping out of the sport. Finally, female student-athletes rated having a sport psychologist of the same gender as more important than male athletes. This result coincides with previous results in which women expressed a preference for a hypothetical "less effective, same gender" therapist over a "more effective, different gender" therapist.[30(pp707)]

Although our study had many strengths and addressed questions that had not been asked regarding potential barriers and facilitators of collegiate athletes' help-seeking, certain limitations warrant discussion. First, due to the survey being part of the student-athletes' annual mental health screening, they supplied their names and, as such, may have been less likely to express their true perceptions about the questions asked. For example, some athletes may not have identified a stakeholder, such as their head coach, as a barrier out of fear of the coach finding out. Therefore, our findings may underestimate the extent to which collegiate athletes perceived the presented beliefs, situations, stakeholders, and identities as barriers or facilitators. Second, all student-athletes were from the same athletic department, which limits generalizability to NCAA Division I athletic departments that have similar levels of embedded sport psychology services. Additional examination is needed, with larger samples drawn from multiple athletic departments, to further delineate the presence and importance of these barriers and facilitators.

Sports medicine professionals, including athletic trainers and sport psychologists who work in collegiate athletic departments, should understand what student-athletes perceive to be barriers to seeking help. Because student-athletes reported barriers related to internal beliefs and attitudes, professionals may find it beneficial to provide both student-athletes and staff with resources and education aimed at developing mental health literacy (as recommended by the NCAA[12]). These resources could take the form of workshops, presentations, or handouts. Also, student-athletes who have received treatment in the past could share their experiences as another way to reduce the stigma and improve attitudes about mental health and help-seeking. Through such sharing, athletes' concerns regarding the efficacy of mental health treatment can be addressed. Though it may not be possible for sport psychologists to gain high-level experience in every sport with which they work, it is clear that their knowledge of and comfort about sport is important to student-athletes. Thus, when sport psychologists begin working with athletes from sports that they do not know well, it is incumbent on them to gain knowledge as quickly as possible. Such knowledge may be gained through viewing the sport; talking with other athletes, coaches, or sport staff (eg, athletic trainers) who have competed (or worked) in that sport; being supervised by a colleague who has worked in the sport; and, potentially, participating in the sport. Finally, educational programs must include training on how sport psychologists can broach topics related to identities with their athlete clients because in client-counselor dyads, differences will always be present.

Future researchers may focus specifically on topics that were broadly covered in our study. For instance, exploration of the effect of stakeholders' attitudes toward mental health and help-seeking may provide valuable data for stakeholders to understand how they affect their student-athletes' well-being. Further, investigations of team culture could inform programming to reduce the mental health stigma in athletic departments. Qualitative studies could "flesh out" the topics we evaluated. For example, applying a qualitative design similar to the one used by Horst et al[29] would allow authors to explore the complexities of sharing identities with a sport psychologist.

We determined that collegiate athletes perceived barriers to and facilitators of mental health care that were similar to what has been found among young adults. Student-athletes reported several internal attitudes and beliefs about mental health (eg, belief in their own self-reliance) as key barriers to mental health care. Student-athletes, regardless of gender or race, indicated that head coaches with negative attitudes about mental health would also serve as a barrier. The ability of sport psychologists to discuss differences in identities was rated as the most important characteristic enabling student-athletes to feel comfortable seeking assistance. Therefore, sport psychologists should receive adequate training to feel comfortable broaching topics related to these differences. Our data suggest a continuing need to provide adequate mental health education to student-athletes and relevant stakeholders. Doing so may improve student-athletes' mental health literacy and help-seeking efficacy, offer realistic examples of what mental health treatment is, and assure them of confidentiality in their mental health treatment.

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