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Original Research

Barriers To and Attitudes Toward Seeking Mental Health Services Among Collegiate Marching Band Artists

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Context: Marching band (MB) artists experience stressors influencing their physical, mental, and emotional health warranting medical support, and they face challenges similar to those of other college students and athletes. Mental health illnesses exist in collegiate and MB settings, but barriers affect access to treatment.

Objectives: To examine MB artists' perceived barriers to and attitudes toward seeking care from mental health professionals. The secondary aim was to explore barriers to and attitudes about seeking mental health counseling between genders and history of pursuing mental health counseling.

Design: Cross-sectional study.

Setting: Online survey.

Patients or Other Participants: A total of 534 MB artists (women = 312, men = 222; age = 19.7 ± 1.4 years).

Main Outcome Measure(s): Participants completed surveys on demographics and past medical history along with the Barriers to Help Seeking Checklist, the Attitudes Toward Seeking Professional Psychological Help-Short Form Scale (ATSPPH-SF), and the Mental Help Seeking Attitudes Scale (MHSAS). Descriptive statistics were calculated to assess demographic data. Cross-tabulations and χ^2 statistics were used to evaluate individual barriers (Barriers to Help Seeking Checklist) between genders. Scales were scored 1 to 7 and 10 to 30 on the MHSAS and ATSPPH-SF, respectively. A 1-way analysis of variance measured differences in the total mean score on the ATSPPH-SF between genders.

Results: The highest barrier reported was *lack of time to seek services* (69.1%; n = 369), followed by 47.6% (n = 254) for *services not available during my free time*. Average scores were 4.0 ± 0.4 on the MHSAS (indicating neutral attitudes toward seeking help) and 17.97 ± 5.48 on the ATSPPH-SF (indicating slightly positive attitudes to seeking help). No differences were seen for the total mean scores on the MHSAS and ATSPPH-SF between genders.

Conclusions: Marching band artists' barriers to and attitudes toward mental health care influenced their ability to seek care in times of need and demonstrated some similarities to those of collegiate athletes. Awareness of the obstacles MB artists face in receiving mental health care will assist health care providers in advocating for improved care in this setting.

Key Words: performers, psychological well-being, access to care

Key Points

- Lack of time was the primary barrier affecting marching band (MB) artists seeking mental health services.
- Marching band artists possessed neutral to somewhat positive attitudes toward seeking help in times of mental distress.
- Athletic trainers and health care providers may influence a culture that embraces mental wellness, further affecting the open-mindedness of MB artists and supporting help-seeking behavior in times of mental distress.
- Athletic trainers in the MB setting should recognize the factors that influence athletes' use of psychological counseling and aid athletes in addressing time barriers.

Mental health includes our psychological, emotional, and social well-being and has been widely discussed since the COVID-19 pandemic, along with the effects of other specific stressors.[1,2] The COVID-19 pandemic may have significantly altered the psychological health of many college-aged students and student-athletes.[3] However, reluctance, stigmas, or other barriers may still prevent individuals from seeking help for their mental concerns.[4] More than 1 in 5 adults has experienced depression, anxiety, or another mental illness.[5] Rates of conditions such as depression were reported to be higher in the 18- to 25-year-old age group (the age range for typical college students).[5]

College is a time when the risk of developing mental illnesses begins to increase, in part due to exposure to specific stressors such as academic load, managing new financial responsibilities, and separation from parents, which are known to give rise to mental illnesses.[6,7] These stressors may increase with involvement in collegiate athletics. Although sport activity confers benefits, athletes are exposed

to additional risk factors that affect the status of their mental health, eg, sport-related injuries and expectations of coaches.[6] Collegiate athletes must manage their educational responsibilities while managing the added demands on their time from maintaining high levels of physical activity. Common psychiatric disorders among collegiate student-athletes include but are not limited to mood disorders, anxiety, emotional, and cultural influences; if left untreated, these conditions can influence or compromise overall health and performance.[8] Among collegiate student-athletes, the general risks for anxiety and depression were 34.1% and 21% to 27%, respectively.[9,10] In comparison, a 40% risk of anxiety and 22% risk of depression were present among the general college student population.[11] However, striking evidence has shown that only about 18% to 34% of young people 16 to 24 years old with high risks for anxiety and depression seek professional help.[12] Female athletes have been described as more willing to seek help, whereas males were linked to a decreased disposition to seek or be referred for health care assistance.[13]

Marching band (MB) artists experience an array of medical conditions that can be unique and separate them from the average college student or student-athlete. For example, medical conditions related to the onset of heat illnesses are often associated with the uniforms they wear, whereas joint tendinopathies, postural concerns, inadequate diets or poor dietary habits, and high sound exposure linked to hearing loss have also been noted.[14–16] As the literature surrounding MB expands, more is being uncovered about the mental and physical demands these artists encounter. Collegiate MBs include musicians as well as color guard, twirlers, and dancers associated with the band. The entire band is essential to setting the atmosphere at large athletic events and is often tasked with keeping the crowd engaged. Marching bands perform on the field primarily during pregame and halftime shows for football teams in stadiums and may travel to away games. In addition to sporting events, some MBs perform in competitions, parades, or other events in front of judges or large crowds, contributing to their overall stress and performance anxiety.[17] Data suggested that student musicians may experience higher levels of anxiety and depression compared with other student body groups, which has prompted interest in health promotion within music education.[18] Araújo et al examined various behaviors and attitudes of collegiate musicians using the Coping Orientation to Problem Experiences (COPE) questionnaire, in which high scores indicate greater use of coping strategies to deal with stressful events.[19] They found that these musicians' use of coping strategies was poor based on low COPE scores and discussed the concern that limited attention had been given to this area in research and their musical training. In preparation for performances, MB artists spend hours developing skills and physical endurance through marching during band camp (typically before fall classes begin) and weekly throughout the school year. Marching styles can vary widely among collegiate bands; many take on a military marching approach or a performative dance-like presentation. For many collegiate MB artists, rehearsals, performance requirements, class, and social life demand a balancing act. As with other collegiate sports, the onset of injuries, illnesses, and pressures associated with educational requirements can influence mental health and their willingness to seek help.

More researchers are beginning to explore barriers to seeking mental health care and why individuals choose not to seek care. The World Mental Health International College Student initiative aimed to collect findings regarding barriers affecting treatment use in college students: only one-fourth of students indicated they would seek treatment after developing emotional problems.[20] Many barriers to seeking care are affected by sociodemographic factors such as culture, educational level, and financial status.[21] Other barriers include but are not limited to perceptions of weakness and lack of awareness that a mental health concern is present.[22]

Many health care providers are becoming familiar with mental health demands in traditional settings but are less aware of the mental demands affecting MB artists. As athletic trainers (ATs) and other health care professionals continue to enter emerging settings, such as collegiate MB, investigating the mental demands MB artists face to further support the push for more trained medical personnel on collegiate MBs' care teams is vital. Attention to the specific needs of MB artists from a medical perspective has grown over the years; however, most of the available literature on collegiate MB not pertaining to musicality addresses heat exposure, uniforms, and eating patterns.[23,24] Performance anxiety, the effects of COVID-19 that sparked mental health concerns globally, and the combined general mental health risks in the collegiate environment are all topics worth exploring in MB artists.

To appropriately advocate for access to mental health care in MB, we need a better understanding of the physical and mental health demands MB artists face and how their demands are similar to or different from those of other closely related populations. Furthermore, we must seek to understand the disposition MB artists have toward obtaining mental health treatment and their access to resources.

Our primary aim was to examine the perceived barriers and attitudes of MB artists toward seeking professional psychological help for mental health concerns. A secondary aim was to explore barriers and attitudes between genders and history of seeking mental health counseling.

METHODS

Study Design

This was an observational study with a cross-sectional design and part of a larger investigation of mental health and wellness among collegiate MB artists. The data were descriptive in nature. We conducted a web-based survey using Qualtrics software from fall 2022 to spring 2023 to capture the mental health profiles of collegiate MB members.

Participants

A total of 1033 students initiated the survey, 91 either did not start or go past the first question, and 330 started but did not finish the survey. This yielded a 65% response rate. We removed individuals who identified as gender diverse (n = 78), and their data will be the framework of another study. We also removed individuals who did not entirely complete the questionnaires. This left 534 artists (women = 312, men = 222; age = 19.7 ± 1.4 years) from collegiate MBs across the US. Inclusion criteria were being a college student between the ages of 18 and 26 years and a current member of a collegiate MB in the United States

who actively participated in their college's performance season (eg, collegiate football games, National Football League halftime shows, Macy's Thanksgiving Day Parade, and other invitationals). We excluded students who were inactive with their band and those who did not understand English. This study was approved by the institutional review board and all recruits consented before participation.

Study Procedures

We began recruiting participants during the fall of 2022, as that aligned with most collegiate MBs' active seasons, when their staffs also had potentially greater access to those students. Approximately 220 MBs nationwide were invited to participate. A directory of collegiate MBs (n = 220) and their associated directors, staffs, or both was developed (using publicly available websites and resources). Each primary MB director was contacted via email regarding our study and was then asked to share the link to our survey with their students. The recruitment letter detailed the purpose of our study, procedures, explanation of inclusion and voluntary participation, and contact information for the research team should they have any further questions or concerns. Throughout the collection period, follow-up emails were sent to each band director.

Instrumentation

Demographic Questionnaire. Basic demographic questions asked for self-reported age, gender, height, weight, and academic year or status. *Academic status* was defined as freshman (first year), sophomore (second year), junior (third year), or senior (fourth or fifth year). Additional questions pertained to the type of involvement each participant had in MB (years in the band, primary section, etc) and the participant's overall mental health history (history of having a personal concern with their mental health, history of seeing a mental health professional for any concern, if they had taken and were currently taking any psychiatric medication, hospitalization for mental health reasons, etc). If an individual answered *yes* to taking medication, we asked for the name(s) of the medication(s) and length of use. Sections of the band were broken into band/instrumental and auxiliary. Band/instrumental consisted of brass (trumpet, French horn/mellophone, trombone, euphonium/baritone, tuba/sousaphone), woodwind (clarinet, piccolo/flute, alto saxophone, tenor saxophone), percussion (snare drum, tenors/quads, bass drum, cymbals, front ensemble), and auxiliary (drum majors, color guard, dancers, majorettes/twirlers).

Barriers to Help Seeking Checklist. The Barriers to Help Seeking Checklist (BHSC) contains 17 items.[25] Items capture whether the respondent classifies any components as barriers when seeking or obtaining mental health care (*yes* or *no*). This tool also helps to identify an individual's possible fears about seeking help that may involve stigmas, availability of services, or others' knowledge of their mental health concerns. The instrument was initially created for use among medical students but was later adapted with permission by Lopez and Levy to be used among collegiate athletes.[25,26] The Cronbach α was 80 for their sample.[25]

Attitudes Toward Seeking Professional Psychological Help-Short Form Scale. Validated tools such as the Attitudes Toward Seeking Professional Psychological Help-Short Form Scale (ATSPPH-SF) have been used to assess behaviors related to the use of mental health services.[21] The ATSPPH-SF conceptualizes the idea that a person's overall attitude to receiving help affects the seeking and embracing of access to care. The ATSPPH-SF is a 10-item scale that provides an understanding of one's help-seeking behaviors. Respondents select the extent to which they agree or disagree with the mental health statements.[21,27] This survey also captures information on gender and ethnicity, so that data can be compared. Each of the 10 items is rated on a 4-point Likert scale, and the total score is between 10 and 30. A higher total score indicates a more positive attitude toward seeking professional psychological help and possibly greater intentions of seeking future treatment in the presence of mental distress, whereas a lower score indicates a negative attitude toward seeking professional psychological help.[21,27,28] This tool is a shortened form of the original 29-item scale and has been examined across the collegiate population.[27]

Mental Help Seeking Attitudes Scale. The Mental Help Seeking Attitudes Scale (MHSAS) is a 9-item tool evaluating an individual's likelihood of seeking professional help for mental health concerns.[29] Mental health professionals include psychologists, psychiatrists, clinical social workers, and counselors. A *mental health concern* can range from a personal difficulty such as the loss of a loved one to a diagnosable mental illness such as anxiety. Each person receives a mean score based on responses ranging from 1 to 7. A score of 1 indicates an *unfavorable* attitude; 4, a *neutral* attitude, in which the individual is indifferent about the helpfulness of mental health support; and 7, a *favorable* attitude.[29] This instrument was developed to quantify positive or negative attitudes toward mental health support and one's perceived attitudes regarding the usefulness of obtaining mental health support.[30]

Data Analysis

We used SPSS statistical software (version 28; IBM Corp) for all analyses with an α of $<.05$. Means, SDs, and frequencies were calculated for all demographic data and scores on the barriers and attitude scales for descriptive statistics. Crosstabulations and χ^2 statistics were computed to examine individual barriers (BHSC) between genders. Gender was analyzed dichotomously as *man* and *woman* for this study. Respondents who were gender diverse were excluded from the analysis. Expected cell counts were >5 for all statements on the BHSC between genders. One-way analysis of variance was conducted to assess differences in total mean scores on the ATSPPH-SF and the MHSAS between genders.

RESULTS

Our final sample was 534 MB artists (women = 312, men = 222; age = 19.7 $\pm$ 1.4 years). Representation by race, gender, academic status, and marching background can be found in Table 1. Most of our participants were first-year college students (27.3%, n = 146) and White (80.9%, n = 432) and had 4 to 6 years of total MB experience (47.2%, n = 252).

Background and History of Help Seeking

When we evaluated mental health and help-seeking history across our sample, 77.2% (n = 412) of our participants

Table 1. Participant Demographics

Variable	All (N = 534)	Women (n = 312)	Men (n = 222)
	Mean ± SD		
Self-reported measurements			
Height, cm	171.5 ± 9.9	165.9 ± 6.9	179.2 ± 7.9
Weight, kg	74.5 ± 18.1	69.9 ± 16.5	80.8 ± 18.2
Body mass index, kg/m^2	25.3 ± 5.6	25.4 ± 5.8	25.1 ± 5.2
		% (No.)	
Ethnicity			
Asian American	4.1 (22)	3.8 (12)	4.5 (10)
Black/African American	3.9 (21)	3.5 (11)	4.5 (10)
Hispanic/Latinx	5.4 (29)	4.8 (15)	6.3 (14)
Indian/Native American	0.4 (2)	0.3 (1)	0.5 (1)
Pacific Islander	0 (0)	0 (0)	0 (0)
Multiethnic	4.7 (25)	5.4 (17)	3.6 (8)
Other	0.6 (3)	1.0 (3)	0 (0)
White	80.9 (432)	81.1 (253)	80.6 (179)
Academic status, y			
Freshman (first)	27.3 (146)	26.3 (82)	28.8 (64)
Sophomore (second)	24.5 (131)	24.7 (77)	24.3 (54)
Junior (third)	19.5 (104)	19.2 (60)	19.8 (44)
Senior (fourth, fifth)	28.6 (153)	29.8 (93)	27 (60)
Marching band section			
Brass	45.1 (241)	34.3 (107)	60.4 (134)
Woodwind	34.1 (182)	41.3 (129)	23.9 (53)
Percussion	10.1 (54)	7.7 (24)	13.5 (30)
Auxiliary unit	10.7 (57)	16.7 (52)	2.3 (5)
Years of experience			
<1	1.7 (9)	0.6 (2)	3.2 (7)
1–3	5.8 (31)	6.7 (21)	4.5 (10)
4–6	47.2 (252)	47.4 (148)	46.8 (104)
7–9	40.3 (215)	40.1 (125)	40.5 (90)
10+	5.1 (27)	5.1 (16)	4.5 (10)
Level(s) of involvement			
High school	2.6 (14)	3.8 (12)	0.9 (2)
College	8.2 (44)	7.7 (24)	9.0 (20)
Competitive (ie, Drum Corps International)	0.4 (2)	0.3 (1)	0.5 (1)
High school and college	83.9 (448)	84.3 (263)	83.3 (185)
All	4.9 (26)	3.8 (12)	6.3 (14)
Mental health factors			
Previous mental health concern	77.2 (412)	76.3 (238)	78.4 (174)
Mental health clinician use	50.9 (272)	51.3 (160)	50.5 (112)
Psychiatric medication (currently taking)	18.7 (100)	19.6 (61)	17.6 (39)

reported having had concerns for their mental health at some point. Overall, 50.9% (n = 272) had a history of having seen a counselor, psychiatrist, psychologist, or other mental health professional for mental concerns. In our sample, 18.7% (n = 100) were currently taking psychiatric medication (eg, antidepressants, antipsychotics, sleeping pills, minor tranquilizers).

Barriers

Individual BHSC barriers and significant associations between genders for statements 1 ($\chi^2_{1,534} = 21.1$, $P < .01$), 2 ($\chi^2_{1,534} = 29.1$, $P < .01$), 3 ($\chi^2_{1,534} = 20.2$, $P < .01$), 4 ($\chi^2_{1,534} = 19.5$, $P < .01$), 6 ($\chi^2_{1,534} = 6.42$, $P = .01$), 10 ($\chi^2_{1,534} = 7.2$, $P < .01$), and 12 ($\chi^2_{1,534} = 10.1$, $P < .01$) are shown in Table 2. The greatest barrier reported on the BHSC was *lack of time to seek services* (69.1%; n = 369), followed by 47.6% (n = 254) for *services not available during my free time*.

Attitudes

The mean score for all participants on the MHSAS was 4.0 ± 0.4 (Table 3). This identified a somewhat neutral attitude (a score of 4 is considered a neutral inclination toward seeking help from a mental health professional). Differences were found for *useless–useful* ($F_{1,533} = 21.9$, $P \leq .01$), *unhealthy–healthy* ($F_{1,533} = 9.58$, $P = .014$), *disempowering–empowering* ($F_{1,533} = 25.4$, $P \leq .01$), *unsatisfying–satisfying* ($F_{1,533} = 21.5$, $P \leq .01$), and *undesirable–desirable* ($F_{1,533} = 11.1$, $P = .045$). Women's mean scores were slightly higher for most responses except for questions 2, 5, 8, and 9 (Table 3). No differences were present for *unimportant–important*, *ineffective–effective*, *bad–good*, and *hurting–healing*. The total mean score for all participants on the ATSPPH-SF was 17.97 ± 5.48 (women = 17.9 ± 5.6, men = 17.9 ± 5.3), indicating more positive attitudes toward seeking professional help among the marching artists. No differences were noted for the ATSPPH-SF total mean score between genders ($F_{1,533} = 0.001$, $P = .970$).

Table 2. Barriers to Help Seeking Checklist

Barrier[a]	% (No.)			
	All (N = 534)	Women (n = 312)	Men (n = 222)	*P* Value
1. Lack of available services during my free time	38.0 (203)	46.2 (144)	26.6 (59)	<.01
2. Lack of time to seek services	69.1 (369)	78.2 (244)	56.3 (125)	<.01
3. Services not available during my free time	47.6 (254)	55.8 (174)	36 (80)	<.01
4. Difficulty finding or accessing services	37.1 (203)	44.9 (140)	26.1 (58)	<.01
5. Lack of confidentiality	22.5 (120)	23.1 (72)	21.6 (48	.69
6. Fear diagnosis will become part of my school record	27.9 (149)	32.1 (100)	22.1 (49)	.01
7. Fear the dean's office will know I am using services	10.5 (56)	11.9 (37)	8.6 (19)	.22
8. Fear the athletic director (band director) will know I am using services	11.0 (59)	12.2 (38)	9.5 (21)	.32
9. Feat of stigma for using services[b]	31.9 (170)	34.9 (109)	27.6 (61)	.07
10. Fear using services will have a negative impact on my career	25.8 (138)	30.1 (94)	19.8 (44)	<.01
11. Fear coaches (directors) will know I am in counseling[b]	12.6 (67)	14.4 (45)	10 (22)	.13
12. Belief that "no one will understand my problems"	36.7 (196)	42.3 (132)	28.8 (64)	<.01
13. Counselor will not understand needs of athletes (band members)	28.3 (151)	33.3 (104)	21.2 (47)	<.01
14. Fear I will be recognized	27.0 (144)	31.7 (99)	20.3 (45)	<.01
15. Fear teammates (band members) will know I am using services	20.8 (111)	22.4 (70)	18.5 (41)	.27
16. Fear I will be considered weak	36.7 (196)	39.1 (122)	33.3 (74)	.17
17. Lack of knowledge of services offered	37.6 (201)	42.3 (132)	31.1 (69)	<.01

[a] Items are reproduced in their original format.
[b] One data point was missing for the question; the total number of respondents was 533.

DISCUSSION

We examined the types of barriers MB artists face in obtaining care for mental health illnesses and concerns, while also exploring their general attitudes toward mental health. Participants in our study cited a lack of time as the greatest barrier; the average scores for attitudes concerning mental health statements were slightly positive.

Barriers and Facilitators

Although limited research has addressed mental health and the specific culture, style, and demands of collegiate MBs, it may be helpful to review the current literature on barriers to health among similar groups, such as musicians, athletes, and the general student population, as MB artists also belong to those populations. Mental concerns such as performance anxiety are not new among musicians, for whom the exposure of public performances can cause fear of a negative evaluation.[31] Perkins et al assessed 20 musicians from UK music conservatories using a qualitative design involving constructs around students' experiences of health and well-being.[32] In their sample, 55% of students reported feeling "psychological distress" within the environment of the music conservatory, and 30% specifically described experience with mental illness. Whereas many students identified places of support, only 20% acknowledged seeking support from counselors and 40% from "welfare teams" (known to help with physical and mental challenges) as their optimal sources of health and well-being.[32] Interestingly, they made the connection between the idea that some individuals may not recognize a mental concern as easily as they would a shoulder injury; for example, a visible physical impairment is reinforced by others who may encourage the injured person to seek evaluation. Thus, in general, an aspect of care depends on self-reliance and recognizing that a mental concern even exists for which help should be sought. Vaag et al compared 880 Norwegian music and arts institution students with general student populations for the prevalence of anxiety and depression symptoms and self-reported anxiety and depression disorders. Anxiety and depression symptoms

Table 3. Scores for the Mental Help Seeking Attitudes Scale

Question	Mean ± SD			*P* Value
	All (N = 534)	Women (n = 312)	Men (n = 222)	
If I had a mental health concern, seeking help from a mental health professional would be extremely				
1. Useless–useful	5.5 ± 1.4	5.7 ± 1.3	5.3 ± 11.5	≤.01
2. Unimportant–important (R)	3.1 ± 1.8	3.0 ± 1.9	3.2 ± 1.7	.37
3. Unhealthy–healthy	6.1 ± 1.3	6.2 ± 1.3	5.9 ± 1.2	.014
4. Ineffective–effective	5.1 ± 1.5	5.2 ± 1.6	4.9 ± 1.5	.06
5. Bad–good (R)	2.3 ± 1.4	2.2 ± 1.3	2.4 ± 1.4	.06
6. Hurting–healing (R)	2.5 ± 1.4	5.4 ± 1.4	2.6 ± 1.3	.49
7. Disempowering–empowering	4.8 ± 1.6	5.0 ± 1.5	4.6 ± 1.6	≤.01
8. Unsatisfying–satisfying (R)	3.2 ± 1.6	1.5 ± 0.9	3.5 ± 1.6	≤.01
9. Undesirable–desirable (R)	3.2 ± 1.7	3.1 ± 1.7	3.4 ± 1.6	.045
Average mean score	4.0 ± 0.4	4.0 ± 0.5	4.0 ± 0.4	.52
Total score	35.8 ± 3.8	35.9 ± 4.1	35.7 ± 3.4	.49

Abbreviation: R, reverse coded.

were higher in the music and art students (34%) than in the general student population (26.5%), and the prevalence of mental disorders in music and art students (23.4%) was greater than in the general student population (15.4%).[18]

Collegiate athletes have expressed widespread stigma about receiving care for mental health concerns.[12] This stigma has been associated with a negative feeling that others would now be aware of their challenges. Whereas more resources have surfaced in collegiate sports to prioritize mental health, other elements may still influence the underuse of mental health services, such as demands on time, experiences in the environment, and linking mental support with weakness, that push college-level students away from receiving care, reinforcing negative mentalities and behaviors around mental health.[8,21]

Many times in the conversation about mental health, we focus only on the negative aspects, but it is worth noting, contrary to present literature, that our participants did not frequently cite fear, lack of knowledge of available services, or a belief that no one would understand their problems as barriers hindering them from seeking psychological help if it was needed.[26] Our study revealed that the chief barrier affecting the use of available services was time limitations. Lack of time is a theme consistently present throughout the literature and supported in our findings.[26,33] Gulliver et al summarized themes that emerged from focus group sessions discussing barriers and facilitators for athletes seeking care; the leading barrier was stigma, with both lack of time and limited accessibility as additional common themes.[34] To reduce these barriers and facilitate better care, the following were suggested: education, improved awareness of mental health difficulties and services, encouragement from others, increased time available, integration of mental health into athlete life, and positive relationships with staff.[34] These facilitators highlight interventions that could be adopted across the MB setting to aid in addressing current dispositions about accessing mental health care professionals.

Ebert et al examined the barriers experienced by full-time college students across 8 countries (including the United States) with mental disorders.[20] Only 24.6% of students indicated they would seek psychological help for future emotional concerns, and of those, 28.6% also had associated risks for mental disorders.[20] The barriers or attitudes most often reported were an internal preference to handle mental health concerns independently (56.4%) and preferring to talk to close friends and family (48%).[20]

Our findings of relatively positive attitudes toward mental health care are consistent with previous literature, specifically with respect to our MB artists' ATSPPH-SF scores. Karaffa et al found that among 573 veterinary medical students (median age = 25 years), help-seeking attitudes scored 19.55 ± 5.88 and the students' attitudes were positively related to their willingness to seek mental health services.[35] Regarding their intentions to seek psychological counseling and attitudes toward obtaining psychological help, 55.7% were above the mean score on the ATSPPH-SF scale (27.4 ± 5.64), reflecting positive attitudes toward seeking psychological help.[28] Women displayed higher intentions to seek professional psychological help, similar to the gender differences we noted. On the MHSAS, we had higher scores indicating that receiving help from mental health professionals would be extremely useful, healthy, and empowering. These responses and attitudes may speak to the openness of MB artists and their receptiveness to mental health promotion and education if implemented in their setting but are worth further exploration.

In 2020, the National Collegiate Athletic Association pushed for increased support to address mental health concerns such as distress, hopelessness, anxiety, and other mental health conditions among athletes in the collegiate setting. As far back as 2013, the National Collegiate Athletic Association published documentation and training on best practices to promote mental well-being among student-athletes, with 4 main components: access, identifications and referrals, preparticipation screenings, and environmental support.[5] For example, in athletics, strategies for overcoming barriers to accessing help include improving patients' and coaches' mental health literacy.[22] Unfortunately, most collegiate MBs do not fall within the athletics department at their institutions and therefore do not have access to the same mental health resources as student-athletes. This highlights the necessity and importance of MB artists having access in their schedules to the mental health services that are available to all students on campus (ie, through the student health center).

Clinical Significance

We sought to explore mental health in MB artists with the goals of both shedding light on a topic that is often stigmatized and investigating a population that is highly underrecognized in comparison with other sport and physical activities. These results bridge research gaps in understanding the barriers to and attitudes of MB artists in seeking mental health care. Access to an AT could help to address some concerns about lack of time and increase access to care and resources such as telehealth, extended-hours and after-hours therapy, and counseling. Given the unique challenges of the physical and mental demands these artists experience during MB activities, navigating resources from a medical standpoint may be more layered and nuanced, requiring a multidimensional approach. Also, adopting consistent practices for MBs across the nation may pose challenges, although efforts could be made by individual institutions and affiliated health care providers. For example, MB personnel could identify currently available campus resources or work with health care providers to identify new ways to promote mental health literacy. Additional considerations should include establishing more equitable care among campus organizations that are affiliated with athletics, such as that of a college's MB. An important aspect of improving students' mental well-being is establishing an environment that places the student's overall wellness at the forefront. These efforts may include normalizing open discussions about mental health, maintaining compassionate language surrounding mental illness, conducting preseason screenings, implementing educational training for staff and band leaders, posting positive mental health messaging in the band hall, and well-established referral plans.

Overall, mental health access barriers may affect the long-term risk of mental health conditions, such as anxiety and depression, in MB artists and other college-age students. Negative attitudes toward seeking help for mental health concerns and damaging perceptions regarding reporting emotional and

mental concerns may prolong conditions and lead to further comorbidities. Addressing these barriers and rethinking our approach as health care providers is key. Understanding a patient's attitudes regarding mental health care supplies clinicians with context for the mental health experiences of their patients and will lead to a more holistic approach to general care as both the barriers faced and attitudes offer insight into the use (or lack thereof) of mental health resources.

Limitations and Future Research

The US geographic regions in which our participants were located varied widely, which may have affected our findings. Specifically, some barriers could have been a result of the band's natural environment and location, causing a regional effect. We were unable to extract data on participants' institutional level (eg, Division I) that could have emphasized any regional/institutional commonalities or differences. We did not collect information on whether a participant had access to an AT or health care provider for education. The race and ethnicity in the sample population of this study were not diversified, influencing the generalizability of the results. We used the BHSC, ATSPPH-SF, and MHSAS to uncover perceived and personal barriers rather than to focus on and draw attention to specific socioecological, historical, or geographic factors that affect access to care (although we are aware that these factors would innately influence perceptions and attitudes). Lastly, we did not have access to the medical records of participants and therefore could not verify the accuracy of statements surrounding a participant's diagnosed mental health conditions or medications.

Future investigators should continue to explore mental health barriers faced across different genders, races and ethnicities, institution types (eg, large versus small universities, historically Black colleges and universities), and specific mental health conditions. The effects of socioecological and historical problems should be examined within performing arts. Particularly, MB is unique in that it combines physical activity with performing artistry; thus, using double instrumentation such as surveys and interviews would be useful for exploring social and marching-specific factors that affect a performer's mental health. We should also assess the presence of ATs in the MB setting and how they intervene for psychological concerns. Finally, we should develop and measure the effectiveness of MB-specific mental health protocols, evaluating the framework of mental health resources on college campuses and where the MB falls within that structure.

CONCLUSIONS

Our study highlighted that MB artists had somewhat positive attitudes about seeking professional psychological help that could speak to their overall frame of mind and their future receptiveness to mental health care. The most common barrier to accessing mental health care was a lack of time. Our results also demonstrated that knowledge of services, finding services, and stigmas surrounding weakness were not significant barriers in this population, which may reflect the efforts made by the affiliated institutions or an existing positive culture present in their college MBs but is worth further investigating. However, many of our participants were split in their attitudes about the overall necessity of seeking mental health support in times of mental distress; further mental health literacy initiatives and advocacy could bridge these gaps for better use of services. Increased awareness of the barriers facing and attitudes of MB artists toward receiving help for mental health aid health care providers in advocating for and improving mental wellness across this setting.

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