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The Experiences of Athletic Trainers After the Death of a Student-Athlete by Suicide

Maegan M. Milliet, MS, LAT, ATC*; Elizabeth R. Neil, PhD, LAT, ATC†; Toni M. Torres-McGehee, PhD, ATC*; Ginger Gilmore, DBH, LAT, ATC‡; Kenya Moore, MS, ATC*; Zachary K. Winkelmann, PhD, LAT, ATC*

*Department of Exercise Science, University of South Carolina, Columbia; †Department of Health and Rehabilitation Sciences, Temple University, Philadelphia, PA; ‡Athletics Department/Sports Medicine, University of Alabama, Tuscaloosa

Context: The National Collegiate Athletic Association's 2016 and 2024 *Mental Health Best Practices* documents outline essential guidelines for athletic programs, including mental health recognition, referral pathways, and critical incident management. Despite these recommendations, there remains a significant gap in literature and practice regarding the response to and management of suicide bereavement among athletic trainers (ATs), highlighting the need for further exploration of their experiences and institutional responses after a student-athlete's death by suicide.

Objective: To explore the lived experiences of collegiate ATs after the death of a student-athlete by suicide.

Design: Qualitative.

Setting: Individual interview.

Patients or Other Participants: Twelve ATs (age = 37 ± 7 years; credentialed experience = 14 ± 7 years) who were providing patient care to a student-athlete who died by suicide.

Main Outcome Measure(s): Each AT completed a semi-structured, audio-only interview. Interviews were audio recorded and transcribed verbatim. Analysis followed the consensual qualitative research tradition using a 3-person coding team. Credibility and trustworthiness were established through member checking, triangulation, and internal auditing.

Results: Participants revealed several experiences and reactions after the death of a student-athlete by suicide that focused on their *institutional reaction*, their *emotional reaction and coping mechanisms,* and *shared advice* for other ATs moving forward. After the student-athlete death by suicide, ATs shared their *institutional reaction*, which included a collaborative approach with resources and changes to policy, procedures, and their overall system. They also shared their *emotional reaction and coping mechanisms* after the death, which included a grief response influenced by guilt, concern for other student-athletes, and the use, and lack of use, of support systems and formal therapy. Finally, they provided *shared advice* concerning death by suicide that included taking care of oneself and taking mental health seriously.

Conclusions: After the death, most participants expressed grief and concern for others but often did not recognize themselves as needing help. Institutional policy and provider postvention strategies are recommended.

Key Words: mental health, NCAA, grief

Key Points

- Athletic trainers reported that their institutions adopted a collaborative approach to crisis response, counseling, and policy changes, emphasizing coordinated mental health postvention management.
- Collegiate athletic trainers experienced intense emotions, including guilt, shock, and sadness, after the death by suicide of a student-athlete. Many providers prioritized the well-being of others over their own, often overlooking the need to seek professional mental health support for themselves.
- Institutions should implement postvention strategies to facilitate recovery and mitigate negative impacts on the emotional well-being of individuals affected by suicide.

In 2016, the National Collegiate Athletic Association (NCAA) released the *Sports Science Institute Mental Health Best Practices* document, which recommends that institutions prepare procedures for recognizing and referring common mental health challenges and emergencies.[1] By definition, a mental health emergency encompasses life-threatening situations in which imminent harm to oneself or others is evident, such as suicidal thoughts or attempted suicide.[2] In a mental health emergency, athletic trainers (ATs) should initiate a screening for suicide risk and promptly refer individuals with suicidal thoughts, actions, or behaviors for specialized care, which often yields the best outcome for the patient.[3] Although screening data indicate a reduced risk of fatality,[4] student-athletes have a high prevalence of death by suicide.[5] Suicide has risen to the second leading cause of death among NCAA student-athletes, suggesting a need for us to explore the planning and response to these deaths.[5]

The NCAA published the second version of the *Mental Health Best Practices: Understanding and Supporting Student-Athlete Mental Health* in 2024.[6] The current

document provides recommendations for all athletic personnel, including ATs, on how to appropriately respond to emergencies, recognize signs and symptoms of mental health disorders, and encourage those facing mental health challenges to seek care.[1,6,7] The document outlines that all NCAA member schools should have a written and rehearsed mental health care plan that involves the full spectrum of care, including critical incident management. The NCAA suggests that institutions consider creating a postcrisis plan that addresses how support will be provided to all personnel after a traumatic event such as a death by suicide.

Regardless of the patient outcome, critical incident management should be provided to health care providers who interact with individuals who have attempted suicide or died by suicide.[1,3] This process is needed to guide interventions after the critical incident experience. Guidelines should include programming and resources to help the student-athlete, other individuals (eg, coaches, teammates, support staff), and the AT cope with and manage their mental health.[3] The lack of literature detailing post–student-athlete death by suicide experience creates a gap in sports medicine regarding provider and institutional response plans. This study aimed to explore the lived experiences of collegiate ATs after the death of a student-athlete by suicide.

METHODS

Research Design

A consensual qualitative research approach was used to explore the lived experiences of the ATs after the death of a collegiate student-athlete by suicide. The University of South Carolina Institutional Review Board determined this study to be exempt. We followed the Standards for Reporting Qualitative Research quality assessment guidelines for qualitative research.[8]

Interview Protocol

Members of the research team (ZKW, MMM) created a semistructured interview protocol. After creating the protocol, questions were sent for content validation to 3 qualitative study and mental health content experts from the research team (ERN, TMTM, GM). Modifications were made to the protocol in terms of the structure and flow of the questions. Before participant interviews, the principal investigator (PI; MMM) completed a pilot interview with an AT who had previously had a secondary school student-athlete die by suicide. The pilot interview ensured the interview protocol's efficiency and allowed interviewee feedback; however, it was not used in the data analysis. Minor grammatical changes to the protocol were made after the pilot interview. Table 1 provides the final interview protocol.

Participants and Sampling

This study focused on ATs in the collegiate setting who had experienced a student-athlete die by suicide between January 2016 and April 2023. The authors entered a data-use agreement with the National Center for Catastrophic Sport Injury Research (NCCSIR) database. The NCCSIR conducts surveillance of catastrophic injuries and illnesses related to organized collegiate sports in the United States. The injury surveillance data from NCCSIR identified 66 collegiate student-athlete deaths by suicide between January 2016 and April 2023. We removed 3 student-athlete death records from the dataset for being related to club sports or the deaths having occurred postgraduation, leaving 63 NCAA student-athlete deaths by suicide. Table 2 provides the demographics of all student-athletes from the database to provide perspective.

To recruit the participants for the study, the research team gathered data from the NCCSIR database and available media stories regarding the student-athlete death by suicide. From this point, the research team matched the student-athletes' institutions and identified the AT(s) for the sport using publicly available information. The inclusion criterion for the study was that the individual was the AT for an NCAA athletic team at the time of the death of a student-athlete on that roster who died by suicide while enrolled at the institution. We sent invitations to participate via email to 59 ATs who provided care to the team that the student-athlete was on at the time of death.

The recruitment email contained the purpose of how we selected the individuals (example: "You are or were the [AT] at [college] when [student-athlete full name], who was on the [sport] team, died by suicide"), followed by the purpose and specifics of the interview questions (example: discuss mental health training, response to the death, resources, and policies), as well as information on compensation, confidentiality, and mental health support after the interview. The recruitment email then asked the potential participant to reply with dates and times that would work best for a future interview.

An online, audio-only interview was scheduled for interested individuals, and interviews were conducted until data saturation was achieved. Data saturation was achieved when similar stories continued to emerge during the interviews, suggesting that we were confident in the patterns of the dataset. In total, 12 ATs (age = 37 ± 7 years; credentialed experience = 14 ± 7 years; men, women = 3) participated. Table 3 provides the pseudonyms and demographics of each participant.

Procedures. The investigator (MMM) conducted audio-only interviews (48 ± 18 minutes) teleconferencing (Zoom Video Communications) between October and December 2023. After the interviews, participants were sent mental health resources, including ATs Care and the 988 National Suicide Hotline, via email in case the discussion evoked an emotional response. Individuals were also compensated for their time sharing their individual stories.

Reflexivity. In conducting this research, the team acknowledges the potential biases that may have emerged during the interviews and the coding process, influenced by our experiences with mental health and suicide. We began by acknowledging these biases and minimizing them through collaboration, diversity of perspectives, and structured discussions. We implemented several strategies that we have presented below in accordance with the International Association for Health Professions Education practical guide to reflexivity in qualitative research.[9]

- **Personal Reflexivity**: The coding team (MMM, ZKW, ERN, TMTM) was mindful of personal reflexivity when creating the interview protocol. Three members had previous experiences screening student-athletes or

Table 1. Interview Protocol[a]

Background
1. Tell me about your experiences with mental health in athletic training.
2. Have you had previous mental health care training?
a. If yes, what was it about? Was it helpful?
b. If not, why have you decided not to do professional development in this area?
3. What areas in mental health were you least prepared for when starting your career?
a. What further training would be helpful?
4. Do you have a role in managing a student-athlete in a mental health crisis at your institution?
a. If yes, what is your role in managing mental health for the student-athletes?
5. If not, are you interested in playing a more significant role, and what do you need to feel prepared?
I want to start our interview by asking if you can tell me about the student-athlete death by suicide that happened on [month and year].
6. How did you hear about the student's death?
7. How did the coaches and/or teammates react to the student-athlete death?
8. What resources were offered by the institution as a response?
a. Were these available to everyone at the school or specific to athletics?
9. Was there a policy, action plan, or referral process for mental health before the death?
a. If yes, do you believe it helped manage this case?
b. If no, have there been changes to policies and procedures following the death?
10. Following the suicide, tell me about any particular tasks or jobs you had to take on. This could be anything.
a. How did you feel taking on the role/task/job?
b. Who helped you manage that role/task/job?
11. Tell me about how the experience has changed the way you work now.
a. Did you take off time from work following the death? If yes, could you share what it was like for you to return?
12. How do you feel the institution responded to everything when you look back now?
13. Can you describe how you reacted to finding out the individual had died from suicide?
14. Tell me about any ways in which it affected you.
15. Did you speak to anyone or use resources following the student-athlete death for your coping and mental health?
If yes,
a. Who did you speak with? What resources did you use? Please tell me more about your experience using these individuals or resources.
b. Did you choose to seek out these resources yourself, or were you referred?
c. For how long following the student-athlete death did you use the resources? Please explain.
If no,
a. What resources were available to you that you chose not to use?
b. Could you share why you decided not to use any resources?
16. What has it been like talking to me today about the student-athlete who died from suicide?
17. What advice would you give other athletic trainers following a student-athlete death from suicide?
18. Is there anything else you feel I should know about your experience we have not covered?

[a] Reproduced in its original format.

students for suicidal ideation, and 2 members had previous personal experiences with death by suicide of a family member or friend. Three team members had academic roles involving teaching mental health policy and procedures and critical incident management, which could have influenced the interview protocol. The PI, trained in suicide prevention, took field notes to limit bias from their training as they heard the participants' responses.

- **Interpersonal Reflexivity:** Two team members are faculty colleagues, and one supervised the PI as a research student, which could have influenced the power dynamics of the team. Two coding team members had previous personal relationships with 1 participant. To limit bias, the data were deidentified before coding.
- **Methodologic Reflexivity:** The team regularly checked in with the PI and encouraged counseling to maintain objectivity. We intentionally limited interviews to 1 to 2 per day to manage emotional and cognitive load. We adhered to ethical and rigorous methods, including the consensual qualitative research tradition. The PI also received feedback during her research proposal and defense and during coding meetings, which ensured ongoing reflexivity. Recruitment involved dialogue with potential participants who declined to participate. The PI provided empathy and breaks during interviews if participants became emotional.
- **Contextual Reflexivity:** The timing of the project coincided with recent NCAA deaths in spring 2022 and the emergence of the NCAA best-practices document, influencing our decision to conduct this study.

Data Analysis. The audio file was transcribed verbatim after the interview using otter.ai transcription services embedded in Zoom. After transcription, the investigator cross-analyzed the audio recording and transcription for accuracy and then deidentified any specific names, businesses, states, or schools mentioned before analysis. Next, the investigator sent the deidentified transcript to the interviewee for member checking to verify their transcript's accuracy and ensure that the captured responses met their intended response. Two participants emailed back edits to their respective transcripts.

Data were then analyzed using the consensual qualitative research method.[10] Three researchers from the project (MMM, ZKW, ERN), who included 2 experts and 1 novice coder, completed the analysis process using an inductive coding approach. Phase 1 of the review consisted of the

Table 2. Demographics of Student-Athlete Death

Demographic	No. (%)
Sport	
Baseball	3 (4.8)
Basketball	5 (8.0)
Cheerleading	1 (1.6)
Crew	1 (1.6)
Fencing	1 (1.6)
Field hockey	1 (1.6)
Football	22 (35.0)
Golf	2 (3.2)
Lacrosse	6 (9.5)
Soccer	5 (8.0)
Softball	1 (1.6)
Squash/racquetball	1 (1.6)
Swimming	2 (3.2)
Cross-country and/or track and field	10 (15.9)
Water polo	1 (1.6)
Wrestling	1 (1.6)
Year of Student-Athlete Death	
2016	6 (9.5)
2017	5 (8.0)
2018	10 (15.9)
2019	14 (22.2)
2020	8 (12.7)
2021	9 (14.3)
2022	9 (14.3)
2023	2 (3.2)
NCAA division	
I	32 (50.8)
II	13 (20.6)
III	18 (28.6)
Area of the country	
Northeast	15 (23.8)
Midwest	18 (28.6)
South	18 (28.6)
West	12 (19.0)

Table 3. Participant Demographics

Pseudonym	Gender	Age, y	Years of Experience	NCAA Division
1. Jess	Woman	43	20	III
2. Nick	Man	40	20	III
3. Aly	Woman	45	24	II
4. Winston	Man	33	11	I
5. Cece	Woman	29	2	III
6. Paul	Man	25	3	II
7. Robby	Man	38	15	I
8. Walt	Man	46	21	II
9. Sam	Man	40	17	III
10. Ernie	Man	30	7	I
11. Ryan	Man	39	18	III
12. Russell	Man	38	10	I

Abbreviation: NCAA, National Collegiate Athletic Association.

coding team individually reviewing 4 transcripts to identify core ideas. The coding team then met after reviewing transcripts to discuss findings and create a preliminary codebook containing domains and categories. The domains closely aligned with the interview protocol due to the focused research question within a defined community. However, the categories were developed specifically to the new insights discovered during the interviews.

For phase 2, the coding team used 2 transcripts from phase 1 and introduced 2 new transcripts to confirm the validity of the initial codebook. The team met to make revisions and finalize the consensus codebook.

To transition to phase 3A, the coding team divided the transcripts evenly. Each member independently coded 4 separate transcripts for domains and categories from the consensus codebook. In phase 3B, transcripts were exchanged among the coding team to review the coding. Afterward, the coding team had a final meeting in which all codes were confirmed with at least a two-thirds agreement. The consensus codebook and 3 coded transcripts were sent to an individual not on the coding team (TMTM) for internal auditing that did not result in any changes to the codebook or coding process. A cross-analysis was conducted to extract interviewee quotes from each category. Categories were assigned classifications based on how often the participants spoke about the category. Categories were assigned *general* if identified in all or all but 1 transcript (n = 11–12), *typical* when identified in more than half of the transcripts (n = 7–10), *variant* when identified in half but more than 2 transcripts (n = 3–6) participants, and *rare* if specified in 1 or 2 transcripts.[10]

RESULTS

Participant responses to the interview protocol related to institutional reaction, emotional reaction and coping mechanisms, and shared advice were coded and categorized to describe and provide context to the participants' experiences. The Figure charts the domains and categories. Table 4 provides the frequency counts and labels for each category.

Domain 1: Institutional Reaction to the Death by Suicide

The *institutional reaction to the death by suicide* domain included 3 categories, focused on a collaborative approach, the abundance of resources provided to students and staff, and changes to the system made after the death by suicide.

Collaborative Approach. Participants described their institution's collaborative-care approach to mental health emergencies, using multiple personnel to convey messages. The collaborative approach included the initial meeting of the ATs with other personnel from campus to deliver the news. In addition, the collaborative approach category also focused on using established care teams and relationships to communicate with personnel. The category emphasizes the interconnectedness of multiple parties in responding to a suicide. In response to the student-athlete death by suicide, participants mentioned how the institution responded by bringing together staff, students, and, in some cases, other professionals. For example, Paul shared his institution's response:

> We got a message in our team group chat saying that we are having a team meeting that night at 7, saying that it is important that everyone is there. Do not be late. I went that night, and when I got there, our interim athletic director was there, another person from the university, and then a police officer, too. So that was a red flag. Our interim athletic director comes up, and she breaks the news to us that [student-athlete] was found earlier that day. There were counselors there the night that they got us all together to inform us of [the student-athlete]'s passing. There were 2

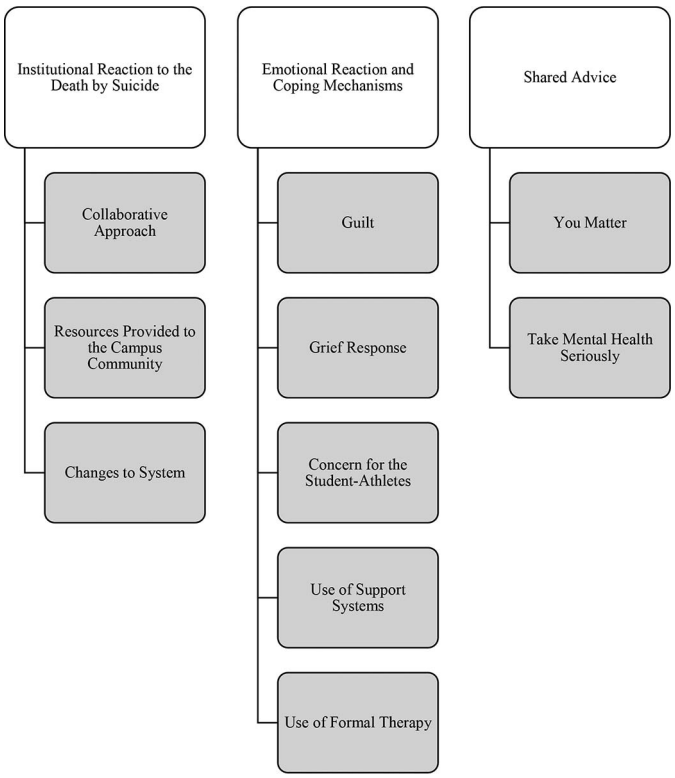

Figure. Charting of domains and categories.

Table 4. Frequency of Categories (n = 12)

Domains and Categories	Frequency Count	Frequency Label
Institutional reaction to the death by suicide		
Collaborative approach	12	General
Resources provided to the campus community	12	General
Changes to system	11	General
Emotional reaction and coping mechanisms		
Guilt	11	General
Grief response	12	General
Concern for the student-athletes	11	General
Use of support systems	10	Typical
Use of formal therapy	10	Typical
Shared advice		
You matter	10	Typical
Take mental health seriously	9	Typical

counselors there, one from the school and one from the hospital, and then our team physician, who is trained in a lot of mental health background, was also there.

Ernie described the collaborative approach after a suicide attempt that resulted in connecting with the hospital staff when the patient was admitted. He shared:

> Our director sports medicine gets a [notification] through EPIC that lets us know that there's someone in the hospital. Our sports medicine department knew pretty quickly that someone had been checked in the hospital, and then, you start seeing the [emergency department] notes and what they're doing and what they're assessing for. I think the situation becomes very, very real—very quickly. In this scenario, our sports administrator was notified, and our sports psych department was notified, and our coaches were notified. To the extent. I'm sure you know, HIPAA [the US Health Insurance Portability and Accountability Act] is still being protected, but, I think, to the extent that they, whatever information needed to be and could be shared was but I think it helps get people up on the gravity of the situation and starting to formulate different plans if this pans out as worst case scenario—what are we prepared to do and offer to everyone to let them, you know, help navigate through those scenario.

Russell shared a similar experience collaborating with institutional staff to convey the message. He said:

> We gathered everybody together. We had our main, our director of athletic counseling, address the team, the head coach, and the team, and we had counseling and grief staff there to meet with athletes who needed it. Again, we wanted to bring everybody together so we could all grieve and get the help we needed right then and there in the immediate crisis. Throughout that time, there were just lots of referrals to our athletic counseling staff.

Resources Provided to the Campus Community. All participants talked about the various resources provided by their institutions after the student-athlete death. Due to the role of the AT in managing psychosocial concerns, there is a need to explore the resources that the institution responded with. The ATs in our study shared about the use and integration of resources such as counseling, social services, chaplains, memorial services, and ceremonies. Each of their lived experiences after the death by suicide was affected by the resources available to the student-athletes as they were navigating new job responsibilities and demands from peers and other student-athletes.

Ryan shared,

> The coaching staff and our administration immediately put together a hotline for [student-athletes] to contact on their own time and in safe spaces to come and speak with people, social services, and otherwise to address their feelings, their thoughts, and their emotions. [The institution provided] counseling, individual and group counseling, and open hours so people could walk into a certain place to address it, or they could call and make an appointment. They needed to work with the police on the investigation, which can be very traumatizing as well, to relive some of the moments that occurred leading up to the [death]. So, there was support in that area.

Some participants noted preexisting programs on campus for mental health services. Robby explained,

> We had a program called CAPs [counseling and psychological services], and it was an on-campus resource that was offered to the student-athletes as somebody they could go talk to about how they were feeling and trying to work through what had happened and helping the student-athletes get through the situation.

Sam mentioned the use of religious services at his institution:

> We have a church on our campus and a chaplain who's involved as a part of the care team in regard to grief and providing counseling when a student dies. I know our counseling staff tried to connect with as many students, as many of those friends and families as they could in regard to [the student-athlete's] death.

Sam further touched upon the accessibility of the resources that were provided by the institution. "[Resources] were allocated to the whole student body. It was anybody, whether you are a student-athlete or not, could utilize those resources." Cece referred to a similar instance of campuswide resources by stating:

> Later on in the semester, they had a memorial service for the students. Of course, they offered counseling services. An email was sent out offering grief counseling services to anyone on campus who was affected by the tragedy. The institution responded very well. They realized the impact and the gravity of the situation, and not that it just impacted athletics, that it impacted our whole campus in a really big way.

Changes to System. The system of mental health recognition and referral for their institution varied by participant. Regardless of the plan in place, Ernie stated he felt it was not possible to prepare for the death of a student-athlete by suicide:

> I do not think you can fully prepare someone for what might happen until it happens. You can get [ATs] comfortable and give them tools like an emergency action response flow chart, like this is happening, follow these steps. But until [the institution] actually experiences it, I don't think [the institution] can fully prepare to know what that's like.

Participants shared how their institutions' reactions to the student-athlete death involved changes to the system, including developing new procedures and documents to guide the response plan. Walt mentioned implementing a "mental health emergency action management plan, which is something that the NCAA has been pushing, anyway. But we put that into place. That is the only real change." Other participants discussed multiple changes that occurred postvention as a response to the death. Nick shared about his job duty changes, "Following the situation, we took it upon ourselves as a department and with our medical directors and the other professionals we have on campus to sit down and formulate robust mental health policies." Paul went further into detail about referral pathways and collaborative approaches by stating:

> We now have a thorough referral process. We are all trained in some capacity, and when I say we, I mean our ATs, the coaches, and all the athletic staff. We get together once a year to go over the emergency action plan for a mental health crisis, the referral process, how we are going to go about it, and how we are going to help the student-athlete.

In addition to policy and procedural changes, some participants mentioned mandatory trainings for institutional staff. For example, Ernie stated, "Everyone on our staff is getting trained to be officially Mental Health First Aid certified. Our sports department is certified instructors now. Not only sports medicine but athletics as a whole." Similarly, Ryan shared his institution's shift to emphasize the recognition of mental health emergencies, not only for staff but also for student-athletes:

> There's an initiative by the university and the department to make sure all coaches, staff members, and administration are trained to handle such events and recognize red flags. It has now been incorporated into our language during our preseason meetings to help students be aware of and recognize red flags among their peers.

Another way participants noted changes to the system was with added staffing. Sam explained:

> We were able to allocate a specific mental health counselor to athletics through our counseling office that comes to [staff] meetings, meets with teams, and offers specific hours for student-athletes. It provided a gateway for athletics to have somebody that is the point person in terms of mental health for athletics.

Domain 2: Emotional Reaction and Coping Mechanism

The second domain pertained to the participants' responses to the student-athlete death, along with strategies they used to reduce or even overcome their emotions.

Guilt. The participants shared feelings of guilt through responsibility after the student-athlete's death by suicide. The guilt was described as not recognizing the signs and symptoms of suicidal thoughts. The ATs went further to describe guilt through the lens of wanting to know the "why" behind the suicide. Participants posed questions about their actions and inactions as a response to the death. For example, Winston said:

> My first initial thought was, "Wow, how did I miss what was going on? What did I do? Or what did I not do that I should have done?" And then, I honestly cannot believe that on this team, it would have been this individual. So, it was a lot of surprises, a lot of initial guilt feeling like, how could I let this happen?

Aly went further into detail and shared her reaction to the student-athlete death:

> I remember talking to the athletic director. I kept asking them, "Was there something that we missed?" I just kept thinking that we missed something. Throughout the spring, was something going on? Like he never said anything. It was one of those responses where you are trying to figure out where it went wrong and where you could have possibly stepped in to help. But at that point, you could not. I just was asking questions. Does anybody know how long he had felt depressed? Or if anybody knew that this was coming? Or if he had told anybody he was going to harm himself?

To a greater extent, Sam discussed reevaluating his actions after an incident while also bringing up the common feeling of responsibility for the events that occurred or fault:

> I think the hard part is as individuals, we always want to know, "Why?" "What could we have done?" "Could I have said something different?" "Could I have done something to stop this?" In reality, it's a decision a particular person makes at that particular time. And they just thought that was the decision they needed to make. It is extremely unfortunate. And you never want to see it happen. But it happens, and it is not your fault. It is not. Do not take the blame for it on yourself.

Self-blame and even the shift of blame were conveyed, with Jess sharing her feelings in the aftermath of the student-athlete death. She said:

> I, unfortunately, for the former director of our counseling center. I blamed her. I needed to blame somebody. I was like, obviously, you did not do your job. I know that is a terrible thing. But in the moment, that was how I felt because I needed to feel like it was not something that I missed and that I could have stopped.

Walt adopted a more systematic approach to his guilt. He mentioned, "It is natural to ask, 'Why?' and 'What could have been done?' Ultimately, it is only helpful when it's to make things better moving forward rather than dwelling on that."

Grief Response. Most participants recounted their personal reactions to the student-athlete death. Initial reactions included shock, surprise, sadness, and confusion. Robby said, "At first, I was in shock and did not really know how to react. There was a lot of confusion and not understanding, and part of that is based on the athlete and what I knew about him." Cece recalled, "There was a lot of, and still has been, a lot of grieving in various stages—crying, anger, frustration. Everybody has gone through the grief process in various ways." Aly expressed the timeline of the grief process by sharing:

> It is still kind of fresh in [my] mind, even though it has been 4 years. I can still picture my last interaction with this person. I can still picture my athletic director sitting there having this conversation with me about what just happened. It really just brings back up a whole lot of emotion.

Some participants also discussed how they managed stressful events. For example, Walt said, "I have always been the kind of person to cope on my own and suck it up. That is a combination of my personality and life environment, I guess. That is how I typically react to things." Aly mentioned her preference to consume her time: "I try to occupy myself and keep myself busy, so I do not try to think about what happened. That's the kind of person I am,"

Similarly, Ernie shared,

> I did not take time off from work because it was like a sense of obligation to be available and there for people who needed it. Sure, maybe that thought [taking time off] crossed my mind. But for me, I needed to stay on a schedule and a routine and have something tangible to do every day. I do not think I would have done very well if I were just lying around the house with nothing to do. I think I would just be more preoccupied with what is going on at work if I were away from it.

Some participants mentioned they did not take time off after the incident for similar reasons, which Ernie elaborated. Paul, who was given the option to take time off, shared his experience:

> The day after, I informed our head AT of what had happened, and he said, "Take as much time off as you need." The next day, I slept in. But as soon as I woke up, I was like, "What am I going to do? Just sit here like in my apartment by myself?" I felt like I needed to be in our athletic facilities as much for myself as for my athletes. I needed some sense of normalcy in a way to be around some of the guys, around the coaches, around people.

Concern for the Student-Athletes

Participants expressed concern and worry about the mental health, safety, and stability of the other student-athletes after the death. Ernie said, "My biggest concern was not necessarily how am I feeling in the moment. It was how is everyone else doing." Winston mentioned his concern for other student-athletes' mental health by sharing, "I was really worried about a chain effect." He goes on to state, "I was really just focused on making sure that the student-athletes were okay." Along the same line, Jess said,

> I just really needed to see the players. I knew that 2 of my seniors were the ones who found [the student-athlete], and I just needed to see them. I needed to see the rest of the guys and make sure that they were okay. That was my sole reason for coming to work the next day.

Russell shared his experience of managing student-athletes' return to practice after the student-athlete's death:

> It definitely was, early on, a trigger for some of the athletes to get back [to practice] after that suicide. I just went right into crisis management mode. I tried to be there for the athletes. That was an overly emotional time within the immediate aftermath of [the student-athlete death]. I made sure to be there for the athletes and let them know that I was there.

Ryan reflected:

> I think the trouble with ATs, at least that I could see being a concern, is that ATs are trained to be there for their student-athletes. There's a team of 30, and 1 person attempts suicide or takes their own life; the rest of them are there struggling, so the obligation for the AT, I feel, is intrinsically to be there for the rest of them as best they can be.

Use of Support Systems. The collegiate ATs used different support systems to cope after the aftermath of the student-athlete's death. Participants' support systems included their personal relationships, professional networks, and peer-support programs such as ATs Care. For example, Aly said,

> The other AT that I was close with. We had worked together for 16 years. She and I had multiple conversations about how we were feeling. So, we were each other's support because we both took it pretty hard.

She also shared her experiences talking about the student-athlete death with others:

> I had felt that talking to the ATs Care people, talking to my coworker, and being able to talk to my husband about [the student-athlete] death. I was fine. I did not feel the need to go elsewhere and talk about anything.

Winston had a remarkably similar experience with his support system. He said, "I relied on my friends and family and used them as support. I prefer to keep things within my close friends and family for what I was going through at that point."

Cece used collective support from colleagues who shared their experiences. She recalled, "As a sports medicine staff and athletic training, we took some time to sit and debrief and support each other." At the same time, Russell received support from ATs who had also experienced a student-athlete death by suicide before. He shared:

> What I appreciated was other ATs from other sports. They showed up there because some of them had gone through a suicide situation 7 years prior. They knew what I was going to be going through. So, they were there to help me with that, as well.

Use of Formal Therapy. The use of formal therapy by the ATs for themselves as a mechanism to process the death had varying perspectives. Jess shared her experience reaching out to counseling services before returning to work to help her manage that process:

> I was not ready yet. I did not know if I could come back and do my job to the level that I needed to do if I did not get help. I immediately called my counselor, whom I had not seen for maybe 2 years, and I was like, I need to come back. For the first several months, I met with her every week, but I have not stopped seeing her since. I wish I would have started sooner, but I thought I was handling it okay.

Whereas some participants recognized and actively pursued formal therapy, others expressed reluctance or hesitancy to seek professional help, opting instead to cope with the aftermath of the tragedy through personal means. Nick mentioned,

> I just never felt that I needed to talk to anybody when it comes to any type of tragedy in my life. I will talk in my own way in terms, but I do not feel like I ever needed counseling or professional help. I have always been able to cope with it in appropriate ways, personally.

Aly said, "I, personally, did not seek out any [professional help]. I was trying to deal with everything on my own terms, on my own timeline."

Paul reflected on his reasoning for not seeking out resources for his own mental health. He contemplated, "Why, if I am sending my athletes to counselors and therapists, why haven't I kind of experienced it myself? But I have not." Ernie explained his reasoning for not reaching out for help:

> Truthfully, I am not the best at seeking out help if I need it, and at the moment I thought I was doing fine. If I wanted to be more proactive, I probably could have reached out afterward and made an appointment. I just did not.

Domain 3: Shared Advice

The ATs were asked what advice they would give to fellow ATs after reflecting upon their own experiences after a student-athlete death from suicide. Within the *shared advice* domain, 2 overarching categories emerged focused on the person mattering and thoughtfully approaching mental health as an AT.

You Matter. The advice from participants emphasized the importance of prioritizing self-care and seeking support in times of need. Jess stressed the significance of seeking support early on and highlighted the normalization of asking for help. She said, "First and foremost, seek out support sooner rather than later for yourself. I think not being afraid to seek help yourself, taking care of yourself, and understanding that it is perfectly normal." Winston emphasized the importance of not neglecting one's own well-being:

> You have to take care of yourself as well. . . even though you are probably going to be looked at as a resource and a lot of effort you're going to have to put in to make sure everyone is getting what they need, you cannot forget about yourself. There are people who would tell me that throughout the whole process, and you just think of it as "I am fine. I am fine. I am fine." And then, at one point, you finally just break down. Luckily, I have a really good support system with my friends and family that could help me through that. Make sure that you take that time for yourself and realize that it is not all on you. It is not your fault. It is not like you should not have guilt about these things. As long as you know that you put in your best care for this person, you should not have any self-blame.

Participants described a self-care foundation for helping others effectively. Cece said, "The first thing would be to make sure that you are taking care of yourself so you can continue to help others around you."

Outside of self-care and seeking professional resources, Russell mentioned the benefit of self-care to prioritize personal well-being. He stated, "Another good piece of advice is taking time away. If an AT has a death of somebody on their team, take time away for your own good."

Take Mental Health Seriously. The shared advice of taking mental health seriously highlights the importance of being proactive in addressing mental health concerns among student-athletes. Participants expressed the process of suicide prevention screening and how creating the dialogue with student-athletes has changed for them. Aly remarked:

> Asking the hardest question, "Are you suicidal? Are you thinking of harming someone else?" Those are the hardest questions to ask, and it still is. Twenty years ago, when all this started, it was really hard. Now that I've had multiple experiences, I'm not afraid to ask those questions.

Paul reflected on the impact of the student-athlete death on his approach to mental health:

> When I graduated with my [professional degree], it was definitely evident that mental health was an issue amongst college athletes, and so it was something that we took seriously. We had different protocols in place, and I guess after [the student-athlete's death] in the first 3 years of my young career. It has really propelled me to take it very seriously, exercise all options, and find solutions for these problems. I now take it much more seriously. Not that I did not take it seriously beforehand, but I'm more cognizant of it. Talking to the guys more. Just doing my best to check on check in on them as people, and not just as the [student-athlete]. I try to get to know them as best I can.

The interview invoked an emotional reflection for some that reinforced the significance of taking mental health seriously. Robby reflected, "Thinking back to everything that has happened and not just this situation, but potentially others that I dealt with in the mental health realm, but it is a reminder that life is fragile for sure."

Winston stresses the importance of being more attentive toward student-athletes but also not shying away from addressing concerns directly:

> I have been a lot more comfortable asking more pointed questions about mental health because, at this point, I can't be afraid anymore. I have already gone through this. I do not want to go through it again. So, if there's anything that I can ask that might be the difference, I've told myself that I just have to ask, regardless of the outcome. Those are the 2 base things: trying to look at things more holistically and just not being afraid to ask those more targeted questions if I feel they're necessary.

Winston went on to say,

> We have to learn from these experiences, and as I continue to get further away from [the student-athlete death], I feel more comfortable sharing what we all went through. Hopefully, this helps someone in the future.

DISCUSSION

We sought to explore the experiences of collegiate ATs after the death of a student-athlete by suicide. Our findings from participant interviews led to the emergence of 3 main domains based on their experiences. The findings share how they emotionally responded to and navigated the experience. The hoped-for outcome of this study is that other colleges and universities will take the participants' experiences to shape how they prepare for and respond to a student-athlete death by suicide.

Institutional Reaction to the Death by Suicide

In response to a death by suicide, institutions must prioritize collaborative care and postvention strategies to manage the crisis effectively, provide support for those affected, and implement lasting changes that enhance mental health care and student-athlete well-being. In such situations, preparatory education, training, and previous experience prove invaluable for providers tasked with managing the immediate crisis and navigating the aftermath of a death by suicide effectively.

Collaboration. Collaborative care is widely regarded as the most effective approach to delivering mental health care.[11,12] In sports medicine, ATs, team physicians, mental health counselors, coaches, and others work together to provide optimal mental health care for student-athletes. Previous researchers identified that licensed mental health professionals feel ATs have a role in behavioral health including care coordination, information gathering, and consistent patient interactions.[13] The interprofessional approach to collaboration could include health care and nonhealthy-care participants such as athletic directors, clergy, and police. Our study participants remembered their institutions' collaborative approach that embraced many members of the institution coming together for a systematic approach to responding to the loss. Previous research in a hospital setting suggests a similar approach in terms of communication practices and administrative duties in the immediate, short, and long term.[14]

Postcrisis Planning and Resources Provided. Postvention refers to the provision of care and supportive actions extended to individuals who have experienced grief due to suicide to facilitate recovery and mitigate negative impacts on their emotional well-being and mental health.[15–18] Previous research identified that only 19% of psychiatric residents felt prepared to manage the aftermath of a patient suicide.[19] Although we do not have data specific to ATs on managing the postvention process, we would expect that the percentage to be lower because of a lack of formal training and infrequent experience responding to death and dying in athletic training.

Expert recommendations for postvention include communication, team organizing, immediate crisis response, identifying and supporting those at risk, memorials, and critical incident review.[20] Despite existing literature supporting these recommendations, colleges and universities may not be implementing postvention interventions at their institutions.[18] Suicide bereavement best practices should highlight both an organizational response focused on restoring a sense of functioning and an individual response that promotes healthy coping and grieving and reduces the risk of suicide contagion. The postvention plan should include (1) contacting, informing, and communicating to others about the student-athlete's death with care by promoting safety and access to resources; (2) providing support and connection to those affected by the death regardless of their title, role, or connection to the student-

athlete; (3) planning memorial and events to commemorate the deceased student-athlete with care; and (4) maintaining a consistent message that mental health support is available.[21] Athletic trainers should be mindful that an institutional postcrisis plan for suicide applies to themselves as providers, meaning they should be offered the same resources described in the best practices above. Although ATs may be part of the postcrisis planning team, the AT who was the direct health care provider for the student-athlete who died by suicide should not be required to be the facilitator of the postcrisis plan. We suggest that nonathletic personnel serve as the coordinator of the postcrisis plan to alleviate the work burden responsibility on the AT. Although best practices for postvention do not yet exist specific to NCAA athletics or athletic training, we recommend resources from the Higher Education for Mental Health Alliance and the Suicide Prevention Resource Center that are focused on college or school-based responses to help guide efforts.[22,23]

Policy Development and Revision. Data suggest that 36% of NCAA ATs lack specific procedures for mental health emergencies such as suicidal ideation or suicide attempt.[7] As stated in other emergency care areas in athletic training, such as sudden cardiac arrest, exertional heat stroke, and exertional sickling, the cause is not 100% preventable, but having an action plan or written policy that aligns with best practices can significantly reduce overall risk.[24]

Many participants mentioned policies and procedures that should have been in place. The experiences of these ATs show that only after a death occurred were there efforts by their institution to implement such policies and procedures. This is a reactive decision-making process that could be avoided through pragmatic and reflective decision-making guided by the NCAA best-practices documents.

In health care, several mechanisms exist for practice reflection, including documentation reviews, morbidity and mortality conferences, and root-cause analysis. These processes allow for discussion about adverse events in patient care leading to death, aiming to analyze medical errors, identify areas for improvement, and explore strategies for enhancing current protocols.[25] These strategies are crucial for enhancing support for the mental well-being of ATs, but the process and expectations should also be communicated clearly to all personnel. Although the death by suicide may not be a failure of the athletic training health care team, it is a critical component to explore areas to create or modify policy respective to prevention, recognition, referral, support, and postvention.[14]

Emotional Reaction and Coping Mechanisms

Athletic trainers responding to a student-athlete death by suicide may experience emotional reactions, including sadness, guilt, and disbelief, while often prioritizing crisis management over personal coping skills. Despite the availability of mental health resources such as ATs Care, many ATs rely on informal support systems and task-oriented duties, demonstrating reluctance to seek professional help due to personal concerns and possible stigma. To best support ATs in these situations, institutions must foster positive work environments, encourage the use of formal mental health services, and implement wellness initiatives that promote self-care strategies.

Guilt and Grief. Previous research indicates that after a death by suicide, it is common for others to express feelings of shock, disbelief, sadness, anger, guilt, and shame.[26–30] In our study, ATs conveying their emotional response to a student-athlete's suicide reflected similar reactions in other health professionals, like nurses and psychiatric trainees.[26–28,30–32] The grief response for health care providers is challenging as they navigate the ethics of patient-provider boundaries. Many clinicians experience disenfranchised grief in which the loss of a patient, in this case a student-athlete, cannot be openly acknowledged or supported in the same way that conventional grief can be mourned, resulting in the dismissal of their feelings.[32,33] In addition, the participants shared feelings of guilt through recurring questions about circumstances, rationale, alternative courses of action, and lack of foreseeability, which are consistent with existing research.[26]

The AT's emotional response may be more challenging after the death of a patient by suicide in comparison with other health care professions. This is not to suggest that other provider relationships are not strong but to emphasize ATs' daily interactions with their patients often as the sole provider for a collegiate sport team. In addition, taking on the roles of both a grieving provider and a member of the postcrisis action plan may create an overlap, leading to a lack of personal time to cope.

Self-Care: Support Systems, Concerns for Others, and Therapy. Previous research regarding critical incidents in athletic training highlighted that ATs use exercise, humor, and time with pets as coping strategies.[34] Interestingly, the data identified that the coping strategies helped with returning to work for patient care delivery yet did not affect their emotional state relative to the critical incident.[34] Participants in our study managed emotional reactions after the student-athlete death by relying on support networks like family, friends, and spouses. This aligned with previous qualitative research in athletic training wherein 94% of ATs ($n = 16$ of 17) who experienced a critical incident in a study used untrained personnel for support.[35]

Participants in our study only occasionally sought formal therapy despite awareness of the resources available, aligning with previous research.[36] Unlike more recent research findings, formal counseling, support groups, and therapy are strongly advocated to facilitate clinicians' coping mechanisms.[37,38] The process of sharing these resources should not be optional. Rather, the process should be a supportive measure focused on reassurance rather than blame for the health care provider.

After a student-athlete's death by suicide, individuals should engage in critical incident debriefing. The institution, specifically the athletics department and sports team, may also engage in necessary reflection. This involves exploring available campus and interathletic mental health resources, implementing policies and procedures, and undertaking preventative efforts for student-athletes. The emergency response debriefing should have a specific policy and procedure on the process, outlining the timing, requirements, and personnel as suggested in the 2024 National Athletic Trainers' Association emergency action plan implementation position statement.[39]

The participants expressed that they typically adopted a crisis management role that often preceded their ability to cope, similar to the experiences of psychologists and mental health professionals.[40] They prioritized others' well-

being, motivating ATs in our study to assume additional job duties instead of taking time off. Previous research exploring the coping strategies of ATs after providing care for athletes exposed to a catastrophic event found that ATs most commonly used task-oriented coping strategies (eg, trying to be more organized, outline priorities) over emotion-oriented (eg, blame myself, focus on inadequacies) or avoidance-oriented coping strategies (eg, watch a movie, take time off).[41] There data are representative of our findings in which most people responded by changing their system. Although emotional responses occurred, the participants expressed coping through work-related tasks such as caring for others.

Although some participants expressed reluctance or hesitancy to seek professional help, explanations why were limited. Barriers to seeking help among other professionals include social stigma, concerns about treatment, fear of emotions, anticipated risks, and reluctance to disclose personal struggles.[40,42,43] By creating a positive work environment and a comprehensive bereavement process, providers can better support themselves and mitigate the adverse effects of their grief.[28,43] Additionally, organizations should establish workplace wellness initiatives and employee assistance programs that promote the adoption of self-care strategies.[44]

Shared Advice

Athletic trainers coping with the loss of a patient often stress the importance of self-care and prioritizing mental health to others, yet often do not seek help themselves. This highlights a gap between advocating for help-seeking behaviors and applying these practices personally. Participants in our study emphasized the use of self-care when advising fellow ATs coping with a student-athlete death by suicide, yet admitted reluctance to seek help. A study on mental health practitioners highlighted the critical role of self-care strategies, given that their well-being significantly influenced their response to crisis management.[45] The paradox in health care lies in our knowledge and advocacy for help-seeking behaviors among peers. However, we often fail to apply these principles to ourselves.[45] In other studies, occupational demands may affect the decision to take time off from work or seek help from others.[46] Athletic trainers may not want to return to a high-stress environment; however, the multitude of studies on work-life balance issues in athletic training highlight time away from work and support networks as positive influences in the collegiate setting.[47]

Additionally, participants emphasized the importance of prioritizing mental health and adopting a comprehensive approach to patient care, echoing findings from research examining nurses' reactions to a patient's death by suicide.[26] Nurses have learned not to downplay the risk of suicide while having a heightened sense of caution in managing patients exhibiting suicidal tendencies and ensuring closer monitoring of such patients.[26] Recognizing the value of proactive change based on past experiences, rather than waiting for adversity, is essential.

Limitations and Future Research

Our study is not without limitations. The interviews focused on ATs' experience relative to the death, which may not comprehensively provide an outlook on how the coaches, institution, teammates, family members, and other stakeholders reacted and responded. Future research should examine the barriers preventing ATs from seeking help, develop and integrate bereavement policies, and determine the effectiveness of critical incident stress management strategies specific to athletic training. Finally, exploring suicide postvention across NCAA institutions may be beneficial to identify protocols and the satisfaction of those responses.

CONCLUSIONS

Our study revealed that after a student-athlete's death by suicide, most ATs discussed their institution's collaborative approach, including resource allocation and policy adjustments. However, the experience caused elevated levels of grief and guilt in the providers, leading them not to recognize or seek help themselves. Policy advancements relative to institutional and provider postvention are recommended.

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Address correspondence to Zachary K. Winkelmann, PhD, LAT, ATC, Department of Exercise Science, 1300 Wheat Street, University of South Carolina, Columbia, SC. 29208. Address email to winkelz@mailbox.sc.edu.