

MENTAL HEALTH IN TRACK AND FIELD

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INTRODUCTION

Track and field (referred to as “athletics” in much of the world) involves athletes participating in different running, jumping, and throwing events, e.g., short-distance sprints, long-distance races, hurdles, high jump, discus, and many more. It may be associated with particular mental health risks and nuanced symptom presentations. This paper aims to be the first to present a narrative review of literature findings related to mental health in this sport.

METHODS

An experienced academic librarian (MH) searched PubMed, SportDiscus, PsycINFO, and CINAHL from January 2008 through September 2023, wanting to focus on research within the past 15 years. Additional articles were reviewed for possible inclusion based on reference lists of the original articles found. Studies were selected if they included information on track and field athletes and mental health symptoms or disorders and excluded if they were not published in English. General mental health articles were included where athlete-specific research was unavailable, and general sport-related research was included

where track and field-specific research was unavailable.

FINDINGS

Mood disorders

Depression is felt to be equally common in athletes as a whole and in the general population¹. However, there is reason for concern among track and field athletes specifically. A study conducted over three years and involving 465 athletes at a Division I U.S. college found that 23.7% of the athletes across 12 sports reported clinically relevant depressive symptoms². Specifically, track and field athletes had the highest depression prevalence (35.4%) compared to other sports. Analyzing by gender across the sample, female track and field athletes had the highest prevalence (37.5%) compared to any gender in any sport. Additionally, a study of 402 internationally competing track and field athletes found that about one out of six reported having experienced suicidal ideation³.

Researchers have speculated as to reasons for track and field’s disproportionate risk for depression^{2,4}. Specifically, track athletes’ performance is usually based on single events that often occur over very short

periods of time versus much longer in team sports, such that there may be more pressure focused on just a few seconds to minutes. Additionally, there are many competitors in a single track and field event, with only one winner. In contrast, half of the athletes in team competitions will be winners. Another factor may be higher injury rates in track and field athletes—and injury may predispose to depression. Another study has replicated the general finding that athletes in individual sports (such as track and field) as opposed to team sports may be at greater risk for depression and further explored why this might be the case⁵. It found that a tendency of individual sport athletes to negative attribution after failure (i.e., blaming themselves for a competitive failure) was associated with greater depression risk.

Nonfunctional overreaching (NFO) and overtraining syndrome (OS) are phenomena that must be distinguished from depression in track and field athletes. NFO and OS are characterized by psychological and physiological disturbances, decreased performance, and longer performance decrement after intense training⁶⁻⁷. Ideally athletes recover quickly from intense



Image: Illustration.

training and make performance gains beyond their previous baseline. However, NFO may require weeks to months for full recovery after intense training, and the more severe OS usually requires at least two months for recovery⁷. Symptoms that overlap across depression, NFO, and OS may include amotivation, appetite change, fatigue, insomnia, and weight loss. Importantly, depression, NFO, and OS are not always mutually exclusive, and scenarios can occur in which ongoing NFO/OS can lead to superimposed depression. One potentially helpful way to distinguish NFO/OS from depression is via the domain(s) of the role dysfunction: sport performance in NFO/OS, versus not only sport but also cognitive, interpersonal, and work performance in depression⁸.

NFO and OS may be more common in track and field athletes, especially those running long distances, than in other types of

sports, because of the significant physical demands placed on this athlete population. One study found a NFO lifetime prevalence of approximately 60% in elite male and female runners, and 33% in nonelite female runners⁹. Similarly, another review found that symptoms of OS appeared in >60% of distance runners during their athletic careers¹⁰.

Little is known about the other major mood disorder—bipolar disorder—in track and field athletes. However, the peak age of onset of bipolar disorder correlates with typical peak ages for track and field performance (twenties)¹¹. Moreover, intense aerobic exercise as in track and field athletes may be a risk for precipitating mania in those with bipolar disorder¹²⁻¹⁴. Case reports exist of elite endurance runners experiencing mania¹⁵⁻¹⁶, especially after increased running intensity and/or in-season racing¹⁶.

Management

It is important to be aware of general medical conditions that may disproportionately affect track and field athletes and that may impact the mental health of this population and masquerade as depression. For example, anemia has been associated with depression¹⁷. Iron-deficiency anemia may be relatively common in endurance athletes such as distance runners, owing to factors including insufficient dietary intake (whether part of an eating disorder or not)¹⁸. Runners may be particularly sensitive to any degree of fatigue—as they push their bodies to extremes—when suffering from anemia. If fatigue is a prominent component of an athlete's presentation of apparent depression, laboratory evaluation for anemia should be considered.

Thyroid dysfunction is also an important consideration in any population of patients with mood or anxiety disorders, as it may present as depression or anxiety or may worsen those disorders if present¹⁹. In recent years, several well-known elite distance runners and their physician have discussed the controversial diagnosis of endurance training-induced hypothyroidism²⁰. However, data supporting a negative effect of training on thyroid function is limited²⁰. Findings do not support the concept of overtraining-related hypothyroidism²⁰⁻²¹. Specifically, no aspect of training, including weekly mileage, pace, and accumulated years of running, has been found to be associated with an increased prevalence of hypothyroidism.²¹ However, one study suggests that the rate of hypothyroidism, based on self-report from athletes, may be somewhat higher than the expected prevalence of hypothyroidism based on previous studies of the general population.²¹ The authors speculated that this may reflect a heightened awareness of symptoms of hypothyroidism among runners versus the general population, as well as a lower threshold for health professionals to seek out and treat both clinical and subclinical hypothyroidism in endurance athletes. Additionally, results demonstrated a three-fold increase in hypothyroidism among those who began running at or before age 10²¹, which is consistent with previous findings that thinness in childhood is associated with adult hypothyroidism²². When considering NFO/OS, practitioners should take care to ensure that other medical conditions that can result in

underperformance, not only including iron deficiency with or without anemia and thyroid disease, but also asthma, adrenal disease, diabetes mellitus or insipidus, infection, and malnutrition (due to eating disorders or other causes), are not contributing²³.

Assuming any general medical contributors have been considered and are being appropriately managed, psychotherapy, especially cognitive behavioral therapy (CBT), may be helpful for track and field athletes with depression¹. Additionally, mindfulness-based approaches may not only improve mental health symptoms of depression and anxiety but have also been suggested to improve sports performance in track and field athletes²⁴. If depression is moderate to severe, antidepressant medications may be appropriate. Bupropion may be a medication of choice in athletes, as long as there is no comorbid eating disorder that involves restricting or purging, and especially if there is no or only minimal comorbid anxiety (as bupropion can sometimes worsen anxiety)²⁵. Note that bupropion has been on the World Anti-Doping Agency 'Monitoring List' for many years now, meaning that this organization is monitoring for any trends that may suggest inappropriate use, but it is not prohibited, and sports psychiatrists still feel comfortable prescribing it²⁵. Selective serotonin reuptake inhibitors (SSRIs) are also frequent choices. SSRIs such as fluoxetine, escitalopram, and sertraline, which have relatively few side effects such as weight gain or sedation that could be

problematic for track and field athletes, should be considered²⁵.

If overtraining syndrome is suspected, the typical intervention is reduced physical workload⁷. In true overtraining, symptoms should subsequently improve. If the symptoms represented depression without an element of overtraining, symptoms might well worsen with reduced exercise, as the athlete may now miss out on the antidepressant benefits of exercise²⁶.

Especially in northern latitudes, people may be more susceptible to depression during winter months²⁷. In some sports, athletes may be relegated to indoor practice and/or competition during winter. This may predispose them to worsening mood during that time of year²⁸. Runners, however, may uniquely be able to train outdoors year-round. One study has demonstrated mood improvement in seasonal affective disorder when patients received outdoor natural light exposure during a one-hour walk every morning²⁹. This may be worth considering in runners demonstrating a seasonal depressive pattern if the choice exists between training in an indoor facility versus outdoors.

Recommended management approaches for bipolar disorder include mood stabilizing medication with close attention to side effect profiles^{31,36}, mood tracking³¹, and adequate sleep to mitigate exercise-associated mania³⁶.

Anxiety and related disorders

Like depression, anxiety-related disorders appear to be equally common in athletes

as a group and in the general population¹. However, also similar to depression, individual sport athletes may be at higher risk than team sport athletes for anxiety³⁰⁻³². This may owe to several factors. Starting at young ages, motivations for athletes to join individual sports disproportionately include goal-oriented, anxiogenic reasons such as controlling weight or winning scholarships, whereas team sport athletes tend to join their sports to have fun with friends³⁰. Moreover, individual sport athletes are more likely to train in a single sport throughout the year, suffer injuries, set extreme personal goals, receive less social support, and be more perfectionistic, all of which may be associated with anxiety³³⁻³⁴.

There is some information available on specific anxiety-related disorders in track and field athletes or runners. For example, there is a complicated relationship between aerobic exercise such as running and panic attacks. Research generally shows that exercise has an overall anxiolytic effect, but it can also precipitate acute anxiety and panic attacks, with up to one third of patients with panic disorder and/or agoraphobia reporting increased anxiety during aerobic exercise³⁵. The more intense the exercise, the more likely panic disorder sufferers are to report that exercise worsens their anxiety³⁵. Thus, running—an often intense form of exercise—may be particularly likely to worsen anxiety in panic disorder patients. The association between exercise and panic may relate to the physical sensations of exercise, e.g., tachycardia and tachypnea, mimicking those of panic, and thus the

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Image: Illustration.

panic disorder-suffering exerciser worries they are going to have a panic attack, which exacerbates further panic symptoms³⁶. It is possible that some people with pre-existing panic disorder may opt-out of running as their sport of choice, due to this possible short-term exacerbation of their condition. Conversely, one study suggests that participation in adolescent sport might decrease the risk of panic disorder (more so than other anxiety disorders) in adulthood³⁷. It is possible that early sports participation may act as a form of exposure therapy such that youth learn not to fear symptoms such as increased heartbeat, rapid breathing, and sweating via desensitization to those symptoms³⁷.

People with pre-existing social anxiety disorder may also opt out of track and field, and any other individual sports. One study of 180 students showed a correlation between social anxiety and avoidance of individual but not team sports³⁸. Another showed that individual sport athletes in youth sports reported increased social anxiety compared with youth involved in team sports³⁹.

It is important to distinguish social anxiety disorder from sport-related performance

anxiety. In social anxiety disorder, fears are focused on interaction with and scrutiny by others⁴⁰. Conversely, in performance anxiety, the symptoms are limited to sport participation, wherein around the time of sport participation, the athlete fears that they will not be able to perform in the desired manner, or that the situation will be too challenging, dangerous, or harmful, and consequently they experience anxious arousal, cognitive appraisals, and/or behavioral responses⁴¹. Sport-related performance anxiety does not necessarily represent a diagnosable mental health disorder but is often the source of referrals of athletes to sports mental health clinicians. This type of anxiety may also be more common in individual sports than team sports, as the athlete feels more pressure to perform well as an individual⁴²⁻⁴³. Additionally, in many team sports, coaches can have continuous contact with team members throughout competitions. In contrast, in many track and field events, once the competition has begun, the coach and other supports typically cannot make meaningful contacts to help regulate anxiety levels. Among

runners specifically, sprinters compared to middle- and long-distance runners may be more likely to suffer from performance anxiety⁴⁴. Conversely, one manifestation of performance anxiety—gastrointestinal upset—may be particularly common in long-distance runners⁴⁵.

Management

CBT with exposure therapy is the psychotherapeutic approach of choice for many anxiety disorders in athletes, as in any patients⁴⁶. If an athlete specifically presents with panic attacks, the clinician should evaluate if the panic seems worse when exercising. If so, treating the panic disorder, and discouraging phobic avoidance of sport, would be the recommended intervention. Continued sport could be used as exposure therapy in which an exposure hierarchy, starting with slow jogging and leading up to full-intensity sprinting, could be undertaken. Cognitive restructuring could accompany the exposure intervention.

In the presence of performance anxiety, first, it should be ensured that the athlete is engaging in appropriate training for the event in question⁴⁷. For example, if a runner

is training for a 10 kilometer race, but only running 10 kilometers total per week, they might have appropriate performance anxiety for a competition for which they are underprepared. Once it is established that appropriate training is being undertaken, other strategies to address performance anxiety in track and field include: running progressively more miles at the goal race pace to build confidence in the ability to compete at that pace; developing individualized mental routines so that the athlete feels in control of their environment⁴⁷; participating in competition walk-throughs so that the competition scenario is not new to the athlete on competition day⁴⁷; practicing what they would do if negative thoughts come into their head; using regular visualization of success, including all senses and various scenarios⁴⁸; and developing verbal triggers that remind the athlete what they want to be thinking during difficult moments such as physically painful moments in a running event⁴⁷.

For isolated performance anxiety in athletes, medications are not generally utilized. Beta-blockers should be avoided in runners, as these medications have been shown to decrease 20 kilometer running time, endurance, and $VO_{2\max}$ ⁴⁹. Additionally, benzodiazepines should be avoided in many track and field athletes, owing to side effects such as decreased reaction time, muscle relaxation, and sedation^{26,40}.

If anxiety is moderate to severe, medications may be needed, and SSRIs are the category of choice. Again, SSRIs with fewer side effects that could be problematic for track and field athletes should be tried first²⁵.

Eating disorders

Eating disorders have been shown to be more common in athletes than in the general population, and this is especially true in “leanness sports” such as distance running in which lean physique may be advantageous¹. Eating disorders include anorexia nervosa, bulimia nervosa, binge eating disorder, and other specified/unspecified eating disorder. The other specified/unspecified eating disorder category may include track and field athletes who otherwise meet the criteria for anorexia nervosa but who do not meet the “significantly low body weight” criterion. This may be relatively common among some runners, such as sprinters, who may

have more muscle mass than others with eating disorders. Despite the frequency of eating disorders in athletes, research suggests that track and field coaches may not be sufficiently equipped to identify the problem⁵⁰.

An important potential consequence of eating disorders in female track and field athletes is the female athlete triad, which includes low energy availability (insufficient caloric intake, whether inadvertent or due to disordered eating), menstrual cycle disturbances, and low bone mineral density⁵¹. Athletes with the triad who continue participating are at risk for bone stress injuries. A more recent conceptualization of the female athlete triad is “relative energy deficiency in sport”⁵². This is similar to the female athlete triad, but it is expanded to include all genders and most organ systems⁵².

Times of transition—whether temporary or permanent—out of sport might be particularly high risk for eating disorders in the track and field population. Such transitions include retirement from sport, injury, or the off-season⁵³. During these times, athletes may fear bodily changes and consequently overcompensate for decreased physical activity by markedly and inappropriately decreasing their caloric intake, which can be a setup for disordered eating⁵³. Female distance runners may be particularly susceptible to disordered eating during transition⁵⁴.

Management

Track and field athletes with eating disorders should be managed by a multidisciplinary team, including primary care/sports medicine physicians, dietitians, and licensed mental health professionals such as psychiatrists and/or psychologists. Athletes with eating disorders should typically have their electrolytes, liver, renal, and thyroid function, blood counts⁵⁵, and ferritin¹⁸ checked. Dual energy X-ray absorptiometry (DXA) is recommended for athletes with amenorrhea for six or more months or with prolonged oligomenorrhea (<six menses in 24 months)⁵⁵. Electrocardiography is recommended for athletes with eating disorders who experience syncope, recurrent near syncope, palpitations, resting supine heart rate <50 beats per minute, rapid weight loss, weight <80% of ideal body weight, or hypophosphatemia⁵⁵. Higher levels of care including hospitalization, residential

treatment, partial hospitalization programs, or intensive outpatient programs should be considered⁵⁵.

Fluoxetine is a medication option that is approved in some countries for bulimia nervosa, but other antidepressants are often used off-label as well, both for core eating disorder symptoms and for any comorbid depression and anxiety⁵⁶. Lisdexamfetamine may be helpful for binge eating disorder⁵⁷, but as a stimulant it is prohibited in competition at most elite levels and would typically require a therapeutic use exemption⁵⁸. Bupropion is contraindicated in anyone with restriction or purging as part of an eating disorder, as it may increase the seizure risk in those circumstances⁵⁹.

Substance use and other addictive disorders

In general, athletes use many substances at lower rates than the general population⁶⁰. However, exceptions include binge alcohol, oral tobacco, non-prescription opioids, and anabolic-androgenic steroids⁶⁰. No large-scale studies of track and field athletes specifically have been conducted to determine the relative risk of this group compared to other athletes. However, individual sport athletes, such as those in track and field, are believed to use substances at lower rates than are team sport athletes⁶¹.

Just as in general populations of athletes⁶², alcohol is likely the most commonly misused substance among track and field athletes. One report found that use rates of alcohol among college athletes was higher than in the general public (75-93% for male athletes, and 71-93% for female athletes). However, track and field athletes were among the lower risk sports in this study⁶². One of the significant short-term problems caused by alcohol consumption is increased risk of dehydration during physical activity⁶³. Additionally, acute alcohol use has been shown to decrease speed and endurance⁶⁴, of obvious consequence to many track and field athletes.

Track and field athletes in different events are at differing risks for use of performance-enhancing drugs (PEDs). Sprinters, as power athletes, are at relatively higher risk for use of anabolic-androgenic steroids, growth hormone, and growth factors (e.g., insulin-like growth factor and insulin). Distance runners are at relatively greater risk for use of substances that increase



Track and field athletes are not immune to a wide variety of mental health symptoms and disorders.



oxygen exchange, such as recombinant human erythropoietin and darbepoetin alfa, hypoxia mimetics that stimulate endogenous erythropoietin production such as desferrioxamine and cobalt, artificial oxygen carriers, and autologous or homologous red blood cells⁶⁵. They also may be at risk for abuse of beta-2 adrenergic agonists, e.g., albuterol, formoterol, and salmeterol. While they may be at less risk than sprinters, distance runners may also use androgens, with the goal of reducing body fat⁶⁶. Both sprinters and distance runners may misuse stimulants, whether to improve endurance, increase anaerobic (e.g., sprint) performance, decrease feelings of fatigue, improve reaction time, or cause weight loss^{65,67}.

Many studies have examined excessive exercise as an addictive or compulsive behavior and have variably labeled it as “exercise addiction”⁶⁸, “exercise dependence”⁶⁹, “compulsive exercise”⁷⁰, “positive addiction”⁷¹, or “obligatory running”⁷². As the latter label suggests, running is the sport often studied in these reports. While the Diagnostic and Statistical Manual of Mental Disorders fifth edition does not include exercise addiction, it is increasingly recognized as one type of behavioral addiction⁷³. It has been defined as excessive exercise undertaken to provide either pleasure or relief from internal discomfort (e.g., from anxiety or stress).

It can be difficult to discern exercise addiction from normative, adaptive exercise in high-level track and field athletes⁷⁴. However, a defining feature is repeated failure to

control the behavior and maintenance of the behavior despite negative consequences⁷⁵. Associated symptoms include tolerance (increasing amounts of exercise needed to get the desired effect), withdrawal (anxiety, irritability, restlessness, and insomnia in the absence of exercise), lack of control (unsuccessful attempts to cut down), intention effects (unable to adhere to one’s intended exercise regimen), time (great amount of time spent preparing for, engaging in, or recovering from exercise), reduction in other activities, and continued exercise despite knowing it is causing problems⁷⁶. Despite the common “more must be better” mentality of those suffering from exercise addiction, one study of 74 elite track and field athletes demonstrated that those with high levels of exercise addiction displayed worse performance across track and field events⁷⁷.

Exercise addiction and eating disorders have been closely correlated. Eating disorders are often accompanied by extreme levels of exercise, commonly in the form of vigorous aerobic activity such as running. Athletes may have primary or secondary exercise addiction⁷⁸. In primary exercise addiction, exercise itself is the objective. In secondary exercise addiction, weight loss is the objective, and excessive exercise is driven by an eating disorder⁷⁸. Male athletes have been shown to have higher rates of primary exercise addiction, while females have higher rates of secondary exercise addiction⁷⁹.

Exercise addiction prevalence varies based on the population studied, with higher rates

found in professional athletes compared to recreational ones⁷⁸. Within running specifically, one study found that, of those participating in a U.S. four-mile road race that attracts runners of all levels, 26% of 240 male runners and 25% of 84 female runners were classifiable as “obligatory runners”⁸⁰. “Obligatory runners” were defined as scoring high on the Obligatory Running Questionnaire⁸¹, which includes Likert scale items such as “I will not exercise if I feel sick or injured” and “When I miss a scheduled exercise session, I may feel tense, irritable, or depressed”. Another study found that 30.4% of triathletes (whose sport includes running) were found to have primary exercise addiction, and another 21.6% secondary exercise addiction⁷⁹.

Management

Psychotherapeutic approaches, including individual and group treatments, are generally the mainstay of treatment for addictive disorders. Approaches such as relapse prevention, which take a CBT approach, may be well-suited for this goal-driven population of patients⁶⁶. Twelve-step facilitation, motivational enhancement, and network therapy are also reasonable approaches⁶⁵⁻⁶⁶.

If medications are needed to treat specific substance use disorders, such treatment should be undertaken with attention to side effect profiles and prohibited lists at higher levels of sport. For opioid use disorders, methadone and buprenorphine are on some prohibited lists, including that of the World Anti-Doping Agency⁵⁸. Naltrexone (oral and

TABLE 1	
Mental health symptoms/disorders	Unique manifestations in track and field athletes
Mood disorders	<p>Depression may be more common in track and field than in other sports.</p> <p>Nonfunctional overreaching and overtraining syndrome may manifest as depressive symptoms.</p> <p>Iron-deficiency and thyroid dysfunction may contribute to depressive symptoms.</p>
Anxiety and related disorders	<p>Physical sensations of aerobic exercise may exacerbate panic symptoms in athletes with panic disorder.</p> <p>Athletes with social anxiety disorder may struggle with the focus on the individual in sports such as track and field.</p> <p>Sport-related performance anxiety may be common in individual sports such as track and field.</p>
Eating disorders	<p>Eating disorders may impact track and field athletes in any events and at any weight.</p> <p>Bone stress injuries may be a manifestation of an eating disorder in track and field athletes.</p> <p>Times of transition out of sport (e.g., injury, off-season, retirement) are especially high risk for eating disorders.</p>
Substance use and other addictive disorders	<p>Alcohol is likely the most commonly misused substance among track and field athletes.</p> <p>Track and field athletes across events may use performance-enhancing drugs.</p> <p>“Exercise addiction” may be common among runners, and results in excessive amounts of exercise despite negative consequences from it (e.g., inability to decrease exercise even if it worsens an injury).</p>

Table 1: Summary of unique manifestations of specific mental health symptoms/disorders in track and field athletes.

extended-release injectable formulations), acamprosate, and disulfiram are approved in some countries for treatment of alcohol use disorders⁸². Gabapentin and topiramate are sometimes used off-label for this purpose⁸². In track and field athletes with comorbid eating disorders and alcohol use disorders, liver function tests should be monitored particularly diligently when using naltrexone or disulfiram, as these agents should not be used if liver function is significantly compromised⁸³. Importantly for runners, who can be of low body weight, some references suggest giving a lower dose of acamprosate, or not using it at all, for patients weighing less than 60 kilograms⁸³⁻⁸⁴. For exercise addiction, the treatment entails the athlete working toward a reasonable amount of exercise given their particular context⁷⁸. Clinicians must be thoughtful in their approach to this issue, as track and field athletes seeking mental health help may hesitate to trust a clinician whose response is that their problem is that they are exercising too much.

GENERAL PRINCIPLES OF SUPPORT FOR TRACK AND FIELD ATHLETES

Track and field athletes face many stressors⁸⁵, any of which may contribute to the mental health symptoms and disorders from which this sport’s athletes may suffer. To buffer against these stressors, general recommendations for athletes and members of their entourage, including their family members, have included (summarized in Box 1):

- Early participation in a variety of sports—as opposed to single sport specialization at a young age—may be beneficial for athletes who ultimately select track and field as their sport of specialization⁸⁶. This may help prevent burnout, injury, and exit from sport and promotes gradual, sustainable development in this particular sport⁸⁶.
- Positive relationships should be established among athletes, parents, and coaches, as these have been shown to be helpful for optimizing longevity and success in track and field⁸⁷.
- Coaches’ feedback to track and field

athletes should be positive and constructive⁸⁸. Olympic track and field athletes have reported that skills-mastery motivational approaches (focused on exerting effort and improving personally in a specific task) are more helpful than ego/performance-centered approaches (focused on demonstrating superior performance compared to others)⁸⁶, and the former are associated with lower rates of depression, anxiety, and burnout in athletes⁸⁹.

- Members of the athlete entourage should avoid putting excessive pressure on track and field athletes⁹⁰. Intrinsic motivation (e.g., enjoyment and satisfaction in sport) versus extrinsic motivation (e.g., pressure from others, trophies, records) is associated with longevity in track and field⁹¹.
- Members of the entourage should promote enjoyment of training, competing, and socializing within the sporting framework⁸⁶. These factors are associated with positive perceptions of

Box 1

- *Encourage young athletes to participate in a variety of sports.*
- *Promote positive relationships among athletes, parents, and coaches.*
- *Praise effort and personal improvement in specific sporting tasks, as opposed to focusing on the athlete needing to be better than other athletes.*
- *Avoid putting excessive pressure on athletes.*
- *Promote enjoyment of training, competition, and socializing within sport.*
- *Support the values that are important to the athlete.*
- *Encourage sport/life balance.*
- *Make mental health support accessible and destigmatized for athletes.*

Box 1: Recommendations for coaches, family members, health care providers, institutions, and other athlete entourage members to promote and protect the mental health of track and field athletes.

track and field athletes' own abilities and longevity in sport⁹².

- Track and field athletes benefit from support of the values that they hold important. For example, for some track and field athletes, spiritual life provides a deeper meaning to their athletic success, struggles, and disappointments⁸⁶.
- Members of the entourage should help track and field athletes to find the balance that feels right for them among sport training, educational pursuits, and occupations⁸⁵.
- Mental health support should be as readily accessible for track and field athletes as is general medical support. Track and field athletes should be informed how to seek mental health support, and discussions of mental health should be normalized⁹³.

CONCLUSIONS

Track and field athletes are not immune to a wide variety of mental health symptoms and disorders. They may experience nuanced presentations of them (summarized in Table 1), and it is important for clinicians who work with athletes to be aware of the unique considerations within this sport. While events within track and field can vary substantially, an overarching feature of track and field is that it is an individual sport. This has important implications in terms of relatively higher risk for some disorders such as depression and anxiety and relatively lower risk of others such as substance use disorders. Additionally, those competing in "leanness" and/or endurance events within the sport are at disproportionate risk for eating

disorders and exercise addiction. Treatment considerations when working with track and field athletes must include appreciation of the intense physical demands and psychosocial stressors that can exist in this sport, the psychological tendencies of the athletes involved in it, and the salience of medication side effects. Track and field athletes and their entourage can take steps to simultaneously optimize success and longevity in sport and to safeguard athlete mental health.

References

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