



Behavioral Health Care: An International Approach to Student-Athlete Mental Health

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Worldwide, mental illness affects a variety of student-athletes. 41% of student-athletes were frequently overwhelmed. Nearly a quarter of student-athletes reported exhaustion from the mental demands of their sport. 10-21% of student-athletes reported depressive symptoms but did not know how to handle them. With mental illness affecting many student-athletes, the purpose of this study was to analyze a student-athlete's access to both psychological services and resources between the United States Ivy League Conference and Japan's Kansai Big Six League. Results confirmed that the United States focused on performance; whereas, Japan focused on holistic health. Furthermore, young adulthood is a period of heightened susceptibility for mental health disorders, making college an important setting for a student-athlete's early identification and management. Early identification is critical, yet diagnosed student-athletes rarely seek help as 19.4% of student athletes experience some form of mental health disorder, 360,000 student-athletes struggle with depression, and only 18% of student-athletes seek treatment when struggling with poor mental health.

Keywords: holistic health, help-seeking behavior, mental health programming, psychological services, stigma

A student-athlete's mental health is important; yet, psychological services/care is underutilized (Schleider et al., 2020). This is a problem as substance and mental health disorders negatively impairs a student-athlete's performance and functioning and is the second largest cause of disease and disability worldwide (Mathers et al., 2008). Without access to psychological services and institutions advocating for the help-seeking behavior of their student-athletes, student-athletes continue to struggle as mental health concerns spread to different areas of their life (e.g., substance abuse, academic failure, unemployment, adverse social outcomes, etc.). Some student-athletes may not want to seek help, but it is vitally important for student-athletes to

be given a variety of opportunities to access psychological services and receive cognitive and behavioral interventions for distressing symptoms they may be experiencing. Student-athletes having access to these mental health services and cognitive/behavioral interventions could be a helpful approach in combatting negative mental health experiences domestically and abroad. Through an understanding between the United States and Japan's healthcare structure (the focus of our paper), this paper will fill a gap in the literature by examining whether structural, cultural, and interpersonal factors between Japan and the United States positively or negatively affect whether behavioral health services are likely to be accessed by student-athletes at their respective institutions.

The reason we selected the United States and Japan for comparison was their unique healthcare structure. With the United States private insurance model and Japan's free healthcare model, this paper will look at institutional resources and help-seeking behavior. By comparing the results between student-athletes in both countries, researchers will gain a better understanding of whether healthcare structure has anything to do with the stigma and help-seeking behavior of student-athletes. Based on our findings, each healthcare model could be further examined to determine if certain healthcare variables positively or negatively affect a student-athletes access to psychological services.

Using a summative qualitative content analysis, which is a research method for the subjective interpretation of content or text data (Hsieh & Shannon, 2005), our sample population for the United States include NCAA member institutions within the Ivy League Conference; whereas, our sample population for Japan include institutions of the Kansai Big Six League. These two specific groups of institutions have been chosen based on university prestige and similarities of athletic department structure. Viewing each individual institution's website, the purpose of this study was to examine the mental health services provided and details regarding if there are any specific student-athlete specialists on their respective campuses. Internal mental health resources are likely available that are not located on the institution's websites; however, we have taken this approach to reflect what student-athletes may see if they do not feel comfortable asking their coach or support staff about mental health resources and decide to search these resources on their own. From these findings, the information could help determine if student-athletes have access to a variety of mental health programs tailored to their role as student-athletes, and the extent in which student-athletes feel comfortable disclosing their mental health concerns with peers, coaches, administrators, and social workers/care providers.

Literature Review

Mental Illness

Worldwide, mental illness affects a variety of cultures. Some cultures believe mental illness is a result of spiritual warfare (e.g., certain West African cultures). Other cultures believe individuals with mental illness are inherently bad, have something wrong with them, and should be avoided at all costs (e.g., certain Indian cultures). For the purposes of our study, however, the definition of mental illness we will be using to discuss Japan and the United States is from the World Health Organization (WHO), which is a United Nations agency to promote health, keep the world safe, and serve the vulnerable. According to the WHO, mental illness is defined as, "a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior" (World Health Organization, 2022).

Individuals domestic and abroad struggle with their affective, behavioral, and cognitive functioning. In Japan, children and adolescents report emotional and behavioral problems before the age of 14 and even more children and adolescents before the age of 24 (Masuda, 2009). More children than ever are reporting distressing symptoms, yet fewer youth in Japan are seeking help (Masuda, 2009). In comparison, the United States is seen as a prosperous nation that can offer different mental health programming. The United States has spent more money on mental health services than any other country in the world, yet up to 80% of youth with mental health needs went without service or received insufficient or untested care (Schleider et al., 2020). This lack of access is not a new concept but is often exacerbated by mental health concerns developed during childhood (Masuda, 2009). Many undiagnosed youth and mental health concerns have never been treated; therefore, it is no wonder life-stressors and psychological concerns increase when student-athletes transition to intercollegiate athletics.

Many believe that talking about mental health, especially within intercollegiate athletics, should only be done with licensed professionals. Sport practitioners and clinicians can provide a variety of psychotherapy and resources, but the information does no good if student-athletes do not seek help. What would happen if professors, coaches, and peers, who student-athletes see on a daily basis, were trained to identify individuals struggling with their mental health and had the tools to promote healthy living, thoughts, and attitudes? This does not replace the need for mental health counselors and physicians but creating a welcoming environment/sense of community with others could reduce any underlying fears associated with mental illness and seeking help.

Taken further, there are many mental health concerns student-athletes may not be comfortable sharing with a licensed professional due to fear of being hospitalized or not being understood (e.g., eating disorders, suicidal/homicidal ideations). This does not reduce the impact mental health professionals can have when working with these topics, but many mental health concerns are heightened when student-athletes are fearful of seeking help or do not relieve stress in ways that are adaptive/beneficial for them (Stock & Levine, 2016). When student-athletes use adaptive coping skills to process loss, lack of performance, and setback, they are likely to enact positive behaviors; whereas, student-athletes who use maladaptive coping skills to process loss, lack of performance, and setback, are likely to enact negative behaviors (Stock & Levine, 2016). Negative behaviors may feel good in the moment but do not relieve stress long-term (Bauman, 2016). The negative stress cycle that is created can introduce student-athletes to anorexia nervosa, bulimia, and binge eating, all of which can severely impair affective, behavioral, and cognitive functioning (Brown, 2014; Stock & Levine, 2016). Anorexia nervosa is often conceptualized as a lack of eating, bulimia as vomiting after overeating, and binge eating as excessive eating with no exercise (Stock & Levine, 2016; Thompson & Sherman, 2007). Student-athletes often turn to the aforementioned disordered eating patterns to stay in shape, maintain societal expectations, and enhance their way of life. (Greenleaf et al., 2009; Thompson & Sherman, 2007).

In addition to eating disorders, substance abuse is another concern for student-athletes, coaches, and administrators in the United States and Japan. With 1,825 student-athletes dying from alcohol related incidents each year, accessing services becomes even more important for student-athletes (Hingson et al., 2009). By accessing psychological services, student-athletes are able to learn adaptive self-care strategies to help prevent drug and alcohol abuse from occurring. Reducing any help-seeking barriers that may exist is important as addiction takes the lives of

student-athletes and is comorbid with mental illness and other presenting concerns (Brown, 2014).

Finally, many mental health concerns of student-athletes in the United States and Japan are not being treated. There are many reasons this may exist (stigma, low help-seeking behavior, health and finance structure). This is a problem, especially when student-athletes do not feel comfortable seeking help or are facing barriers to seeking help for disorders and presenting concerns such as bipolar, schizophrenia, sexual violence, hazing, bullying, and sexual discrimination (Brown, 2014). If students are not accessing services, they are not receiving treatment and their psychological needs are not being met (Alang, 2015). The need for mental health services within intercollegiate athletics is of paramount importance (Cutler & Dwyer, 2020). Therefore, it is important for institutions to provide treatment for disorders and presenting concerns not closely monitored and to be a positive resource for student-athletes who hold multiple intersecting identities (Brown, 2014; Cutler & Dwyer, 2020).

Stigma

Many factors prevent student-athletes from accessing psychological services. For the purposes of our study, however, we will be focusing on the United States and Japan's conceptualization of stigma, help-seeking behavior, and their health and finance structures. This focus will provide distinct similarities and differences between the United States and Japan and how accessing psychological services could be strengthened in both countries. Beginning with stigma, there are two different types. Self-stigma is a negative attitude where a student-athlete may think lowly of themselves for seeking help (Wahto et al., 2016). Public stigma, however, is concerned with negative attitudes others may have toward a student-athlete seeking help (Wahto et al., 2016).

According to research from Alang (2015), stigma prevents access to treatment and contributes to unmet psychological needs. This is a problem for student-athletes in the United States and Japan as student-athletes believe they can solve their own mental health concerns by attempting to diagnose themselves, believing their symptoms will go away without treatment, and assuming help is not needed (Alang, 2015). Stigma in the United States and Japan have similar characteristics. Student-athletes in Japan are often more intrinsically driven, guarded, and choose to go through their mental illness alone; whereas, student-athletes in the United States also keep their mental health to themselves, but are more likely to open up to close friends and family than student-athletes in Japan (Alang, 2015).

Student-athletes who choose to keep their mental health to themselves may first view this as adaptive (i.e., not having to talk about their mental health with others) but can later become maladaptive by negatively affecting their cognitive functioning and athletic/academic performance (Rafael et al., 2018). It may be comfortable for student-athletes in Japan and the United States to keep their mental health and well-being to themselves, but battling mental health concerns alone often exacerbates stress and psychological symptoms (Eisenberg et al., 2009; Topkaya et al., 2017; Vogel et al., 2007). The more a student-athlete tries to seek help, the more isolation and stigma can prevent them from doing so (Eisenberg et al., 2009; Topkaya et al., 2017). Through stigma's association with negative attitudes, research also shows that public stigma is often mediated by self-stigma (Topkaya et al., 2017; Vogel et al., 2007; Vogel et al., 2017). When public stigma is internalized, it often leads to more self-stigma. This is a problem

as stigma surrounding mental health services is already a major barrier to accessing psychological services (Cutler & Dwyer, 2020; Hogan, 2003).

Help-Seeking Behavior

Young adulthood is a period of heightened susceptibility for mental health disorders, making college an important setting for a student-athlete's early identification and management (McGorry et al., 2011). With early identification, stress is often reduced (Ryan et al., 2018). This is critical, yet according to an American College of Sports Medicine statement in 2021, approximately 30% of female student-athletes and 25% of male student-athletes report having anxiety, 35% of elite athletes struggle with disordered eating, burnout, and depression, and only 10% of all college athletes with known mental health conditions seek help from a mental health professional (ACSM, 2021). Low help-seeking behavior is a problem, especially when considering that collegiate student-athletes are an at-risk population with many barriers to accessing support (Cutler & Dwyer, 2020; Watson, 2006).

In understanding the relationship between stigma and help-seeking behavior, it is an important connection for researchers, professors, coaches, and administrators to make in order to strengthen the mental health and well-being of student-athletes in Japan and the United States. In the United States, stigma and lack of knowledge often prevent help-seeking behavior from taking place (Bauman, 2016). McAllister et al. (2017) reinforce this point as those with mental health concerns often do not seek help due to stigma. Many student-athletes feel conflicted when seeking help and often think seeking help minimizes mental toughness and goes against who they are as a person (Bauman, 2016; Ryan et al., 2018). Considering this cognition is common in both countries, the United States and Japan's student-athletes often do not seek help due to stigma and lack of knowledge (Rafael et al., 2018). Given student-athletes in both countries are not getting the help they need (Gavrilova et al., 2017, Gulliver et al., 2012), the lack of knowledge (e.g., knowing the symptoms of their mental health concerns, expectations from seeking help, and lack of mental health literacy) often keep student-athletes from accepting and coping with their mental health and psychological well-being. Student-athletes who are not able to take their mental health seriously have a much harder time with their identity, misinterpret their symptoms, think nothing is wrong, and attribute mental health concerns to over-training and busy schedules (Gulliver et al., 2012; Ryan et al., 2018). Misdiagnosis and overprescribing is already a common occurrence in both countries, which can sometimes be attributed to a country's health and finance structure (e.g., how mental health services are delivered and giving a diagnosis that is covered by insurance).

Health and Finance Structure

The United States uses a private insurance model for their healthcare system (Robertson-Preidler, 2020); whereas, Japan uses a universal healthcare system. With the United States private insurance model, universal coverage is not guaranteed, individuals often pay out of pocket, and access to services are not combined. Although the United States implements different policies to increase equitable access to healthcare than Japan, the insurance model and universal healthcare model can prevent access to certain services in which various populations are not given the help they need (Robertson-Preidler, 2020). As services are not readily available, many individuals in the United States are not able to access services, especially if their

insurance does not cover the cost and they have to pay out of pocket for services often out of their price-range (Robertson-Preidler, 2020).

With Japan's model, 90% of the population is covered by statutory contributors; whereas, the remaining 10% comes from private contributors (Masuda, 2009). Even with free healthcare, help-seeking behavior was low (Masuda, 2009). With student-athletes not seeking help, the services were there, but student-athletes were not using them (Masuda, 2009). This was interesting as the Democratic Party of Japan was commissioned by the Ministry of Health and Welfare to conduct continuous health reporting on mental health in Japan (Jeong & Niki, 2012). With the aim of promoting positive mental health, the institute noticed one in three adults fulfilled the criteria for mental health disorders, yet were not receiving treatment (Kanehara et al., 2015). Considering the initiative to uncover which populations are at-risk for mental illness is important to Japan, providing mental health education could be a key source for reducing stigma and providing student-athletes access to psychological services. This disconnect between public and mental health services in the United States and Japan often keeps student-athletes and everyday individuals from seeking help; resulting in lower access to psychological services (Gulliver et al., 2012; Masuda et al., 2009).

To put this in perspective, it is important for student-athletes to have access to psychological services as one-in-five adults struggle with mental health concerns (Brown, 2014). Treatment is important, yet student-athletes in different countries are having a difficult time accessing mental health services (Schleider et al., 2020). Many reasons such as stigma and lack of education prevent access to psychological services, but even with different healthcare structures, countries are still struggling to give student-athletes the help they need (Jeong, & Niki, 2012).

Methods

A summative qualitative content analysis was used to analyze the United States' Ivy League conference and Japan's Kansai Big Six league. This approach is used when an analysis involves counting and comparisons of keywords or content, followed by a subjective interpretation of content or text data (Hsieh & Shannon, 2005). The standard approach for this analysis is (1) selecting the content that will be analyzed, (2) defining the units and categories of analysis, (3) developing a set of rules for coding, (4) coding the text according to the rules, and (5) analyzing the results/drawing conclusions (Hsieh & Shannon, 2005). This study was done in October of 2020, did not require IRB approval (human participants were not involved), and was viewed weekly between October and December (two months). The two-month timeframe was to account for any changes to the institution's websites. During that timeframe, no changes were observed.

In total, 22 websites were examined to determine the psychological services institutions provided to both student-athletes and non-student-athletes. The respective institutions websites were viewed to mimic what student-athletes may see if they do not feel comfortable asking their coach or support staff about mental health resources and decide to search these resources on their own. With an emphasis on finding which programs provided access and resources to students and if specific treatment interventions were offered to student-athletes, the distinction between what an institution provided to student-athletes and non-student-athletes could determine if there was a shortage of material, access, and treatment for the student-athlete population. Coding with specific labels (e.g., annual health checks, counseling center, health services, mental health

external resources page, mental health/initiatives for student-athletes, student-athlete mentorship programs, and student-athlete workshops/training), these labels enhanced the analysis by examining the number of student-athlete services and non-student-athlete services offered for each institution measured (Hsieh & Shannon, 2005; Krippendorff, 1980).

Coders

A Master's student was the primary researcher during the beginning phase of data collection. The Master's researcher was led by an advanced Ph.D. researcher who has extensive experience with data collection and coding. All decisions were discussed between the Master's student and the advanced researcher to ensure all methods, procedures, and results were given ample consideration. If both the Master's student and advanced researcher did not reach the same coding decision, a third-party expert in the Social Psychology and Clinical Mental Health Counseling program was used to resolve any coding conflicts. We were able to agree on all coding decisions and did not need to consult with the third-party expert.

Procedures

Each website was viewed independently where data was entered for the eight Ivy League institutions and the six Kansai Big Six League institutions. These institutions were selected based on university prestige and similarities of athletic department structure. The data were collected by the Master's student and placed in an Excel Spreadsheet. Data that was not appropriate for the collection was reviewed by the Master's student and the advanced researcher. Labels that did not advance the intended research were removed. When consensus was reached, an interrater reliability analysis using the kappa statistic was utilized to find consistency between the raters. The consistency determined level of agreement between the Master's student and the advanced researcher to interpret the information found on each website.

Following data collection, the corresponding labels/data were analyzed to find themes between the Ivy League institutions and the Kansai Big Six League institutions. If discrepancies or errors were found within the data, corrective action was taken to regain an appropriate assessment between the institutions. Through extended dialogue and viewing the websites and data, the coders were able to agree on all themes from the data analysis.

Using the eight Ivy League institutions and the six Kansai Big Six League institutions, multiple steps were taken. To begin, the Master's student and the advanced researcher created an Excel spreadsheet to record data on the mental health resources offered by both the Ivy League and Kansai Big Six League institutions. Next, seven categories were used as comparative factors between the Ivy League institutions and the Kansai Big Six League institutions. These seven comparative factors were selected based on the literature and the corresponding health structure of the United States and Japan. Intended to determine general themes, the seven comparative factors (i.e., annual health checks, counseling center, health services, mental health external resources page, mental health/initiatives for student-athletes, student-athlete mentorship programs, and student-athlete workshops/training) captured the findings from each institution's website.

Finally, once labels were created, each institution was searched by (1) typing the institution's name followed by mental health resources, (2) annual health checks, (3) mental health initiatives, and (4) student-athlete workshops/training. These were selected to receive

information about what each institution offers for their student-athletes but also to capture if there were any other mental health programming opportunities implemented by each institution.

Results

Annual Health Checks

None of the Ivy League institutions required an annual health check from their student-athletes and non-student-athletes. Consistent with the health structure of the United States (i.e., private based insurance model; Robertson-Preidler, 2020), Ivy League institutions gave student-athletes and non-student-athletes the opportunity to complete an annual health check using the institutions health services, but the annual health checks were not required. Interestingly, as none of the United States' Ivy League institutions required an annual health check, all of Japan's Kansai Big Six league institutions required an annual health check. Without an annual health check, student-athletes and non-student-athletes from Japan's Kansai Big Six League were not able to participate in class, lecture, or sport.

The results for annual health checks support a different focus between the United States and Japan, which was highlighted by Robertson-Preidler (2020) and Kanehara et al. (2015). In the United States performance seemed to be the primary focus (Robertson-Preidler, 2020). This is not negative (i.e., performance); however, too much emphasis on performance could lead to discrepancies in other areas (e.g., a student-athlete's holistic health). Holistic health in the United States, which seems to be prioritized much lower than performance, becomes problematic as student-athletes could be performing at the highest level of competition, yet if their holistic health is not taken care of, they may not perform at full capacity. Japan on the other hand, seemed to recognize the importance of a student-athlete's holistic health as annual health checks were used as a baseline for starting/continuing the season. The difference, however, is that Japan seemed to focus heavily on holistic health, which is a good practice as a healthy student-athlete is likely to consistently perform at higher levels.

Counseling Center

Each Ivy League and Kansai Big Six League institution had a counseling center that could be used for student-athletes and non-student-athletes. The counseling center for Ivy League institutions often involved opportunities to set appointments and provided external links for student-athletes and non-student-athletes to engage with mental health resources. The Kansai Big Six League also contained counseling centers for student-athletes and non-student-athletes to schedule appointments; however, the websites did not include external links for student-athletes and non-student-athletes to access material for mental health resources. Consistent with existing literature, mental health resources were available, but student-athletes were often not aware they existed or how to access them (Gonzalez-DeHass et al., 2005; Masuda et al., 2009; Way et al., 2020).

From these results, it is important for counseling centers to provide access to all student-athletes. This could start with websites being user-friendly and having websites that are easy to navigate. For student-athletes with high demands and stressors, they may not have the energy to sift through a website where they cannot easily find the information they are looking for. Thus,

having websites that are user-friendly could be a step in the right direction for student-athletes seeking help from counseling centers at their respective institutions.

Health Services

All institutions from the Ivy League conference and the Kansai Big Six league had a health service that student-athletes and non-student-athletes could access. The Ivy League institutions had several physicians, doctors, and practitioners to aid student-athletes or non-student-athletes; whereas, the Kansai Big Six League did not have as many physicians and health service models. This distinction aligns with the healthcare structure between the United States and Japan: The United States' private insurance model and Japan's free healthcare model (Kanehara et al., 2015; Robertson-Preidler, 2020).

Moreover, the current service models between the United States and Japan can create a surplus or shortage of primary care providers, in which student-athletes having access to the right providers could be beneficial for help-seeking behavior. In the United States there seems to be an overflow of providers; however, many student-athletes do not seek help because they feel they would not be able to relate to the practitioner (Gill, 2008; Martin et al., 1997). In order to combat this, it could be beneficial to give student-athletes the opportunity to meet with practitioners who specialize in sport. This is not always feasible (i.e., only hiring/contracting sport practitioners), but it could also be helpful in training non-sport practitioners to develop a sport lens to the extent they can relate to the perspective/experiences of student-athletes.

In Japan, however, a lower number of practitioners could make it difficult for student-athletes to schedule an appointment. If resources are being utilized and student-athletes are scheduling appointments with providers, there is a limited number of student-athletes that a practitioner will be able to see each day. Results suggest that more providers could be advantageous for student-athletes seeking help. Just like the United States, though, it may be helpful to have sport practitioners assess student-athletes (Gill, 2008). Sport practitioners could help student-athletes open up about their mental health, but will also have sport/athlete experience knowledge that non-sport practitioners may not have.

Mental Health External Resources Page

The Ivy League institutions all had external links for student-athletes and non-student-athletes to access. Whether the links were accessed or not, the Ivy League institutions had several external links to help student-athletes and non-student-athletes with their mental health (e.g., stress, anxiety, depression, etc.). Oppositely, only one Kansai Big Six League had external links to help student-athletes and non-student-athletes with their mental health (e.g., Ritsumeikan University). The external links for Ritsumeikan University provided student-athletes and non-student-athletes with several mental health models to help student-athletes and non-student-athletes with stress and anxiety.

The results for the mental health external resource pages suggest that having links on service webpages could be beneficial for student-athletes seeking help/accessing psychological services. The resources could be a way to provide additional information before scheduling a consultation or could be a way for student-athletes to gain access to resources before meeting with a practitioner. Having loads of information on a webpage could have its limitations, however, (e.g., it might result in certain student-athletes trying to diagnose themselves and avoid

treatment since the necessary information is provided on the webpage; Alang, 2015), but by putting the information out there, it could give student-athletes the courage to seek help. Regardless of which approach is taken, providing mental health resources could be a great way to get student-athletes to care about their mental health to the extent they are not neglecting their thoughts and feelings. This could lead to more student-athletes seeking help and could be a positive step in reducing stigma and low help-seeking behavior (Masuda et al., 2009; Robertson-Preidler, 2020; Vogel et al., 2017; Way et al., 2020).

Mental Health Initiatives/Programming (SA)

The following mental health initiatives/programming were implemented from Ivy League institutions (e.g., Brown University: HEALTHY Athletes; Columbia University: SUCCESS THROUGH WELL-BEING; Cornell University: Especially for Student-Athletes; Dartmouth College: DARTMOUTH Cares; Harvard University: Crimson Mind and Body Performance Program; Princeton University: The Student-Athlete Experience; University of Pennsylvania: Mental Health Resources For All Student-Athletes; and Yale University: YUMatter Initiative). Each Ivy League institution and their corresponding mental health initiative/programming served as a specific aid for the student-athlete population. Considering the mission and purpose of each Ivy League institution was different, the inclusion of student-athlete mental health initiatives gave a tailored approach to helping the student-athlete population with their mental health and daily demands they face. Comparatively, for the Kansai Big Six League's institutions, none of their websites contained mental health initiatives/programming for student-athletes. This is in line with previous research as there is often not enough programming in place to increase a student-athlete's mental health and well-being (Way et al., 2020).

Results for the mental health initiatives and student-athlete programming led to high inclusion rates in the United States and high exclusion rates in Japan. The United States implemented several programs tailored toward student-athletes, which gave student-athletes the opportunity to feel included with programming that was beneficial for their mental health. In contrast, as Japan's mental health initiatives and student-athlete programming was not found on their websites, it seems that student-athletes were not given the opportunity to interact with programs tailored toward their student-athlete roles. As a result, this could lead to student-athletes feeling excluded and could cause them to think their institution is not providing the appropriate resources to feel a sense of belonging and inclusion to their team, school, sport, and academic experience. With mental health programming playing a significant role in a student-athlete's development, having specific programs tailored to student-athletes could be a helpful way to enhance their holistic health and performance (Kanehara et al., 2015; Robertson-Preidler, 2020).

Student-Athlete Mentorship Program

In measuring specific mentorship programs designed for the student-athlete population, only three institutions had mentorship programs specifically tailored to student-athletes (Harvard University, Princeton University, and University of Pennsylvania). The remaining Ivy League institutions had mentorship programs; however, they were not specifically designed for student-athletes. Pertaining to student-athlete mentorship programs, only three were found for the Ivy

League conference; whereas, none of the Kansai Big Six League institutions had student-athlete mentorship programs.

These results suggest that student-athlete mentorship programs may not be a priority for certain collegiate institutions. Additionally, even though student-athletes have their team, coaches, professors, and peers, sometimes student-athletes need a group of people to take their mind off their current athletic and academic responsibilities. Mentorship groups could include alumni, employers, or former student-athletes from the university. Allowing student-athletes to be a part of mentorship groups could open the door to conversations student-athletes may not feel comfortable having with their coaches and professors about their mental health. As a result, mentorship programs could be helpful for student-athletes in the United States and Japan.

Student-Athlete Workshops/Training

Websites for the Kansai Big Six League did not contain workshops/training opportunities for student-athletes. The Ivy League conference, on the other hand, had six institutions with workshops/training for student-athletes. Those schools include Brown University, Columbia University, Harvard University, Princeton University, University of Pennsylvania, and Yale University. The workshops/training were offered to student-athletes but were not required.

These results suggest a higher focus in the United States on workshops and training for student-athletes. This could be an effective way to build a student-athlete's confidence and knowledge; however, it could also be beneficial for workshops and training to include mental health. Whether topics include mindfulness, seeking help, accessing mental health resources, maintaining positive thinking patterns/emotion regulation techniques, etc., these topics could give student-athletes additional information that could positively enhance their mental health and well-being. Thus, implementing various mental health workshops and training could be helpful for student-athletes in the United States and Japan.

Discussion

The present study examined 22 websites to determine the psychological services Ivy League institutions in the United States and Kansai Big Six League institutions in Japan provided to student-athletes and non-student-athletes. Specifically, emphasis was placed on whether structural, cultural, and interpersonal factors between Japan and the United States positively or negatively affect whether behavioral health services are likely to be accessed by student-athletes at their respective institutions. Several of these findings are important and can be used by social workers, clinicians, coaches, and academic faculty/administrators to further advance how institutions advocate for the mental health and well-being of their student-athletes.

In particular, the results of our study suggest that the United States focused on the performance of student-athletes; whereas, Japan focused on the holistic well-being of student-athletes. Consistent with the literature, the healthcare structure of both countries played a key role in a student-athlete's access to psychological services (Jeong & Niki, 2012; Robertson-Preidler, 2020). The United States private insurance model placed emphasis on practitioner volume (variety); however, more practitioners did not increase the help-seeking behavior of student-athletes. Instead, student-athletes often avoided practitioners. Considering this is problematic on many levels, student-athletes are often not using the resources provided by their

institutions. As a result, student-athletes are not getting the help they need, which often leads to negative health outcomes (Stock & Levine, 2016).

As negative health outcomes were similar within Japan and the United States student-athletes, Japan's institutions did not have as many resources as the United States (e.g., student-athlete programming, workshops, training, self-help interventions, etc.). Having access to fewer resources, Japan's student-athletes were not seeking help. Because of this, the limited number of resources provided to Japan's student-athletes may have attributed to low help-seeking behavior.

In contrast, Japan provided fewer practitioners for student-athletes to access, but lower volume did not change a student-athletes help-seeking behavior. Whether high or low practitioner volume, the healthcare structures of Japan and the United States were different, yet produced similar help-seeking outcomes (i.e., low help-seeking behavior). Some student-athletes chose to avoid institutional resources; whereas, other student-athletes did not know institutional resources were available (e.g., how to access counseling/health/contracted services, when to set up appointments, where to go, etc.).

Considering counseling centers, health services, private practice contracted, and fully embedded models are a key resource for student-athletes, the resources are not helpful for student-athletes if they do not know how to access them (Way et al., 2020). In the United States several self-help interventions were provided on Ivy League Websites. This was helpful for student-athletes if they went looking, but if student-athletes did not feel comfortable reaching out to their coaches and support staff about their mental health or never took the time to search the institutions website, the information would not be helpful for those particular student-athletes. Moreover, as Japan had limited resources and programming tailored toward student-athletes, having mental health campaigns, emails, or trainings could be a helpful way to inform student-athletes of available resources. Knowing which resources are available to student-athletes could be helpful, but in order for student-athletes to feel comfortable seeking help, it is important for several barriers to be addressed (e.g., stigma/lack of education and low help-seeking behavior).

As stigma often plays a part in the low help-seeking behavior of student-athletes (Eistenberg et al., 2009; Rafael et al., 2018), it is evident that lack of resources and education play just as much of a role. Therefore, it is important for institutions to inform student-athletes of the resources that are available. Doing so could be a great way to change a student-athlete's attitude toward seeking help. For the Ivy League institutions there was ample programming tailored toward the student-athlete. However, student-services and various departments could increase the volume and rate in which they are providing mental health information to their student-athletes. Student-athletes may not engage with the resources at first, but education is a great first step to changing the stigma surrounding a student-athletes help-seeking behavior.

With Ivy League institutions providing more resources than the Kansai Big Six league, it is imperative for both countries to educate student-athletes (Way et al., 2020). Regardless of which healthcare model a country uses, stigma is an issue, yet stigma could be lowered through education (Jeong, & Niki, 2012). The NCAA's mental health best practices documents are great resources for reducing stigma and Japan creating similar documents could be helpful for their practitioners and coaches. A previous mental health best practices document from 2020 focused on clinical licensure of practitioners providing mental healthcare, procedures for identification and referral of student-athletes to qualified practitioners, pre-participation mental health screening, and health-promoting environments that support mental well-being and resilience (NCAA, 2020). As Japan and the United States take the time to educate their student-athletes on available resources, how to access them, and how to create more resources tailored toward the

student-athletes development, it could be a great opportunity to change the cognitions of student-athletes', coach's, and administrator's thoughts toward seeking psychological services. Resulting from student-athletes having access to the aforementioned mental health resources, it can help student-athletes in coping with their multiple roles, while also helping them live a healthier life (Hingson et al., 2009).

As countries use different models to enhance the mental health and well-being of each culture (e.g., the United States private insurance model and Japan's free healthcare model), implementing behavioral healthcare with public health visits could be beneficial (Evans et al., 2016; Kanehara et al., 2015; Schleider, 2020). By doing this, both countries could step out of narrow treatment options and could allow each health service to be viewed as important. In turn, student-athletes may become more comfortable discussing mental health concerns with coaches, peers, and social workers/care providers, which may result in increased access to mental health services and higher help-seeking behavior.

Limitations and Future Directions

We acknowledge several limitations to our study. First, our summative qualitative content analysis did not capture the subjective experiences from human participants. Extending this research to include interviews or surveys with student-athletes from the United State and Japan could be a great follow-up study to see if similar results still hold. Second, our data was collected in 2020. The COVID-19 pandemic put a stop to our original plans, but this data could be used to compare findings from 2020 and now and whether institutions in the United States and Japan are providing more mental health resources/opportunities for their student-athletes. Third, only two coders were used for our analysis. Both coders reached agreement on all items but a third or fourth coder may have changed our procedures and analysis. Fourth, we only analyzed content that was posted on each institution's website. Again, this was done to reflect what student-athletes may see if they do not reach out to coaches/support staff and try to seek out mental health resources on their own, but we acknowledge internal resources are likely available that are not posted on each institution's website. Finally, we spent a little bit of time on our literature review; however, we wanted to emphasize the importance of different factors that may contribute to student-athletes not accessing mental health services (stigma, lack of education, low help-seeking behavior, health and finance structure). Even with these limitations, there are several areas of scholarship future researchers could pursue. A closer examination of how many student-athletes reach out to their coaches for internal mental health services compared to student-athletes who primarily look on their own for services could be helpful, as well as a more detailed analysis on the differences between the United States and Japan's health and finance structure and actionable steps that can be taken to reduce stigma and increase help-seeking behavior for student-athletes.

Conclusion

Student-athletes, regardless of which country they are a part of, should be given the opportunity to seek help and access psychological services. Considering access to psychological services is important for student-athletes in Japan and the United States, the healthcare structure of both countries can prevent access from taking place. This becomes problematic, especially for student-athletes struggling with substance abuse and mental health disorders, in that substance

and mental health disorders account for the second largest cause of disease and disability worldwide, and often result in student-athletes dying 25 years earlier than the general population (Mathers et al., 2008). The importance of collegiate institutions having psychological services readily available for their student-athletes is paramount, yet a student-athlete's access to psychological services continues to decline (Mathers et al., 2008; Wahto et al., 2016). It is apparent that researchers, coaches, professors, and social workers/care providers are in need of new approaches to enhance the help-seeking behavior of their student-athletes.

Finally, as the United States and Japan use two different healthcare structures, the ultimate barrier is reducing stigma. Once collegiate institutions instill a culture of help-seeking behavior and mitigate irrational beliefs, only then can student-athletes feel comfortable seeking help. In studying this issue between how Japan and the United States approach a student-athlete's mental health, countries across the world could learn from both countries to navigate stigma and help-seeking behavior within their student-athlete populations. If applied, stigma could be reduced, help could be provided, and administrators could know that their investment in psychological services are not being wasted. 41% of student-athletes are frequently overwhelmed (Ryan et al., 2018). Nearly a quarter of student-athletes report exhaustion from the mental demands of their sport (NCAA, 2016). 10-21% of student-athletes report depressive symptoms but do not know how to handle them (Armstrong et al., 2015). In providing education and reducing stigma, student-athletes could have access to psychological services to prevent a student-athlete's mental health concerns from increasing. As a result, not only could a student-athlete's holistic health improve from their access to psychological services at their respective institutions, but student-athletes could also be educated on how to access the mental health services and resources available to them.

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