Determining Intention to Provide Culturally Responsive Clinical Mental Health Care to Collegiate Student-Athletes

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Mental health care providers' cultural responsiveness related to athletics is crucial to their clinical care provision for student-athletes on college campuses. However, little research has been conducted in applying a theoretical framework to explore providers' intentions to provide culturally responsive clinical care to this specific student population. Understanding providers' perceptions of student-athletes is integral in assuring clinical care provision that is responsive related to the culture of athletics. The purpose of this study was to test a conceptual model that adapted the Theory of Planned Behavior to explore the determinants of providers' intention to be culturally responsive to the unique needs of collegiate student-athletes. For this study, cultural responsiveness was defined as the cumulative level of a provider's self-efficacy related to communicating with student-athletes, empathy specific to student-athletes, positive attitudes toward the culture of athletics, and knowledge related to the culture of athletics. Data were collected using an online survey method, and the responses from 153 participants were analyzed using multiple regression analysis. The results indicated that all survey scales were stable and reliable on which to base our data analysis results. Additionally, results suggested that the adapted TPB can be a useful framework in predicting mental health care providers' intention to

be culturally responsive to student-athletes' unique needs. Implications for research are discussed.

Keywords: clinical care, culturally responsive, student-athlete, Theory of Planned Behavior, athletics

In recent years, the NCAA has openly recognized that mental health concerns are serious in intercollegiate athletics. Along with new regulations, the NCAA has, and continues to raise awareness of student-athletes' mental health needs, requiring member NCAA institutions to create and implement mental health protocols that include access and/or referral to licensed mental health professionals (Klenck, 2014; NCAA SSI, 2016; Way et al., 2019). Researchers and sport psychology professionals have long called for in-house mental health services within intercollegiate athletics (Connole et al., 2014; Hack, 2007; López & Levy, 2013). However, when mental health services are not provided "in-house" student-athletes may encounter barriers to seeking services independently. For example, a collegiate student-athlete may feel misunderstood and less likely to develop a relationship with a mental health professional who has little to no background or understanding of sports or collegiate athletics (Hack, 2007). Additionally, most university counseling centers operate during normal business hours, often coinciding with classes, practice, and competition schedules, making it difficult for student-athletes to attend counseling sessions (López & Levy, 2013). It is also common for campus counseling centers to become overbooked and restrict students to a fixed number of sessions, making it even more challenging to meet student-athletes' needs in a timely manner (Gill, 2008; Goodwin, 2017).

The internal culture of a college or university athletics program has a huge impact on the way coaches and student-athletes behave, and the standards they expect from each other. The culture of athletics is often referred to in a negative way. However, a culture is the expression of a team's values, attitudes, and beliefs about sports and competition (Taylor, 2018). It is grounded in an identified sense of mission and shared goals. According to the National Collegiate Athletic Association (NCAA), there are over 520,000 student-athletes who compete in sanctioned athletics nationwide (NCAA, 2022). Along with their non-athlete counterparts, student-athletes are likely to encounter the typical "college struggles" (e.g., adjustment difficulties, social isolation and withdrawal, difficulty coping, identity confusion) during their 4-5 years on campus (Bissett & Tamminen, 2020). However, given the additional demands (e.g., competitive pressures, practice, injury and rehabilitation, strength and conditioning, competition, travel, tutors, study hall hours) of being an athlete, student-athletes may experience additional psychological distress that could result in various negative outcomes including, but not limited to: performance obstacles and anxiety, prolonged injury rehabilitation, disordered eating and eating disorders, identity confusion, and un/expected retirement from sport (Bissett & Tamminen, 2020; Carr & Davidson, 2014; Coppel, 2014; Hack, 2007; Klenck, 2014). Additionally, past research has shown that collegiate student-athletes and non-athletes experience depression at similar rates, despite the common perception that athletes are "immune" to various mental health concerns (Armstrong et al., 2015; Maniar et al., 2005; Wolanin et al., 2015). Finally, it has been consistently and historically shown that at least 15% to 20% of student-athletes who experience mental health concerns do not seek mental health services,

partially out of fear that a provider would not understand the culture of athletics (Moreland et al., 2018; Murray, 1997; Parham, 1993; Watson & Kissinger, 2007). Thus, professionals trained and knowledgeable in working with this population can make a case for providing collegiate student-athletes with more accessible mental health services from clinicians who provide culturally responsive care.

Aim of Study

Research has explored athletic directors' and coaches' perceptions and preferences in regards to sport psychology professionals (Bader & Martin, 2019; Connole et al., 2013; Jones et al., 2022; Zakrajsek et al., 2013; . However, there is no existing literature that explores mental health care providers' self-efficacy, empathy, attitudes, and knowledge toward providing clinical services and support to collegiate student-athletes. Research is needed to explore what impedes providers from clinical care provision that is culturally responsive related to the culture of athletics. Therefore, this study used an adapted Theory of Planned Behavior (TPB) to assess mental health care providers' self-efficacy related to communicating with student-athletes; empathy specific to student-athletes; positive attitudes toward the culture of athletics; and, knowledge related to the culture of athletics, simultaneously in an attempt to understand the antecedents of their behavior to provide culturally responsive care to student-athletes.

Theory of Planned Behavior

The Theory of Planned Behavior (TPB) states that behavioral achievement depends on motivation (intention) and ability. Then it suggests that behavioral intention, in turn, is determined by five major determinants—attitude towards behavior, subjective norms, social norms, perceived power, and perceived behavioral control. Meaning that the degree to which individuals see a certain behavior positively (attitude), or foresees that substantial others want them to engage in the behavior, and believe that they are capable of carrying out the behavior, serve as direct determinants of the extent of their intention to perform the behavior (Ajzen, 1991). By and large, attitudes are the overall evaluation of the behavior by the individual (Ferdous, 2010). Beliefs determine these judgments about the extent to which one has access to resources or opportunities necessary to carry out the behavior effectively (Ajzen, 1991). Barriers to behavior are present when they require prerequisite knowledge, resources, and/or the cooperation of others (Gilbert et al., 1998). For behavioral intentions where skill or social cooperation is required, the TPB is used.

Conceptual Model

To explore the factors influencing mental health care providers' intentions to provide culturally responsive care to student-athletes, we built a theoretical model based on the Theory of Planned Behavior (TPB) (see Figure 1). Our research adapted the TPB by incorporating three variables (self-efficacy, empathy, and knowledge) and investigated how these variables influence individual's intentions to provide clinical mental health care to collegiate student-athletes. To the best of our knowledge, this was the first time to incorporate these three variables together into TPB to understand mental health care providers' behaviors.

Like the TPB, our model suggests that behavioral achievement depends on motivation (intention) and ability. It comprises four variables that collectively represent a person's actual control over the behavior: self-efficacy related to communicating with student-athletes, empathy specific to student-athletes, positive attitudes toward the culture of athletics, and knowledge related to the culture of athletics. The research model used in this study predicts mental health care providers' behavior by grafting the predictive model based on our operationalization of the term 'cultural responsiveness.' According to our model, a provider's level of cultural responsiveness predicts their intention to be culturally responsive, and ultimately, clinical care provision that is responsive related to the culture of athletics.

Conceptual Model
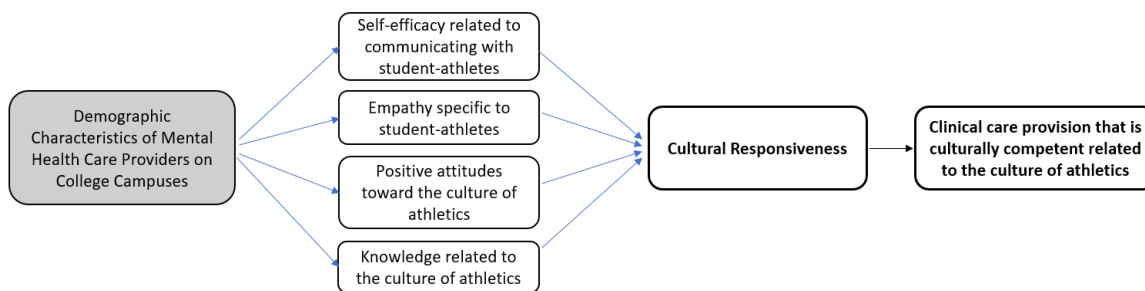
The variables used to operationalize cultural responsiveness in this study were informed by the NCAA Campus Stakeholder's Guide for Student-Athlete Mental Health. Recommended by the NCAA Task Force to Advance Mental Health Best Practice Strategies, this guide is a resource designed for stakeholders who work outside of athletics to understand the unique cultural aspects of collegiate student-athletes and educational approaches for working with student-athletes.

Data and Research Methodology

Participants and Recruitment

Participants in this study were licensed, clinical mental health care providers who worked on American college or university campuses. This convenience sample was drawn from listservs shared by professional organizations, including Alliance of Social Workers in Sports; American College Counseling Association; American Counseling Association; Big Sky Sport Psychology; and the Collegiate Counseling & Sport Psychology Association. Following approval from the University of North Carolina at Greensboro Institutional Review Board, the study's primary investigator (PI) contacted participants three times to take part in the study and complete the online questionnaire powered by Qualtrics (Provo, UT). First, the PI sent an email to all potential participants, including a personal introduction, an explanation of the study, a description of the incentive opportunity, and a survey link. The PI sent a second email 14 days later to remind prospective participants to complete the survey and thank those who had already done so.

Finally, the PI sent an email to the same list, 28 days following the original communication thanking those who had completed the survey and reminding those who had not. The survey was open to participants for 30 days. Once clicking on the Qualtrics survey link embedded in recruitment emails, participants choosing to complete the web-based survey provided consent electronically. After the survey, participants could choose to enter a raffle to win one of 10, $50 Visa gift cards by clicking on a separate Qualtrics link that was not linked to their survey answers.

Instrumentation

Demographic Information

Participants indicated their highest degree achieved; type of clinical license; affiliation with professional organizations; how many years in clinical practice; which department(s) on campus they aligned with; and percentage of student-athletes on their caseload (Table 2). These items were adapted from previous measurements of health care providers' cultural competency specific to their population of interest (Marra et al., 2010; Schim et al., 2003). With the exception of types of clinical licenses, binary variables were created for each predictor to compare participants who identified as one or another. For example, female was a binary variable created to compare participants who identified as male or female.

Table 2

Survey Variables

Variable	Description	Scale
Demographics	Participants were asked to provide personal information such as highest degree achieved; type of clinical license; affiliation with professional organizations; how many years in clinical practice; which department(s) on campus they report to; and, percent of student-athletes on their caseload	These items were adapted from previous measurements of health care providers' cultural competency specific to their population of interest (Marra et al., 2010; Schim et al., 2003).
Empathy General	Items to measure a clinician's general empathy were adapted from the Interpersonal Reactivity Index (Davis, 1980) and the Toronto Empathy Questionnaire (Spreng et al., 2009).	Sixteen items were answered on a 5-point Likert scale assessing how often the statements were true for the participants, ranging from "Rarely" to "Almost always." High scores indicated higher levels of participant empathy.

Empathy specific to student-athletes	For this study, nine items that measure empathy were adapted from the IRI and TEQ. A second scale was designed to measure a participant's empathy specific to student-athletes, using a similar adaptation of the IRI and TEQ.	This athlete-specific scale included six items measured on a 5-point Likert scale ranging from "Rarely to "Almost always." High scores indicated higher levels of participant empathy specific to student-athletes. 1)
Self-efficacy General	The items used to measure a participant's self-efficacy were adapted from the Self-Efficacy Formative Questionnaire (Erickson & Noonan, 2018) and the General Self-Efficacy Scale (Schwarzer & Jerusalem, 1995).	For this study, the scale we designed to assess a participant's general self-efficacy adapted nine items from the Self-Efficacy Formative Questionnaire and the GSW. Participants were asked how well each item described them as a licensed clinician, ranging from "Not at all" to "Extremely well." Higher scores indicated higher levels of general Self-Efficacy.
Self-efficacy specific to student-athletes	Six additional items were adapted to assess a mental health care provider's self-efficacy specific to student-athletes.	These items were answered on a 5-point Likert scale asking how well the statements describe them in their work with student-athletes, ranging from "Not at all" to "Extremely well." Higher scores were associated with higher levels of self-efficacy specific to student-athletes.

Knowledge	For this study, knowledge questions captured baseline knowledge to measure the extent to which participants have stored factual information in long-term memory and how well they can retrieve and respond with that information when asked a question about the culture of athletics. Items scored the participants' knowledge about care coordination; alcohol and substance use; body image and disordered eating; anxiety; depression; sleep disorders; physical injury and NCAA policies.	These items were scored as "0" for incorrect responses, and "1" for correct responses. Thus, a participant with a higher score exhibited higher levels of knowledge about the culture of athletics.
Attitudes	Items to measure a participant's attitudes toward student-athletes were adapted from the Sport Attitude Survey (Yakut et al., 2016), and the Positive Thinking Scale (Diener et al., 2009). For this study, seven items were adapted from the SAS and PTS to measure a participant's attitudes toward the culture of athletics.	They were answered on a 5-point Likert scale asking participants to indicate how much they agree or disagree with each statement, ranging from "Strongly disagree" to "Strongly agree." Based on the scales from which our tool was adapted, higher scores indicate more positive attitudes.
Intentions	Items to measure a participant's intentions to provide culturally responsive care to student-athletes were adapted from the Clinical Cultural Competency Questionnaire (Like, 2011).	Our survey presented participants with five items to be answered on a 5-point Likert scale asking participants how likely they are to do each, ranging from "Extremely unlikely" to "Extremely likely." Participants with higher scores were more likely to intentionally provide culturally responsive care to student-athletes.

Self-Efficacy

We used two measures of self-efficacy (Table 2). To measure *general self-efficacy*, we adapted nine items from the Self-Efficacy Formative Questionnaire (SFQ; Erickson & Noonan, 2018) and the General Self-Efficacy Scale (GSE; Schwarzer & Jerusalem, 1995). The SFQ was written for teaching professionals, so items related specifically to the classroom were removed; other items were adapted to represent student-athletes rather than students in academic settings. The GSW was adapted by removing items that were about personal self-efficacy, and adapting items about external influence, to make them specific to the culture of sports. Participants indicated how well each item described them as a licensed mental health care provider, ranging from X = "*Not at all*" to Y = "*Extremely well.*" To measure *self-efficacy related to communicating with student-athletes*, we adapted six items from the SFQ and the GSE. Participants indicated how well each statement described them in their work with student-athletes, from 1 = "*Not at all*" to 5 = "*Extremely well.*" Higher scores were associated with higher levels of self-efficacy.

Empathy

Items to measure a clinician's general empathy (Table 2) were adapted from the Interpersonal Reactivity Index (Davis, 1980) and the Toronto Empathy Questionnaire (Spreng et al., 2009). The Interpersonal Reactivity Index (IRI) defines empathy as the reactions of one individual to the observed experiences of another (Davis, 1980). Participants answered 28 items on a 5-point Likert scale ranging from "*Does not describe me well*" to "*Describes me very well.*" The Toronto Empathy Questionnaire (TEQ) represents empathy as a primarily emotional process. In previous studies, the TEQ demonstrated strong convergent validity and positively correlated with behavioral measures of social decoding.

For this study, nine items that measure empathy were adapted from the IRI and TEQ. Our adaptation of both of these scales eliminated items that were very specific to certain life events, including only the items that participants could apply in their clinical practice with student-athletes. They were answered on a 5-point Likert scale assessing how often the statements were true for the participants, ranging from "*Rarely*" to "*Almost always.*" High scores indicated higher levels of participant empathy. A second scale was designed to measure a participant's empathy specific to student-athletes, using a similar adaptation of the IRI and TEQ. Following Dillman (2007), this athlete-specific scale included six items measured on a 5-point Likert scale ranging from "*Rarely*" to "*Almost always.*"

Attitudes

Items to measure a participant's positive attitudes toward the culture of athletics (Table 2) were adapted from the Sport Attitude Survey (Yakut et al., 2016), and the Positive Thinking Scale (Diener et al., 2009). The Sport Attitude Survey (SAS) was created to measure important sub-areas in sport beliefs and attitudes, including a participant's belief that sport participation builds character, enhances health, should support diversity, and is important to early education. The scale includes 75 items measured on a 4-point Likert scale ranging from "*Strongly disagree*" to "*Strongly agree.*" Higher scores suggest more positive attitudes. The Positive Thinking Scale

(PTS) has 22 yes/no items with an equal number of positive and negative items. The measure is used to assess a person's positive versus negative thinking about important aspects of their lives.

For this study, seven items were adapted from the SAS and PTS to measure a participant's attitudes toward the culture of athletics. Items we included were initially written for general application about athletes in society, so we adapted them to be more relevant to the participants' attitudes toward collegiate student-athletes and the culture of athletics. They were answered on a 5-point Likert scale asking participants to indicate how much they agreed or disagreed with each statement, ranging from "*Strongly disagree*" to "*Strongly agree*." Based on the scales from which our tool was adapted, higher scores indicated more positive attitudes.

Knowledge

Knowledge items were based on elements of various educational initiatives related to collegiate athletics, including care coordination; alcohol and substance use; body image and disordered eating; anxiety; depression; sleep disorders; physical injury; and NCAA policies (Table 2). We computed the total number of correct items.

Intentions

Items to measure a participant's intentions to provide culturally responsive care to student-athletes (Table 2) were adapted from the Clinical Cultural Competency Questionnaire (Like, 2011). Originally designed as 24 items to determine skills and levels of comfort, our survey presented participants with five items to be answered on a 5-point Likert scale asking participants how likely they were to do each, ranging from "*Extremely unlikely*" to "*Extremely likely*." The original questionnaire measured medical care providers' intentions, so our items were adapted to address mental health care providers. Participants with higher scores were more likely to intentionally provide culturally responsive care to student-athletes.

Measures

Descriptive statistics were computed and included frequencies, means, and standard deviations. Cronbach's alpha was used to determine construct validity. A threshold of 0.70 was used to demonstrate consistency. The General Empathy Scale, adapted from the Interpersonal Reactivity Index (Davis, 1980) and Toronto Empathy Questionnaire (Spreng et al., 2009), showed lower reliability than the other scales but was still within an acceptable range (.67). Overall, however, Cronbach's Alpha tests suggested that these were stable and reliable scales on which to base data results (see Table 3). Knowledge was a summed score, and therefore reliability was not reported.

Table 3

Descriptive Information for all Key Control and Study Variables (Self-Efficacy General; Self-Efficacy Student-Athletes; Empathy General; Empathy Student-Athletes; Attitudes; Knowledge; Intentions)

Variable	*M*	*SD*	Min/Max	Skewness	Cronbach's Alpha
SE general	4.13	.48	2.44/5.00	-.55	.83
SE student-athletes	3.94	.65	1.00/5.00	-1.28	.90
Empathy general	4.32	.41	3.22/5.00	-.43	.67
Empathy student-athletes	4.02	.61	2.17/5.00	-1.05	.76
Attitudes	3.63	.49	2.43/5.00	-.15	.72
Knowledge	3.70	1.28	.00/7.00	-.11	
Intentions	4.29	.63	1.00/5.00	-1.74	.76

Note. SE general = Self-efficacy general; SE student-athletes = Self-Efficacy specific to student-athletes; Empathy student-athletes = Empathy for student-athletes; Intentions = Intentions to provide culturally responsive clinical care to student-athletes.

Results

Respondent Characteristics

Two hundred sixteen surveys were collected, but only data from 153 were included in the final analyses. Surveys were excluded if the participant were not a licensed mental health care provider working with college students or if there were no valid data available. Slightly more than half of the participants (54%) were Licensed Professional Counselors, followed by Licensed Clinical Social Workers (18%), Clinical Psychologists (18%), and providers who have various other clinical licenses, including Marriage & Family Therapists and Licensed Substance Abuse Counselors (16%). More than half of the participants worked within the Counseling Center on their campus (58%), and 6% were aligned with the Athletics Department. And, participants reported an average of 18% of their caseload was made up of student-athletes.

Table 4

Sample Demographics Results (N = 153)

Characteristic	*n* (%)
Gender	
Female	129 (84.3)
Male	19 (12.4)

Other	5 (3.3)
Race/Ethnicity	
Asian	6 (3.9)
Black or African American	8 (5.2)
Hispanic/Latino	5 (3.3)
White	124 (81.0)
Multiracial	5 (3.3)
Other	2 (1.3)
Highest Level of Education	
Master's Degree	112 (73.2)
Doctoral	41 (26.8)
Type of Clinical Licensure	
Licensed Professional Counselor	82 (53.6)
Licensed Clinical Social Worker	28 (18.3)
Clinical Psychologist	27 (17.6)
Psychiatrist	0 (0.0)
Other	24 (15.7)
Alignment on Campus	
Select all that apply	
Academic Department	6 (3.9)
Athletics Department	10 (6.4)
Counseling Center	89 (58.2)
Student Health Services	19 (12.4)
Student Life	48 (31.4)
Student Affairs	15 (9.8)
Other	18 (11.8)
Sport Organization Membership	
No	136 (88.9)
Yes	17 (11.1)
Cultural Awareness Training	
No	40 (26.1)
Yes	113 (73.9)
Cultural Awareness Training-Student Athletes	
No	96 (62.7)
Yes	57 (37.3)
School Association/Division	
NCAA Division I	47 (30.7)
NCAA Division II	14 (9.2)
NCAA Division III	29 (19.0)
NAIA	11 (7.2)
NJCAA	9 (5.9)
NCCAA	1 (0.7)
Other	16 (10.5)

Did participant play college/pro sport?
No	136 (88.9)
Yes	17 (11.1)

Three multiple regression models were used to test our conceptual model. Model 1 tested whether several demographic characteristics (i.e., gender, race, number of years practicing in a college setting, and history of sport participation) predicted intention to provide culturally responsive care to student-athletes (see Table 5). None of these variables were significantly associated with intentions.

Table 5

Summary Statistics, Correlations, and Results from the Regression Analysis

	Model 1		Model 2		Model 3	
	Standardized Beta	p	Standardized Beta	p	Standardized Beta	p
(Constant)		.00		.00		.09
Female	.12	.24	.09	.36	.04	.62
White	.06	.53	.01	.91	-.04	.62
Number of years in college setting	-.01	.94	-.02	.84	-.11	.21
Did participant play college/pro sport	.13	.18	-.04	.73	-.05	.64
Type of clinical license	.09	.38	.02	.87	.10	.27
Percentage student-athletes on caseload			.24	.10	.10	.42
NCAA			.06	.57	-.07	.46
Received CC training			.18	.08	.25	.00*
Sport organization membership			.08	.58	.00	.98
Self-Efficacy specific to student-athletes					.30	.00**
Empathy specific to student-athletes					.37	.00**
Attitude					.12	.16
Knowledge					-.08	.38
R^2	.04		.12		.45	

Note. Dependent Variable: Intention. $^*p < .05$; $^{**}p < .01$.

Model 2 tested whether demographic characteristics (i.e., gender, race, number of years practicing in a college setting, and history of sport participation), as well as professional factors (i.e., percentage of student-athletes on caseload, working, at an NCAA member institution, participants in cultural responsiveness training specific to student-athletes, and membership in a

sport-related professional organization), predicted intention to provide culturally responsive care to student-athletes. None of these variables were significantly associated with intentions

Model 3 tested whether demographic characteristics (i.e., gender, race, number of years practicing in a college setting, and history of sport participation), as well as professional factors (i.e., percentage of student-athletes on caseload, working, at an NCAA member institution, participants in cultural responsiveness training specific to student-athletes, and membership in a sport-related professional organization) and outcome variables (i.e., self-efficacy related to communicating with student-athletes, empathy specific to student-athletes, positive attitudes toward the culture of athletics and knowledge related to the culture of athletics), predicted intention to provide culturally responsive care to student-athletes.

Participation in cultural responsiveness training related to student-athletes, self-efficacy related to communicating with student-athletes, and empathy specific to student-athletes was positively associated with intentions to provide culturally responsive clinical care to student-athletes after controlling for the other variables in the model.

Discussion and Implications

This research's primary objective was to assess the adapted TPB model in predicting mental health care providers' intentions to provide clinical care to collegiate student-athletes that is culturally responsive related to the culture of athletics. The results suggest that the adapted TPB can be a useful framework in predicting mental health care providers' intention to be culturally responsive to student-athletes' unique needs. Multiple linear regression indicated that mental health care providers who internalized higher amounts of self-efficacy related to communicating with student-athletes and empathy specific to student-athletes were positively associated with intention to provide clinical care that is culturally responsive related to the culture of athletics. Neither positive attitudes toward the culture of athletics nor knowledge related to the culture of athletics were found to be uniquely predictive of the intention to provide culturally responsive care. However, bivariate analyses indicated that all four predictors were correlated and thus predictive of intention to provide culturally responsive care to student-athletes.

The statistical significance of self-efficacy related to communicating with student-athletes makes practical sense ($\beta = 0.30$). Self-efficacy is a person's belief in their ability to succeed in a particular situation and is the determinant of how people think, behave, and feel (Bandura, 1977). According to Bandura, people with a strong sense of self-efficacy develop a deeper interest in the activities in which they participate, form a stronger sense of commitment to their interests and activities, and view challenging problems as tasks to be mastered. Furthermore, successfully performing a task strengthens a person's sense of self-efficacy. A mental health care provider's self-efficacy related to communicating with student-athletes plays an important role in how the provider supports an athlete's health and well-being. Even when things become difficult, a provider with high self-efficacy will remain optimistic and confident in their abilities to communicate with the student-athlete.

The statistical significance of empathy specific to student-athletes is also easy to explain ($\beta = 0.37$). Riess (2017) indicated that empathy plays a critical interpersonal and societal role, enabling sharing of experiences, needs, and desires between individuals. Empathy enables individuals to understand and feel the emotional states of others, resulting in compassionate behavior. Not surprisingly, mental health care providers who had higher levels of empathy

specific to student-athletes reported higher intentions to provide clinical care that is culturally responsive related to the culture of athletics. This result suggests that college and university administrators provide opportunities for clinical mental health care providers to attend training programs to enhance their cultural awareness of various student populations, including collegiate student-athletes. Other ways leadership may help increase empathy among mental health care providers may include providing workshops that increase empathetic listening skills or create environments for providers to challenge any prejudices they have towards student-athletes and discover commonalities. Further supporting the importance of mental health care providers attending trainings or engaging in other professional development specific to the culture of athletics, receiving cultural responsiveness training specific to student-athletes was the only demographic characteristic that predicted intentions to provide culturally responsive clinical care.

Neither attitudes related to the culture of athletics nor knowledge specific to the culture of athletics were statistically significant. This makes practical sense. Participants may hold attitudes toward the culture of athletics for different reasons. Attitudes become stronger when participants have direct positive or negative experiences with student-athletes, and particularly if those experiences have been in strong positive or negative contexts. In this study, the average percentage of student-athletes on a mental health care provider's caseload was 18.3%. This suggests that most participants had no opportunity to develop more positive attitudes related to the culture of athletics through direct experiences with student-athletes. Similarly, participants' lack of experience working clinically with student-athletes could have negatively impacted their level of knowledge related to the culture of athletics.

Regression results of the nine demographic predictor variables (gender; race; number of years the provider has worked in a college setting; if the provider played college or professional sports; type of clinical license; percentage of student-athletes on their caseload; if the provider works at an NCAA member institution; if the provider received cultural responsiveness training specific to student-athletes; and if the provider belonged to a sport-related professional organization) revealed that only receiving cultural responsiveness training specific to student-athletes was predictive of intentions to provide culturally responsive clinical care ($p = .00$). This further emphasizes the importance of mental health care providers attending trainings or engaging in other professional development specific to the culture of athletics.

Conclusions and Limitations

These findings have some important practical implications for colleges to consider. Professional development opportunities for mental health care providers could help providers understand the unique needs student-athletes have compared to their non-athlete peers. These efforts will enrich and improve the clinical care provision for student-athletes who have mental health concerns. Although other potential predictive factors were not significant in this research, it does not mean that they are not important. While knowledge alone was not a sufficient predictor of intentions, it is likely a necessary component for providing foundational knowledge and context critical to the other variables of interest.

Increasing cultural responsiveness specific to collegiate student-athletes' unique needs is beneficial to their clinical care provision from mental health care providers on college campuses. However, the extant research on student-athlete mental health mainly focuses on care-seeking behaviors of the student-athlete, stigma, or coaches' education. This research is one of the initial

attempts to study mental health care providers related to their clinical work with student-athletes. In this research, we developed a theoretical model to examine mental health care providers' intentions to provide culturally responsive care to collegiate student-athletes based on the adapted TPB. The findings confirmed the usefulness of the adapted TPB model in determining intention. Furthermore, the results indicated that a mental health care provider's attendance in cultural responsiveness trainings specific to student-athletes, self-efficacy related to communicating with student-athletes, and empathy specific to student-athletes were identified as the main predictors of their intention to provide culturally responsive clinical care.

Although our study provides initial evidence that our operationalization of cultural responsiveness can be used in the field when working with student-athletes, limitations of this research do exist. First, our sample produced a gender imbalance (84% female participants) and race imbalance (81% White). However, it is important to note that this closely resembles the field of clinical care provision—74% female and 73% White (LeViness et al., 2018). Data were collected in July 2020, during the global COVID-19 pandemic. Therefore, many college and university employees were on summer break and/or not on campus due to public health recommendations. This may have negatively impacted sample size. It is also important to consider that the participants' answers were likely based on their experience before the COVID-19 pandemic.

This study may lead to a systemic recommendation for colleges and universities to offer professional development and cultural responsiveness training opportunities to clinical mental health care providers who work on their campuses.

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