

Sinking under Pressure

A GOALKEEPER'S FEAR

KEY ISSUES

- How can athletes with so much going for them be depressed?
- What does “medicalization” mean?
- When did mental disorder lose its stigma . . . or does it still have a stigma?
- Where can we find the causes of depression in sports?
- Why is voluntary, unforced exercise beneficial for mental health?
- . . . and is depression a disease or a label?

On November 10, 2009, at a railway crossing about 15 miles (25km) from the industrial city of Hannover, in northwestern Germany, two train drivers reported seeing a man wandering on the tracks. They slammed on the brakes while travelling at about 100mph but couldn't stop in time: the man was crushed. A note discovered later confirmed that it was suicide.

Some suicides are explicable. This one seemed to defy explanation. The body was identified as that of 32-year-old [Robert Enke](#), one of Germany's leading sports stars. Widely tipped for the number one position in Germany's squad for the following year's World Cup, Enke had parked his Mercedes, left his wallet inside and walked onto the tracks in front of the oncoming train. Why? After all, he was an affluent, young sports celebrity with a chance of winning one of the most coveted prizes in sport.

Enke's wife Teresa revealed that he had been tormented with depression for years. Enke tried to hide his mental condition, fearful it might damage his professional career. Worse: he thought it might cause authorities to take away his eight-month-old daughter Leila whom he and his wife had adopted earlier in 2009. The couple lost their two-year-old daughter through a rare heart condition in 2006.

As a youth, the precociously proficient Enke was often required to play in teams with older players and his father Dirk Enke told how his son grew anxious. “There were always crises back then because he was scared that he would not be able to keep

up with the older ones,” he told the *Guardian*. “He did not have faith in himself” ([Guardian, November 14, 2009](#)).

Dirk Enke was one of the few people who knew of his son’s condition, which started to manifest in 2002 when Enke was 25. “During the most critical phases, Robert would have fear of the ball being shot at his goal,” he revealed. “He had attacks, he didn’t want to go to training.”

BOX 21.1 PANIC ATTACK

A sudden and irrational response to a situation that results in feelings of acute and disabling anxiety. There are frequently no apparent causes behind the attack. The attacks can last for a few minutes, or several hours.

At this stage, Enke was playing for Barcelona, where he was second choice goalkeeper. His first team appearances were rare and he was loaned out to the Istanbul club Fenerbahçe. He started only one first team game, a 0–3 defeat that turned fans against him. Further misfortunes came when he returned to Spain, where he dropped down a division and was later seconded to Club Deportivo Tenerife, on the volcanic island in the Atlantic Ocean.

Enke’s form improved and, in 2004, he returned to Germany’s [Bundesliga](#) with Hannover FC. He fought his way into contention for the 2006 World Cup, but was overlooked. Germany’s first choice goalkeeper Jens Lehmann retired in 2008, leaving Enke as favorite for the 2010 World Cup spot. Injuries then began to interrupt his progress. He broke his jaw while playing in 2008 and this injury sidelined him for two months. Remember: the depressive symptoms had been manifesting for six years. As his father described them: “The fear of getting up, fear of failure, panic.” Enke was secretly undergoing therapy and was managing his mental disorder. But the jaw injury occasioned a relapse.

Even so, Enke got back into contention for a World Cup place with his best ever form during the first six months of 2009. Then a mystery illness – later diagnosed as a bacterial intestinal infection – struck; he was forced to miss four of Germany’s international games and this seemed to intensify his depression. Enke came close to being admitted to an institute for psychiatric care, but refused.

His father reflected: “He was always very close to taking this step, to be admitted, but then he would always say, ‘if I went into a psychiatric clinic, then that would be the end of football for me . . . That is the only thing I am good at’.” After nine week’s enforced inactivity, Enke returned to play two Bundesliga games. He then took his own life.

Who has the nerve to pronounce they are immune to depression? Who will never experience the severe despondency and dejection that typically come after some kind of disappointment but seem to stick around too long and become a general feeling of hopelessness and inadequacy? Energy becomes a scarce resource and focusing on one task for any period of time becomes too great a challenge. As a life seems

to fall apart, so external circumstances seem to impinge more forcibly, making the situation appear insoluble and perhaps intolerable.

Reminders that life is worth living and that others are far worse off make little impression: reasoned arguments carry no weight when balanced against a complex of irrational anxieties with multiple origins. In fact, many of the most conspicuously accomplished, intelligent, imaginative and all-round successful people have suffered from this sort of condition. Brooke Shields, Elton John, J.K. Rowling, Morrissey, Sheryl Crowe are among the legion of contemporaries. Historically, artists and dignitaries and, such as Ernest Hemingway (1899–1961), Tennessee Williams (1911–83), Paul Gauguin (1848–1903), Vincent Van Gogh (1853–90) and Winston Churchill (1874–1965) experienced moods that weren't at the time called depressions but had many of the characteristics.

Even fictional heroes were prone. In *A Study in Scarlet* Conan Doyle describes the first meeting of Sherlock Holmes and Dr. Watson in 1881. The great detective explains: "I get in the dumps at times, and don't open my mouth for days on end. You must not think I am sulky when I do that. Just let me alone."

BOX 21.2 DEPRESSION

The [World Health Organization \(WHO\)](#) describes depression as "a common mental disorder" i.e. an actual condition rather than just a set of symptoms. WHO characterizes the condition "with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration . . . At its worst, depression can lead to suicide, a tragic fatality associated with the loss of about 850 000 lives every year . . . the leading cause of disability . . . affecting about 121 million people worldwide."

People with depression may experience a lack of interest and pleasure in daily activities, according to the [American Psychological Association \(APA\)](#). And [MedicineNet.com](#) notes that these may include "activities that were once interesting or enjoyable, including sex." This is relevant to athletes, who are drawn to their sports initially for the enjoyment they take from them.

The despondency and dejection typically felt over a period of time are often accompanied by weight loss or gain, insomnia or excessive sleeping, lack of energy, inability to concentrate, feelings of worthlessness or excessive guilt and recurrent thoughts of death or suicide. The experiences of persistent sadness, hopelessness, worthlessness and guilt are also possible.

Particularly pernicious for athletes is the unusual fatigue that is often accompanied by low energy levels, disturbed sleep patterns and a difficulty in concentrating, remembering, or making decisions. There can also be physical symptoms, such as headaches, digestive disorders, and routine pains that do not respond to treatment. Alcohol or drug abuse may be signs of depression.

The two major types of depression have been distinguished as *Dysthymia*, a persistent, mild depression lasting for at least two years with symptoms never disappearing for longer than two months and milder *cyclothymia* – see Box 21.3.

MEDICALIZING HAPPINESS

“Depression has reached epidemic levels,” observed [Anna Moore](#) of the *Observer* in 2009. Fabien Legrand and Jean Philippe Heuze provide statistical backup: “The prevalence of lifetime depression is between 13% and 17% in most developed countries” (2007: 349). Most cases are treated in medical practice. At this second, one in 20 people has depression.

Moore goes on: “Money and success is no defence: writers, royalty, rock stars, supermodels, actors, middle managers have all had it.” Yet 50 years before, practically no one had heard of it, at least not in the sense of a medical condition. So what happened?

Historically, people have been sad, unhappy, melancholy, despondent, desolate, or just, to use Sherlock Holmes’ phrase, in the dumps. Now, depression has become an illness – a disease or a period of sickness affecting both mind and body that has physiological, biochemical or genetic causes and which is usually treated medically.

There’s no particular date when the concept of depression became officially used to describe the group of mood disorders that have probably existed from time immemorial, but around the middle of the twentieth century it was found that some types of mood disorder responded to the administration of drugs that prevented particular kinds of neurotransmitters from dropping to the point where moods were experienced.

BOX 21.3 MOOD/MOOD SWINGS

Unlike emotion, mood is a pervasive, lingering subjective state that is usually diffuse, in the sense that it has no focus. A mood is not usually evaluative: for example, a person may simply be in a good or bad mood, without being pleased or angry with anyone or anything. The word is from the old English *mod* meaning “mind” or “thought.” *Mood swings* usually refer to relatively swift and unexpected vacillations between depression and elation, or irritability and good humor, without obvious antecedents. When such swings become so excessive that they interfere with normal functioning, they become [bipolar](#) mood disorders (once known as *manic depression*), or the less extreme cyclothymic disorder (or *cyclothymia*), in which the individual may go back and forth between mild depression and a slightly elevated mood. But these mood swings are shorter and less severe.

Recall from Chapter 3 that the tiny gaps between neurons in the brain are synapses and these are bridged by chemical neurotransmitters that carry impulses across the synapse to the next neuron. So, neurotransmitters are natural chemicals. Serotonin is one such neurotransmitter. Its name, from *serum-tonic*, gives a clue as to its function: it contributes to a feeling of wellbeing. The drugs known as selective serotonin reuptake inhibitors (SSRIs) were introduced in 1987 for use by prescription in the treatment of mood disorders. One of the first drugs on the market was the Eli Lilly Company's fluoxetine, better known by its brand name [Prozac](#).

Before then, the term depression was not in popular use. As [Moore](#) wrote: "People went to their GPs with 'anxiety' and 'nerves'. Tranquillisers such as Valium were a likely response." (Note: Valium was the trademark for diazepam, the tranquilizing muscle-relaxant drug.)

Originally developed for high blood pressure, then as an anti-obesity agent, fluoxetine was tested on patients with severe mental disorders in which thought and emotions were so impaired that communication was extremely difficult if not impossible. The condition of most these psychotic patients remained unchanged and deteriorated in some cases. Then the fluoxetine was tried on five individuals with milder conditions and it seemed to cheer them up. More testing began in earnest.

Today, about 54 million people around the world habitually take Prozac, which is just one of several prescription drugs known collectively as antidepressants. Between 1991 – i.e. four years after the introduction of Prozac – and 2001, depression in the USA more than doubled. It seemed more than a coincidence. According to the [World Health Organization \(WHO\)](#), depression is set to become second only to heart disease as the world's leading disability by 2020.

BOX 21.4 PROZAC NATION

[Prozac Nation](#) is the title of Elizabeth Wurtzel's best selling book, first published in 1994, when the author was 26, but had already attempted suicide and had been treated for depression – an condition she identifies as having sources in her parents' fractious marriage and her own unfortunate relationships. She recounts her battle against depression while a journalism student at Harvard University. Diagnosed as an "atypical depressive," Wurtzel was prescribed Prozac, a drug she writes about as if it were as central part of the late twentieth century zeitgeist. In the 2001 [movie Prozac Nation](#), directed by Erik Skjoldbjærg, Wurtzel is played by Christina Ricci.

There can't be many more ailments that are such a reliable index of a cultural period, an epoch in fact. Depression didn't begin in the early 1990s, but its official recognition as a sickness that could be clinically diagnosed and treated with medication marked the start of a distinctive process known as *medicalization*.

Doctors became alert to the symptoms of the malady and started to prescribe Prozac, a drug with relatively few side effects (though sleep disturbances, nausea, tremors, changes in body weight have been recorded). Depression was a rubric – a

category under which postnatal, or postpartum psychological adjustments, obsessive-compulsive disorders, panic disorders, eating disorders and premenstrual tension, later known as [premenstrual dysphoric disorders](#) and many other conditions could be subsumed. While the causes of these and other ailments may have been diverse and multiplex, they were rendered treatable, often with a single medication.

BOX 21.5 MEDICALIZATION

The treatment of conditions that may have sources in personal circumstances, cultural surroundings or the physical environment as medical problems that require medical but not necessarily surgical treatment. Medicinal drugs are typically part of the treatment. “Medicalization can obscure the social forces that influence well-being,” writes Peter Conrad in his [The Medicalization of Society](#). “By focusing completely on the neurobiological features of depression . . . it is treated predominantly with antidepressants, while the social environments that frequently feed depression are left unaltered” (2007: 152).

Medicalization continues: today, more people are diagnosed with mental disorders than at any time in history. Are we getting sicker, or less “normal”? Or are we just inventing new kinds of mental disorder? The “bible” of psychiatric disorder is a US manual. The American Psychiatric Association’s [Diagnostic and Statistical Manual of Mental Disorders](#) is used worldwide as a basis for diagnosis, research and medical education. The fifth edition, known as DSM-V, published in 2013, contains diagnoses of conditions such as mixed anxiety depression, psychosis risk syndrome and temper dysregulation disorder, as well as the more familiar binge eating.

Increasingly inclusive criteria permit the medication of people, even children, who may not show any outward signs of illness, and who may be able to conduct their everyday affairs efficiently. For example, DSM-V identifies “at risk psychosis syndrome,” a designation for young people who *might* have psychosis – characterized by abrupt changes in personality. The diagnosis is a label, a medical description of something that *could*, not *will* develop into disorder.

What we now recognize as depression is itself a label used to capture a persistent anxiety that can manifest in several different ways. There are few medical conditions that have such an exhaustive portfolio as depression. The related ailment stress would probably rival it. Both can be treated pharmaceutically and with cognitive-behavioral therapies (CBT). So, when we hear of different people suffering from depression, we should remain mindful that they are probably not all exhibiting the same symptoms, and almost certainly not experiencing the same type of anxiety. Rather, they reveal features that indicate an undesirable mental and possibly physical situation that can be classed as depression and can be treated *as if it were an illness*.

BOX 21.6 COGNITIVE-BEHAVIORAL THERAPIES (CBT)

Cognitive-behavioral therapies, intervention or sometimes modification are designed to modify the manner in which people apprehend, interpret and respond to situations or specific stimuli. They employ techniques for breaking down unwanted habits of thought, beliefs, and sometimes images, and replacing them with more positive ones, a process known as [cognitive restructuring](#).

THE STIGMA OF WEAKNESS

For some, the wonder is not why there are so many reported cases of depression in sports, but why there are so few. In 2006, Leslee A. Fisher and Craig A. Wrisberg answered: “If athletes and athletic personnel believe that ‘real athletes’ do not have any weaknesses and view depression as a weakness, they might be less willing to seek help or help a depressed athlete get appropriate care” (2006: 41).

The Robert Enke case reminds us that there *is* still a stigma attached to mental disorders. But a major effect of medicalization has been to transmute what was once seen as a weakness into an illness, much like a physical ailment. Whether or not the reader accepts that depression and associated mental disorders are in fact illnesses or just cognate – that is, related in certain respects – to illnesses, the reality is that, today, this is how they are diagnosed and treated.

One of the beneficial consequences is that much of the disgrace has been removed, leaving athletes who have suffered to record their experiences. In this part of the chapter, I’ll treat the experiences as case studies. They share a common matrix: a culture that inhibits, yet promotes illness. The ethos of mastery, striving, and bearing pain mitigates against admitting a susceptibility to attacks that can neither be seen nor beaten with sheer persistence or the kind of hard work urged by coaches. The same ethos fosters ambition and an achievement orientation satisfied only by levels of attainment reached by the elite few. Most sports careers involve unexpected reverses brought about by defeats or injuries.

This is compounded by *pressure*, by which I mean the sensation of urgency caused by having to achieve something or perform to a maximal level. Then there is the intimidating feeling that coaches, audiences and the media have impossibly high expectations.

Firsthand accounts suggest depressions begin like dreams. There are no definite start points, in other words: the individual becomes gradually, hardly perceptibly aware that their moods are changing darkly. Sometimes, they can’t identify a reason let alone mount a defense against it. Close examination reveals that there are many causes of depression, or perhaps we should say *depressions* – as we will soon see, there is variety. I’ll group them into four types according to their origins and then provide representative case studies.

The competitive environment inevitably cultivates aims, targets and achievable goals. Reaching goals is rewarding, but failing short can be devastating. Even a single

defeat can be ruinous. There is also a ceaseless series of expectations: literally everyone, from the people who serve in the canteen to journalists who report to the media harbors expectations. In themselves, they have no potency; but the manner in which competitors assimilate and respond to them is crucial. Some athletes thrive, while others wither. Responding to the expectations of others is the mainspring of this type of depression.

Leaving competitive sport is a risky business. The competitor ventures into unknown territory where he or she is no longer surrounded by coaches, trainers or teammates and where goals are never clear. The demands of competition disappear, as do the regimens of training, leaving him or her without familiar patterns or standards of behavior – social norms. But the absence of norms, guidelines, aims and someone or something else's controlling force can create a troubling sense of [anomie](#).

Something else is missing too: the moment when a newly retired competitor leaves the will of the coach, the manager, the crowds, the media, he or she becomes a fully autonomous being, free of the daily grind and no longer subject to the imperatives of others. The sense of self is changed: the ex-competitor is answerable only to him or herself. The response may be to take up new challenges, or become self-absorbed, preoccupied with one's own situation. Either way, the departure from sport precipitates this type of depression.

Readers may know the dispiriting effects of an injury that doesn't respond as readily to treatment as expected. A single injury, or perhaps a sequence of impairments, can have considerable psychological impact. Rehabilitation can bring disorientation as well as recovery. Injuries themselves don't cause depression, though they inevitably lead to changes in mood. The way in which some one reacts to injury is what prompts anything from calmness to calamity.

Very few competitors are so consummately committed to their sport that they have no interests beyond. Sometimes life away from sport can introduce issues that have effects, especially negative ones on a person's ability to train or compete at full efficiency. Trauma unrelated to competition can drive competitors toward this type of depression.

The causes are literally limitless, but we should remain mindful that objective events are not in themselves causes of depression: it is the way a competitor cognizes, or perceives the event or events and, most importantly, responds that matter. Case studies will bring these abstract types of depression in sports to life.

EXPECTATIONS AND DEPARTURE . . .

Expectations. In 1966, before depression had become recognized as a medical illness and subject to clinical diagnosis or before Prozac appeared on the market, a 15-year old Canadian swimmer named [Elaine Tanner](#) was hailed as wonder child. She won seven gold medals at the Commonwealth Games, setting two world records in the process. She triumphed again in the following year's Pan Am Games, claiming another world record and a gold medal.

Four more records tumbled in the run-up to the 1968 Olympics. She was strongly favored to win at least one gold in her best event, the 100-meter backstroke. To the

naked eye she may have done exactly that: in the final she broke the Olympic record and appeared to have won. But the electronic timer suggested otherwise: American Kaye Hall had touched the wall a half-second quicker, leaving Tanner in what was for her the unfamiliar position of second place. "I may as well have been last," said Tanner, who, even at 17, had grown accustomed to winning everything she wanted.

For many, perhaps most, athletes, an Olympic silver medal would have been a glorious achievement, especially when added to the two other medals she picked up. For Tanner, it was an honor that brought insoluble problems. As Stacy Perman, of *Sports Illustrated*, reflected: "That silver medal, quite literally, almost destroyed Tanner" (2002).

To this day, Tanner has no recollection of standing on the podium to receive her medal. She offers her own account of what followed on her website: "I had difficulty setting any meaningful goals and if I made one I had trouble following through. It was if my willpower had been sucked right out of me and there was a desperate emptiness within me that I was incapable of filling for myself having given away all my power years ago combined with the rawness of the emotional pain I now associated with failure" (<http://www.elainetanner.ca/>).

Over the next 25 years, Tanner succumbed to anorexia nervosa and, periodically, contemplated suicide. "I was surviving off a muffin a day and battling with panic attacks and phobias which were now occurring with greater frequency and intensity." Her weight dropped to 87 lbs (39.5kgs), about 40lbs below her optimum competitive weight. The celebrity status she'd acquired quickly disappeared and she spent long periods out of work or trying making ends meet by doing menial jobs.

Success, like beauty, may be in the eye of the beholder, though in sports there is less relativity: there is absolute and universal agreement about the value of winning. Coming agonizingly close to winning without actually succeeding makes second place one of the ambiguous positions in sport. Is it success in beating all but one of your competitors, or is it failure?

Decades after Tanner's second place, the track athlete [Jenny Meadows](#), who, in 2009, came third in the 800 meters IAAF World Championships, reflected that a "bronze medal protected me from a little bit of heartache." The race was won by the [Caster Semenya](#), whose gender was the subject of controversy. Janeth Jepkosgei, who came second in 2009, was the one who would live with the torment, though not as painfully as Tanner, who dropped out of competitive sport, "a broken soul," as she puts it.

Anxiety is a natural human reaction. It would have been unusual had Tanner not been disquieted by the disappointment of losing out on a gold medal, especially having come so close. But her apprehensiveness wasn't temporary. She didn't return to the pool believing that, by the time of the next Olympics, she would be only 21. It's conceivable that she could have followed someone like the Australian Dawn Fraser who was 18 when she won the first of her four Olympic gold medals in 1956, and 26 when she won her last, having competed in three successive games.

Tanner recounts how: "Already feeling emotionally fragile I was welcomed by headlines reading TANNER LOSES GOLD!" Her story offers what seems an extraordinary case study of how others' *expectations* can propel a promising athlete towards depression and effectively annihilate a sports career. It may be more typical than it

appears: we only take notice of those athletes who grow stronger as a result of high expectations. Even they are vulnerable to depression when they leave the environment.

Departure. The British heavyweight boxer Frank Bruno started boxing when he was nine, won the Amateur Boxing Association (ABA) title at 18, won the World Boxing Council title at 33 and retired at 34. That was in 1996. In 2001 he was divorced after 20 years of marriage. There were murmurs of spousal abuse. Worse was to come in 2003 when Bruno was compulsorily admitted to hospital as an emergency case under the Mental Health Act 1983 – a process known as being “sectioned.” He was later diagnosed with [bipolar](#) disorder.

Bruno recorded his own understanding of events for BBC One television’s [Mind Games: Depression in Sport](#) (first broadcast November 25, 2009; producer: Richard Hughes). After 25 years in boxing, he didn’t know what to do. The daily routine of rising early to run, then work out at the gym and the discipline of keeping a healthy regimen had been integral parts of his life. But his *departure* from boxing created a kind of vacuum.

Bruno missed being busy, he missed his trainers, his sparring partners, the journalists, the miscellaneous hangers-on and everyone associated with the sport. Above all, he missed the “buzz” of boxing. Even after being sectioned, he felt “shame,” a feeling compounded by a British national newspaper’s front page headline [BONKERS BRUNO LOCKED UP](#)

... INJURY AND TRAUMA

Injury. “That which does not kill us makes us stronger.” The German philosopher Friedrich Nietzsche (1844–1900) didn’t have the afflictions of athletes in mind when he wrote this, though many athletes who have emerged from depressions actually appear to be fortified by the ordeal. Injuries have killed off the careers of many athletes; they’ve blighted the careers of others. At least one athlete despaired so deeply that she inflicted further damage on herself and yet still emerged stronger.

“Someone who self-harms will usually do it in a state of high emotion, distress and unbearable inner turmoil,” according to the [Royal College of Psychiatrists \(RCPsych\)](#). “Some people self-harm only once or twice, but others do it regularly – it can become almost like an addiction.” Kelly Holmes self-harmed with scissors for two months in 2003. In 2004, she won two gold medals in the 800 meters and 1500 meters at the Olympics.

Holmes was training in the French Pyrenees. At 33, she was already an established middle distance runner, and had been accumulating medals at Olympic, World and European games since 1994. But her only two gold medals were at the Commonwealth Games of 1994 and 2002. The absence of gold at the major events was at least partly attributable to an unhappy knack of picking up injuries.

A stress fracture in 1996 impeded her training for the Olympics, where she finished fourth. The following year, a ruptured Achilles tendon ruined her IAAF World Championships hopes. In the run-up to the Sydney Olympics of 2000, she picked up a virus, but still managed a bronze medal. In 2001, illness forced Holmes to

undergo surgery on her stomach. A calf injury in 2003 was her most recent setback, but she salvaged a silver medal from the World Championships. She told [Sarah Holt, of BBC](#): “I could have retired because of injury but I would have known I gave up because of outside pressure not because I wanted to.”

Holmes’ definition of “outside pressure” was revealing: injuries weren’t caused by the physical demands she made on her body, or the years of oppressively constant training, or even bad luck, but by some kind of external force against which she was apparently battling. That force struck again, this time at the least opportune time, as she prepared for her last hurrah.

“I’d locked myself in the bathroom and turned on the taps so nobody could hear me crying,” [Holmes](#) remembered her reaction to a calf strain and [iliotibial band syndrome](#) that left her contemplating not being able to compete at the Olympics. “I made one cut for every day I’d been injured. With each one I felt I was punishing myself but at the same time I felt a sense of release.”

How do we make sense of this self-destructiveness? Holmes maintained her training as well as she could, secretly lacerating her body every day. Perversely, the “sense of release” evoked by the cutting provided relief from the repressed frustrations the injuries had created.

On the surface, self-harming appears to be a wholly maladaptive strategy, an avoidance response that just doesn’t provide an appropriate adjustment to any situation. But on Holmes’ own account self-harm was [catharsis](#): it relieved her of emotional tensions. Only later, when she sought medical help, was it diagnosed as a symptom of her depression. Holmes trained her way through the depression, privately inflicting pain and damage on herself as if to punish her body for its recalcitrance. Its unreasonable habit of going wrong at the inconvenient times had put Holmes through enough anguish; now it was payback time.

Whatever you think of Holmes’ irrational response to injury, the end result is undeniable: the next year, she won gold medals at both 800m and 1500m becoming only the third woman in Olympic history to complete this [double](#).

Frustration and depression: these are, according to Fraser Carson and Remco C.J. Polman, “emotions commonly experienced by athletes responding to injury . . . they decrease over time and are typically replaced by more positive emotions” (2008: 76).

Carson and Polman stress the influential part played by coping strategies. Depression is almost inevitable. No athlete will shrug off an injury; feelings of dejection, hopelessness and inability disturb any athlete who incurs one. Holmes was no different. Her response was. It contrived to be inimical and efficacious – dangerous and useful.

Holmes’ depressive period was occasioned not by injuries but by her dread of their possible consequences. It’s possible to see through her eyes and understand the torture of constantly being thwarted by a faceless malefactor. Her desolation is comprehensible. But sometimes the causes of a depression are less intelligible. Take the case of Pete Harnisch, the baseball player, who abruptly quit a 13-year chewing tobacco habit during spring training. It was like jumping out of the frying pan and into the fire.

The fire in this instance was a tumultuous period in which he couldn’t sleep, felt constantly tired and became increasingly anxious for no accountable reason. Harnisch

maintains his body chemistry was destabilized when he opted for [cold turkey](#). Baseball is a sport in which mental conditions have remained taboo since the 1950s, when Jimmy Piersall was treated for “nervous exhaustion,” later declared to be bipolar disorder.

In 1997, Harnisch announced: “[I’ve been diagnosed with depression](#).” He was placed on New York Mets’ disabled list and was prescribed paroxetine, an SSRI. Six months later, Harnisch returned looking a little lighter: he’d lost 30lbs at the nadir of his depression and wasn’t fully restored. His form wasn’t good and the Mets traded him to Cincinnati, where he enjoyed a renaissance before closing his active career in 2001. Unlike many athletes who talk openly about depression, Harnisch remained reticent. “He is not comfortable with the term ‘mental illness,’” reported Robert Lipsyte, of the [New York Times](#) in 1998. Perhaps because, in 1990, doctors diagnosed his brother with bipolar disorder. “I see it mostly like a long cold, a cold in my brain,” said Harnisch, maintaining his problem was a physical condition.

Like Holmes’ mental disorder, Harnisch’s depression was a response to an injury. A longterm dependency on tobacco is harmful and damaging to health, so it can legitimately be called an injury. Again, we see the importance not so much of an event, occurrence or condition, but of an individual’s response to a situation.

Trauma. As the cases covered so far confirm, there is no template for depression: the causes are as varied as the responses and, while some athletes rebound stronger and renewed for battle, others either never manage to or just don’t want to. The sources of depression affecting the athletes are in some way embedded in the sports environment. In other cases, they lie far from sports.

Chamique Holdsclaw missed two Women’s National Basketball Association (WNBA) seasons from 2007. Raised in New York by her grandmother from age 11 while her father was coping with schizophrenia and both parents dealt with alcoholism, Holdsclaw played for the University of Tennessee before turning pro with the Washington Mystics in 1999. In 2002, her grandmother’s unexpectedly died from a heart attack and Holdsclaw changed from what [Mike Tierney](#), of the *New York Times*, described as “an effervescent player to a joyless one.”

She despaired at the loss of her grandmother who had been her legal guardian and a bulwark against the fury of her parent’s alcoholic conflicts. Holdsclaw had GRANDMA tattooed on her right ankle. She kept playing and her form held up, though secretly, as Holdsclaw confided to [Kelli Anderson](#), “I was losing it.”

The loss of her grandfather in 2004 pushed her to even greater emotional depths and she stopped playing, due, according to her club, to “medical reasons.” Anderson reflects that rumors of pregnancy, cancer and drugs were rife, though Holdsclaw quashed the rumors by announcing that she had been diagnosed with clinical depression.

In 2005, a move from DC to the Los Angeles Sparks offered Holdsclaw a fresh start. The Sparks found her a therapist who prescribed [bupropion hydrochloride](#), which is an antidepressant in its own right, but frequently used when SSRIs don’t elicit a complete response, and often taken to assist quitting smoking. But new trauma arrived with her father’s periodic disappearances. Holdsclaw took a two-week leave to try to resolve the domestic problem, but returned to LA, dispirited and disconsolate. She overdosed on her prescription drugs and was hospitalized.

BOX 21.7 TRAUMA

This is a Greek word, meaning literally “wound.” Nowadays, it is used for both physical injuries and the emotional shock that accompanies any kind of distressing occurrence. The condition of persistent emotional and mental disturbance that typically involves insomnia and constant vivid recall of the distressing occurrence is known as [post-traumatic stress disorder](#) (PTSD). This disorder can develop in response to, for example, assaults, accidents, disaster, or rape. It is prevalent among military personnel returning from conflict.

Holdsclaw came back but without her appetite for basketball. Five games into the 2007, she announced her retirement from basketball, or at least from the WNBA; she played in the less demanding Polish league. The retirement turned out to be a hiatus, and, at 31, she returned to the WNBA with the Atlanta Dream. “Things happen in life, and you either stay knocked down or you work through them,” Holdsclaw told Anderson. “I became a stronger and better person.”

When Holdsclaw signed a three-year contract and announced, “I feel comfortable with this situation. I feel at home,” it seemed like a satisfactory conclusion to a sorrowful nine-year period. She also claimed to be off her medication. Yet, in May 2010, news started to trickle out that Holdsclaw had requested a move from Atlanta, and, unexpectedly, she signed for San Antonio Silver Stars, age 32.

In all the case histories I’ve offered, depressions and other mental disorders manifested in some way. In sports, the symptoms usually become clear or obvious through the performances or behavior of athletes or ex-athletes. But not always. There are athletes who have coped with depression in an imperceptible way. John Kirwan, for example, had a glittering playing career. A star winger for the All Blacks and, later, a rugby league player in Japan, Kirwan effectively disguised the persistent struggle he had with depression.

Kirwan retired in 2001, aged 36, having made 96 appearances as an All Black, scoring a record 67 tries. His performances on the field were, in many ways, exemplary. But privately, he was depressed. What about? In his case, there was no discernible cause. His depression was a persistent counteraction to the moments of elation he experienced during his triumphal rugby career. Kirwan found a kind of therapy in publicizing his own depression, both in revealing [interviews](#) and in [public health campaigns](#) in New Zealand.

Yet there was little in Kirwan’s onfield performances to suggest he had mental health problems. We have all probably watched athletes performing out-of-their-skin, little realizing they are coping with a mental disorder. In fact, it’s entirely possible that every time we watch a contest, somebody out there has depression. Remember the prevalence: 1:20 people. If medicalization proceeds, more of us will be less “normal” in future. Will it matter?

IS DEPRESSION A BAD THING?

After reading so far, I imagine a collective thought bubble hovering above the heads of readers: “If depression is, as the WHO declares, one of the leading causes of disability, how come some athletes seem to suffer miserably, while others show no signs of distress?”

Paul Keedwell doesn’t include sport in this statement, but he may well have: “There is a perception that depression is an entirely negative influence on success in the artistic, political and scientific arenas” (2008: 137).

But, it’s a skewed perception. Clear analysis reveals a “definite link . . . between depression and creative success,” says Keedwell. From the cases we’ve surveyed, a “definite link” is hard to establish, though several athletes coped with their disturbances positively and responded, in competitive terms at least, successfully. When seen this way, depression – and, indeed, related mood disorders – are not evidence of defective mental apparatus or malfunctioning, but adaptations that yield positive results.

The perspective is influenced by evolutionary psychology, which is predicated on the assumption that, “Culture is the cause of mental content,” as Simon Hampton expresses it, (2010: 29). So, mental disorders don’t develop spontaneously, but as adaptations to circumstances. Hampton explains: “Evolutionary psychologists invoke social conditions and circumstances to explain how evolved mental mechanisms function in modern environments” (2010: xvi).

It’s probable that humans have always been vulnerable to mood disorders, which medicalization has rounded-up into the category depression. Instead of treating them medically, they used depressions as occasions to review themselves and their circumstances and respond differently. In other words, they employed coping strategies, a concept Stephen D. Mellalieu defines as: “What an athlete thinks and does to cope with the competitive experience . . . to influence the emotions that emerge from the emotion-provoking encounter” (2003: 101).

Coping strategies mediate between the mental states and behavior to bring about a resolution or at least some kind of stopgap. Holdsclaw’s apparent restlessness was probably driven by her attempt to avoid any association with her personal tragedies. Unlike Elaine Tanner whose resolution was to leave competitive sport and, in her own words, sink to the depth, Holdsclaw rebounded back into sport, though she never settled. Her depression wasn’t the salient influence on her life: rather, it was the manner in which she coped, or perhaps failed to cope with it that defined her endeavors.

Other athletes, like Kelly Holmes, opted for coping strategies that, bizarre as they were, equipped her for competitive action. The key to understanding the causes and effects of depression is the mediating link, the coping strategy, or the adaptation – how athletes make sense of and respond to their predicament.

I see another thought bubble looming: “Who would want to be a top sports star in an environment so competitive that mental disorders go with the territory?” There are obvious benefits: money, fame and a job that pays for doing something you would have probably carried on doing for fun even if you weren’t getting paid. But, the point about pursuing something for fun is that you don’t get paid for doing it. Once you do, it becomes a job of work.

Take Andre Agassi: he hated playing tennis. He was forced into playing by his ambitious father who – rightly, as it turned out – envisioned tennis as a way out of ordinariness. Over a career, he earned \$30 million in prize money plus several more million from endorsement contracts. He also won 8 Grand Slam titles. Agassi loathed playing tennis; he was deeply unhappy. His sport was demanding in the sense that, to remain competitive, he was obliged to train every day, except when injured, and even then, Agassi relieved a persistent back pain with cortisone in order to train and play.

By the time he retired in 2006, aged 36, Agassi had been playing tennis for about three decades. When, in 2009, he revealed that he'd relieved the [tedium of playing with crystal meth](#) a number of times around 1997, it was really not much of a surprise. He was never diagnosed with a mental disorder, though the maverick cheerfulness he showed on court belied the profound unhappiness he experienced for much of his playing career.

The gym where I work out has indoor tennis courts and I sometimes pause to watch games: the players usually seem to be enjoying themselves. They're clearly motivated but by intrinsic rather than extrinsic rewards. Tennis is one of those activities they find enjoyable or provide relief, pleasure, or amusement. As far as I know, no player at the gym has ever suffered from depression or any other mood disorder as a result of tennis. In fact, there's a body of research that indicates that tennis, or any other kind of noncompulsory physical activity has favorable effects on mental health.

BOX 21. 8 INTRINSIC MOTIVATION

"People who are intrinsically motivated tend to engage in activities for the interest and enjoyment inherent in engaging in the activity itself," writes Kailas Nath Tripathi. There is, according to Jemma Edmunds *et al.*, 'an inherent tendency possessed by all humans to seek out novelty and challenges, to extend and exercise their capabilities, to explore and to learn.' 'Inherent' suggests it is a permanent part of human nature, or essence. On this account, it follows that humans naturally pursue activities that are enjoyable or provide relief, pleasure or amusement. *Extrinsic* motivation entails an incitement from outside an activity, such as money or a prize.

THE BEST DRUG

[Is exercise the best drug for depression?](#) asks Laura Blue, of *Time* magazine (June 19, 2010). She isn't the only one to have asked this question. Since Prozac and other SSRIs re-defined the way in which we view, treat and think about mental disorders, depression has been the subject of medical care. The person with the condition is given care as if they were a patient with an illness or injury. They are conventionally treated with pharmaceuticals and/or CBT.

In 1988, an article by W. Frank Epling and W. David Pierce challenged what was then the commonsense understanding of anorexia nervosa: “Anorexia nervosa is a diagnostic category that is based upon the medical disease model of abnormal behavior” (1988: 482).

Epling and Pierce’s study was published five years after the death of singer [Karen Carpenter](#) through heart failure attributed to anorexia. Carpenter also suffered from depression, though, in 1983, neither condition was widely known as a distinguishable illness. Carpenter’s death drew attention to anorexia and helped give shape to the condition.

Epling and Pierce observed that, in the 1980s, “an underlying personality disturbance or distorted cognitive schemata” were considered the cause of anorexia. (Note: cognitive schemata provide us with a sense of stability with relatively fixed conceptions of the world and ourselves.) But they suggested an alternative “biobehavioral” understanding in which “sociocultural conditions” are underlying causes.

In this sense their approach was similar to evolutionary psychology, which, as we noticed before, situates the cause of mental states in social conditions and circumstances. (We’ll return to this later in the chapter: it offers a striking alternative to medicalization.)

Epling and Pierce’s was a minor, but thoughtful study that raised the possibility that, if mental conditions were brought on by circumstances, then maybe they could be changed by rearranging those circumstances. One question raised in their article concerned the role of vigorous exercise in affecting mental states.

As we saw in Chapter 7, the expansion of fitness culture was rapid and sweeping in the 1980s and the beneficial effects of regular, vigorous exercise were unquestioned. Intuitively, the impact of exercise on mood seemed to be positive. Several research projects supported this, though [the project](#) that appeared to nail the relationship didn’t arrive until 1999.

A research team led by James Blumenthal studied 156 elderly patients diagnosed with major depressive disorders and assigned them to three groups: one engaged in a program of aerobic-exercise; another took the SSRI [sertraline](#); and another combined exercise with medication simultaneously.

Initially, patients who took the antidepressants saw their symptoms relieved sooner, but by 16 weeks the group differences had disappeared. All three groups showed statistically significant and similar improvement in symptoms of depression. The conclusion was that depressed adults who participated in an exercise plan improved as much as those treated with the drugs, or the combination. So, here was a question: was exercise itself as efficacious as drugs?

In some respects, it was more so: those who exercised were actively engaged in a pursuit and so felt a greater sense of mastery over their condition; this provided a sense of accomplishment, which translated to self-confidence and, as later studies were to show, self-efficacy – a concept we discussed in Chapter 6 (see page 134, BOX 6.5).

Taking a pill is basically a passive activity: you just put it in your mouth and swallow, if necessary with water. Exercising on the other hand is active: the participants in the study had to do something for themselves. When their moods improved, they could reflect back on something *they* not a pharmaceutical had done.

So the satisfaction of having brought about a desired result gave them the confidence to repeat it over and over.

Over the next decade several research projects exploring the relationship between exercise and mental health came up with compelling results. By 2009, Ann-Marie Knowles was able to reflect: “There is a wealth of research available supporting the positive effects of exercise on mental health and psychological well-being, which includes reducing anxiety and depression” (2009: 51).

Many studies confirmed the effects of exercise, though few answered the question “Why?” Self-efficacy was cited as a reason by many, including a study of 8–12-year-old children with depressive symptoms by Lois Michaud Thomson et al.: “The experience of mastering something perceived as difficult creates positive psychological changes, including increases in self-confidence, perceived self-efficacy, and ability to cope with stressors” (2003: 421).

What about learning another language? Would this confer on the learner enough self-efficacy to shrug off depression? It’s an active and challenging task that involves mastery. As is stamp collecting, doll making, or [snake charming](#). While some may say these are all kinds of “therapy,” no one claims they have curative powers.

A French study by Fabien Legrand and Jean Philippe Heuze, whom I quoted earlier in this chapter, suggested other explanations: “Several reasons may account for the fact that high-frequency exercise [3–5 sessions per week] is more likely to be associated with psychological benefits in individuals with depression” (2007: 358).

(1) *Metabolic and physiological adaptations* to exercise have an anti-depressant effect. Metabolic refers to chemical processes; physiological to body part functions. (2) *Self-learning* is part of regular exercising: exercisers grow accustomed to the physical sensations associated with energy expenditure “and may even become adept at relaxing while exercising.” (3) *Rumination* usually means thinking deeply about something, though Legrand and Heuze define it as focusing on one’s negative feelings, and exercising often engages people in a way that doesn’t permit rumination. (4) *Neurochemistry of mood regulation*: the researchers detected a “parallelism between the mechanisms underlying the antidepressant effects of exercise and those involved in the therapeutic properties of SSRIs” (2007: 359).

An earlier study by Francis Chaouloff had established that acute running increases brain serotonin synthesis and that the positive mood effects of exercise rely, partly or totally, on this naturally occurring chemical. One slight complication: the subjects were mice on treadmills.

BOX 21.9 SEROTONIN

A chemical produced by the brain, serotonin functions as a neurotransmitter. It’s found in many tissues, including blood platelets and brain cells. Low serotonin levels are associated with mood disorders, particularly depression. Its physiological properties include the inhibition of gastric secretion, stimulation of smooth muscles and the constriction of blood vessels.

It's always wise to avoid the [inductive fallacy](#) when assessing the findings of research conducted on animals, but Legrand and Heuze cautiously advance a similar argument based on humans: exercise can change brain chemistry in much the same way as SSRIs. In fact, the antidepressant effect of exercise starts to work after four weeks, which is "very close to the latency times of 2 to 4 weeks usually required for any therapeutic effect to occur with SSRIs" (2007: 359).

You might think that the French study misses a very important trick: the sociable environment in which exercising takes place. Working out can be hard work, but exercisers have fun, they meet new friends and they get involved in other activities they wouldn't have dreamt of if they hadn't joined an exercise class. To this you can add any number of other social advantages.

Perhaps surprisingly, Legrand and Heuze conclude, "social relations within an exercise group do not play an important part in their relationship between physical activity and depression over a short period of time (i.e., 8 weeks in this study)" (2007: 359).

Maybe nothing life changing occurs inside two months, but, as anyone who exercises regularly knows, it's practically impossible not to meet and form attachments with other exercisers eventually. Even loners get drawn into sociable relationships. Intuitively, we might think that talking to, socializing with, and just interacting with other people has some potential for affecting mood, though perhaps sociability in itself is not potent enough, certainly not over the short haul. But maybe we are overlooking something: without expressly looking at exercise as a recipe for mental health, social scientists have revealed the potential of exercise as a source of empowerment.

When Andrea Abbas studied a group of runners, her intention was to explore how "running culture contributes to the construction of hierarchical social structures." En route she found: "Running does appear to offer individual and group empowerment in the sense that if sufficient individual women and older people succeeded at running they could overturn hierarchies" (2004: 171).

In a different study, this time on male gym-users, Lee F. Monaghan concluded that it was "possible to derive pleasure from the fact that at least some control is being exerted over the ageing body" (2001: 344).

Both studies offer the possibility that exercising, especially in groups, can confer on people feelings of authority, making them feel more able to control their lives and perhaps claim their rights. There's an echo of the argument about mastery and self-efficacy we noted earlier. The physical activity of exercise itself promotes the feeling that someone can instigate desirable change. When combined with the opportunity to share this experience with other, possibly like-minded, exercisers, it evokes a sense of empowerment and control over one's life.

Unlike many other activities that seem to have comparable potential, exercise produces results. As the Monaghan study suggested, the changes in the exercisers' bodies were manifest. Those who worked out regularly didn't just have faith in the power of exercise: the empirical evidence was right there in the mirror. Control over one's own body was palpable.

We're probably approaching the point where everyone accepts that exercise is not only good for our physical health, but for our mental health too. The reasons we've covered are mostly plausible without being convincing. Exercise induces *physical*

changes all over the body: we can see our bodies changing and we can gauge our strength and endurance, though we can't see the chemistry of our brains altering. But an agreeable neurochemical reaction to exercise could be an important reason.

Psychological changes are also involved when someone consciously and vigorously decides to pursue a course of action. The effort involved implicates an exerciser in a venture, undertaking or enterprise that is bound to lead to feelings of self-efficacy and, eventually, mastery.

Social changes too have an impact. Being part of a collectivity in itself introduces powerful changes in individuals. For any exerciser, the feelings of empowerment and of having control over their own bodies are tacit benefits. For someone with mental disorders, their importance is magnified. It may sound vacuous and grandiose, but prospect of being able to manage one's own life in a way that is not just satisfactory but enjoyable is no small achievement.

But wait: "Exercise helps depression' is a myth," objects a contributor to Nancy Schimelpfening's [Depression Blog](#). Another blogger agrees: "Exercise seems to exhaust me emotionally as well as physically."

There are other detractors. In a [2003 article for Sports Illustrated](#), L. Jon Wertheim quoted Dennis Charney, chief of the Mood and Anxiety Disorders Research Program at the National Institute of Mental Health who was dismissive: "Anyone who has had depression will tell you, it's not the kind of thing where you can go for a run and suddenly feel all better," says Charney. "That's a big misconception."

Clearly, exercise is not a panacea: it works only for some. But the cumulative force of the evidence supporting the role of exercise in alleviating mental disorders makes it appear a persuasive alternative to medication.

LIKE A HAMSTRING TEAR

The medical disease model of mental disorder has grown in popularity, particularly in sports. Wertheim observed how a psychiatrist "who had worked with dozens of elite athletes," adhered strictly to a disease model: "[Michael] Lardon stresses to his athlete-patients that depression is 'an imbalance in brain chemistry,' so it is less abstract and subjective."

Many athletes, who have suffered depression and comparable mental problems, find comfort in subscribing to this model. John Kirwan has explained in his 2010 autobiography and in this 2007 [New Zealand television interview](#) how conceptualizing his mental disorder as an illness or injury, helped remove the stigma in his – and we presume many other people's – minds: "If I tore a hamstring would people see it as a weakness?" he asks rhetorically.

This approach has the benefit of changing perceptions about mental illness, but there are all costs, not least of which is simplification. Mental disorders may be *analogous* to physical disorders: they are comparable in certain respects, typically in a way that helps us treat them. For purposes of clarification and explanation, however, analogies between mental disorders and physical ailments are limited.

Mental disorders can be managed, or controlled, by redressing what Lardon calls "imbalances in the brain chemistry." Yet there is no agreement on the origins,

character and status of mental disorder. Over the years, several theorists have argued that the disease model is wrong. For them, the only question is wrong *how?*

BOX 21.10 DISEASE AND LABELING MODELS

Debates over the status of mental disorders guide how they will be understood and treated. Models of mental disorders are [heuristic](#) descriptions or theoretical designs to assist comprehension and explanation. As such, they are not intended as accurate reflections of reality. A disease is a disorder of structure or function that produces specific symptoms and is not the direct result of a physical injury. So, the disease model of mental disorder suggests that there is an objective condition or state that is treatable. It is consistent with the medicalization referred to earlier in this chapter (box 21.5). The underlying premise of the model is that there is a biological dysfunction that causes the mental condition. “Understandably [the model] has been promulgated by physicians and psychiatrists as well as by the health-care industry, especially by pharmaceutical companies,” writes Donald J. Kiesler in his *Beyond the Disease Model of Mental Disorders* (2000: 17).

By contrast, the labeling model offers an understanding of mental disorders as a reaction on behalf of the wider society. In his *Being Mentally Ill: A sociological theory* Thomas Scheff approaches mental illness as a label, or assignation by society: certain types of rule-breaking behavior are defined as deviant and people exhibiting such behavior are called mentally ill. The expectations placed on them, in a self-fulfilling way, make it difficult for the recipients of labels to avoid having their behavior interpreted as anything other than that of a mentally ill person.

Three particularly influential theories of mental illness emerged in the 1960s and 1970s. They were those of [Thomas S. Szasz](#) (1920–), [R.D.Laing](#) (1927–89) and [Thomas J. Scheff](#) (1929–). In his *The Myth of Mental Illness* (1974), Szasz critiqued both the concept of mental disorder as a disease, or even illness, and the psychiatric profession that perpetrated it. In a different, though complementary way, Laing (1965) located the causes of behaviors that are seen as symptoms of mental disorders in the family, where he saw destructive conflicts disguised as “love” and “care.”

Scheff’s *Being Mentally Ill* (1966) proposed that mental disorders are the product of social responses to certain kinds of deviant behavior. Being normal means conforming to an expected standard. Normalcy is a convention: a customary set of protocols and guidelines as to how we should think and act. Deviations are labeled and those who get stuck with a label find themselves unable to shrug them.

In all these and many related arguments, the complexities and diversity of character and content of what is popularly recognized as mental illness meant that it could not be reduced to the status of a disease or straightforward illness. Mental disorder is experienced in the mind, but the implied arena is larger: private conditions are indexed to social processes.

The terms that come under the rubric of mental disorder are, from this perspective, convenient tags, or labels. Once someone gets labeled as suffering from a mental disorder and in need of treatment, whether pharmaceutical or psychiatric (or both) the stigma often sticks. This makes it difficult for them to be anything but someone who suffers or who has once suffered from a mental disorder and, in this sense, isn't totally normal. William Cockerham uses the term "the paradox of normalcy" to describe the process (2010: 259).

While it may serve the purposes of sport to liken, equate or make mental disorders synonymous with physical illness, we should guard against seeing this as the only way to understand mental disorders. According to many scholars, disordered people are often coping with exceptional social predicaments and their symptoms are more reflections of what goes on outside them than inside them.

Depression and associated mental disorders, even those of the most serious nature, have diverse origins and divergent paths of development. Like everything else we have discussed in this book, mental disorders should always be understood in context and conceptualizing them as diseases does not necessarily advance this understanding.

While arguments continue about the causes and treatment of mental disorders, there is consensus over the odious consequences of labeling: historically, shame, disgrace, and humiliation have been associated with mental disorders of even the mildest kind. It's little wonder that an unknown number of athletes have, over the years, chosen to disguise their condition or shrink away from sports rather than risk the pain that stigma usually entails.

An undeniable fact remains: conceptualizing mental disorders, especially depressive disorders, as physical illnesses has been an effective way of erasing the stigma and encouraging more openness among athletes. It has introduced athletes and fans to a way of understanding depression and other mental disorders in a way that's refreshingly free of judgment. The disease model may be one-dimensional in its formulation of mental disorders as purely [neurochemical](#) phenomena, but it has the practical virtue of allowing athletes to disclose what might otherwise have been festering secrets and open up dialogue on a near-taboo subject.

This corner of sports landscape has long been ignored and, while fuller comprehension of the causes of depression may involve analysis beyond the physical, the newfound confidence of athletes to discuss their mental problems is due in large part to a medicalized understanding of its status.

OF RELATED INTEREST

A [BBC World Service](#) report following Robert Enke's death contains an interesting audio interview. It forms a companion to John Kirwan's interview on [TVNewZealand](#). Also of interest are Chamique Holdsclaw's remarks in this [clip](#).

Elaine Tanner's story is revealed in Stacy Perman's "The agony (not to mention the public humiliation, financial disappointment and long-term psychological trauma) of defeat" (in *Sports Illustrated Women*, 2002).

The 8th edition of William C. Cockerham's *Sociology of Mental Disorder* (Pearson, 2010) is a comprehensive overview of the various approaches to mental disorder that situate its origins in culture and society rather than in the chemistry of the brain. To understand why neurochemical explanations have grown in popularity, see Peter Conrad's *The Medicalization of Society* (Johns Hopkins University Press, 2007).

"Exercising to compensate – the effects on psychological well-being" by Ann-Marie Knowles (in *Sport & Exercise Psychology Review*, 2009) reviews some of the research supporting the view that exercise promotes mental health.

The French study cited in the text by Fabien Legrand and Jean Philippe Heuze "Antidepressant effects associated with different exercise conditions in participants with depression: A pilot study" (in *Journal of Sport & Exercise Psychology*, 2007) is small-scale, but with many interesting ideas.

ASSIGNMENT

While playing golf with a police officer friend, a journalist learns that, the previous evening, traffic police stopped a vehicle driven recklessly by a celebrity football player. The athlete explained to police officers that he was rushing to the supermarket to buy a screwdriver in order to take up the floorboards of his home. He said that building contractors who had been working at his house earlier in the day had accidentally sealed his pet cat under the boards.

The journalist laughs and says he intends to chase the story. But the police officer urges caution: there was no cat beneath the floorboards, but the athlete seemed in such distress that medical assistance was called. When paramedics arrived, they questioned him about his medication and the player told them he took 200 milligrams of [Zoloft](#) (the trade name of [sertraline](#)) per day. This is the maximum recommended dose of a drug typically prescribed for depression, panic attacks and sometimes [obsessive-compulsive disorders \(OCDs\)](#).

The journalist becomes even more interested and resolves to write a serious feature rather than a jokey story about the missing cat. His first move is to contact the player via his agent. The player is unhappy about the enquiry and obtains a temporary [injunction](#) preventing the media reporting or even making vague reference to his suspected condition. But, two months later, a court fails to renew the injunction and the player is thrust into the center of a potentially big story. Write three accounts. (a) The journalist's: he wishes to disclose details of the player's condition in a sober and analytical way; why does he believe this is a story that should be told? (b) The player's: he considers his personal difficulties his own business and off-limits to the media; why does he believe this is a strictly private matter rather than a matter of public interest? (c) Your own: what do you think?

ABBREVIATIONS

ABA	Amateur Boxing Association
APA	American Psychological Association
CBT	Cognitive-behavioral therapies
DSM	Diagnostic and Statistical Manual of Mental Disorders
OCD	Obsessive-Compulsive Disorder
PTSD	Post-traumatic stress disorder
RCPsych	Royal College of Psychiatrists
SSRI	Selective Serotonin Reuptake Inhibitor
WHO	World Health Organization
WNBA	Women's National Basketball Association

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