FREE CLINICAL GUIDE

2026 EDITION

CLUTCH TIME

A clinician's introduction to sports and performance psychiatry

FOR PSYCHIATRISTS, PMHNPS, RESIDENTS AND THERAPISTS
WHO TREAT PEOPLE WHOSE WORK IS JUDGED IN REAL TIME

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EVERY CLAIM
LABELED AND CITED

BEFORE YOU BEGIN

Most of the athletes you will treat are not professionals.

The high school point guard, the Division III swimmer, the marathoner who trains before dawn and the surgeon who treats the operating room as game day all bring the same cluster of problems I see in NFL and NBA locker rooms, only with fewer resources around them and far less attention paid to the rules that govern their care.

Sports and performance psychiatry is one of the youngest areas of our specialty and one of the easiest to misunderstand. It has a defined scope, an international consensus statement, a peer-reviewed journal and a growing evidence base, and it also has real gaps, including almost no randomized trials of psychiatric treatment in athletes.

I wrote this guide as an honest introduction you can use in your next clinic session, whether or not you ever work with a team. Every number carries a citation, and every key study carries a tag describing its design and size, so you can see at a glance how much weight a claim can bear. Where the evidence is thin, I say so, and where I am describing my own practice rather than a published standard, I say that too.

Mena Mirhom, MD, FAPA

NFL · NBA · COLUMBIA UNIVERSITY

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CONTENTS

01	The field	SCOPE, ROLES, HISTORY	04
02	The numbers	PREVALENCE, SUICIDE, STRESSORS	06
03	Assessment	WORKUP, DIFFERENTIAL, SCREENING	08
04	Treatment and prescribing	THREE QUESTIONS, ANTI-DOPING	11
05	Ethics: the athlete is the patient	DUAL AGENCY	13
06	Case: J.R., clutch time	A COMPOSITE, WORKED	14
+	Takeaways, the Field Guide, references		15

HOW TO READ THE EVIDENCE TAGS

META-ANALYSIS
Pools many studies; only as strong as the studies inside.

TRIAL
Tests cause and effect; in athletes, often 8 or 9 people.

COHORT · CROSS-SECTIONAL
How common, and which direction; no causation.

SURVEY · QUALITATIVE
What clinicians do and athletes say; no efficacy.

CONSENSUS · POLICY
Expert agreement and rules; the best guide where trials are missing.

ABOUT THE AUTHOR

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PLEASE NOTE

Educational content, not medical advice, and not CME. Every case is a composite. Off-label uses are flagged. Anti-doping and league rules are current as of November 2026 and change yearly; confirm before prescribing.

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CHAPTER 01

THE FIELD

01

What sports and performance psychiatry is, and how a curiosity became a discipline.

CONSENSUS · 15 EXPERTS

The First International Consensus Statement on Sports Psychiatry, developed at the 2023 International Society for Sports Psychiatry (ISSP) Summit, describes a young field concerned with mental health among athletes and with the role of sport and exercise within psychiatry.[1] It distinguishes three fields of activity, and in my experience most clinicians recognize only the first.

1

Competitive and elite sport

Symptoms and disorders in athletes, from youth through professional and retired.

2

Exercise as treatment

Across 218 randomized trials, walking or jogging reduced depressive symptoms against active controls (Hedges' g 0.62), at low certainty.[2]

3

Recreational sport

Mental health and sport-specific problems in everyday athletes, the largest group by far.

TWO LENSES

Within that definition I work through two lenses. **Sports psychiatry**, as I use the term, is care delivered inside a team, where coordination with team physicians, athletic trainers and coaches is constant.

Performance psychiatry treats optimal function as an outcome alongside remission and travels to anyone judged in real time. Evidence is strongest for performing artists,[3] thinner for surgeons and the military, and mostly expert opinion for executives.

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Who does what

The roles overlap and depend on each other, and the IOC recommends that elite athletes have access to an interdisciplinary team.[4] What the psychiatrist uniquely adds is medical diagnosis and workup, prescribing within anti-doping rules, and the management of risk.

ROLE	CORE CONTRIBUTION	TRAINING
Sports psychiatrist	Diagnosis, medical workup, pharmacotherapy within anti-doping rules, risk assessment, psychotherapy	Psychiatry residency; no board certification in sports psychiatry yet
Clinical or sport psychologist	Psychotherapy, assessment, mental skills, team consultation	Doctoral degree and licensure
Mental performance consultant	Focus, routines and confidence; does not diagnose or treat disorders	Varies; voluntary certification
Team physician, athletic trainer	First to notice change; main referral route; return to play	Sports medicine; certified athletic trainer

A short history

1967
Beisser's *The Madness in Sports*, the first sports psychiatry publication[1]

1992
Begel's overview in the *American Journal of Psychiatry*[5]

1994
International Society for Sports Psychiatry founded[1]

2019
IOC consensus on elite athlete mental health[4]

2021
IOC screening and recognition tools published[6]

2024
First international consensus defines the field[1]

MANDATES BEHIND THE FIELD

Since 2019, every NFL club has retained a Behavioral Health Team Clinician, available on site at least 8 to 12 hours a week, who leads education and rehearses a Mental Health Emergency Action Plan.[7] NCAA member schools have been required to follow the Mental Health Best Practices since August 2024.[8]

WHERE RECOGNITION STANDS

As of March 2026 there is no ABMS subspecialty certificate or focused practice designation in sports psychiatry.[9] The ISSP certificate recognizes additional education and does not attest to competence,[10] so a claim of board certification in sports psychiatry deserves a second look.

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CHAPTER 02

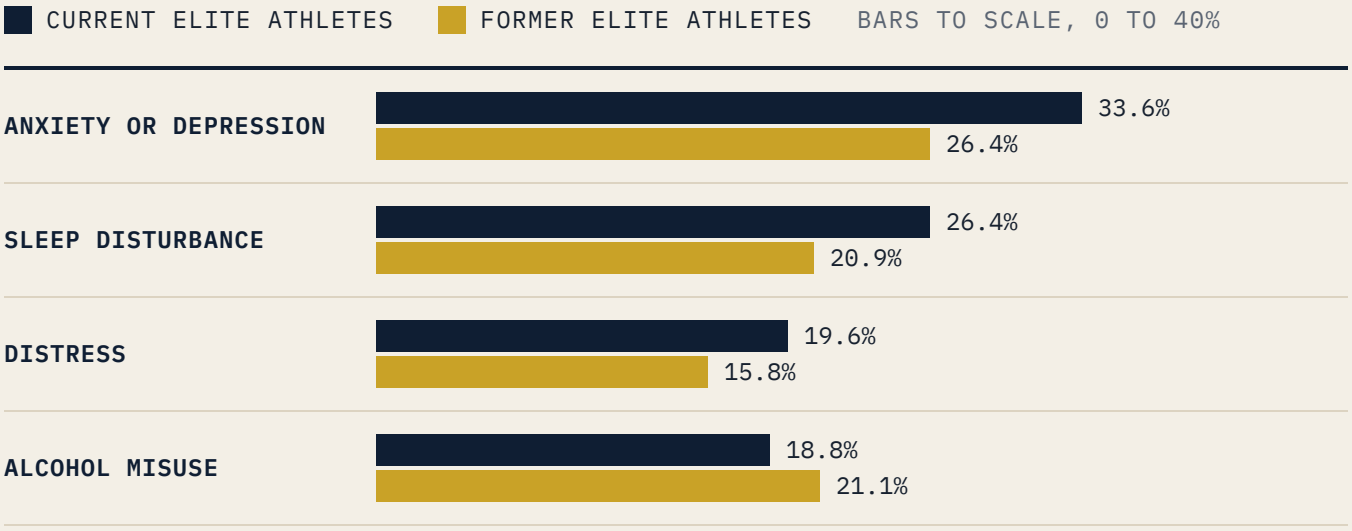
META-ANALYSIS · 22 + 15 STUDIES

THE NUMBERS

1 in 3

current elite athletes report symptoms of anxiety or depression[11]

Gouttebarge and colleagues pooled studies of professional and Olympic athletes for the 2019 IOC consensus meeting: 22 studies of current and 15 of former elite athletes. Fitness and success did not confer immunity.[11]



READ WITH THEIR LIMITS

Mostly self-reported symptoms and cross-sectional designs, very high heterogeneity, male team-sport samples and no matched controls. The authors judged rates broadly similar to, possibly slightly above, the general population.[11]

THE INSTRUMENT MOVES THE ANSWER

Among 2,758 NCAA Division I athletes screened from 2020 to 2023, 21.0% screened positive for sleep difficulty, 14.5% for alcohol use, 11.6% for depression and 7.7% for anxiety.[12]

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RETROSPECTIVE COHORT · 1,102 DEATHS

Suicide is a rising share of college athlete deaths

11.6%

of 1,102 NCAA athlete deaths from 2002 to 2022 were suicides

7.6 › 15.3%

suicide's share of all deaths, first decade compared with second

2nd

most common cause of death over the last decade, after accidents

Whelan and colleagues reviewed every identified NCAA athlete death over 20 years. Suicide incidence rose linearly in men (five-year incidence rate ratio 1.32), rose in women after a low around 2010 to 2011, and was highest among male cross-country athletes.[13] No mandatory reporting system exists, so these are likely undercounts. Context matters: an earlier nine-year analysis found 0.93 suicides per 100,000 athletes per year, lower than in peers of similar age.[14] I read the two together this way: athletes are not a uniquely high-risk group, the trend is moving the wrong way, and team structure can vanish in a single step with injury, being cut or retirement.

Sport adds its own stressors

The questions I add to every standard history.

01 Severe injury, surgery and long rehabilitation[11]

02 Concussion: associated with depressive symptoms, causation not established[15]

03 Involuntary retirement and poor planning[11]

04 High athletic identity and maladaptive perfectionism[11]

05 Psychological, physical and sexual abuse and harassment[16]

06 Low energy availability, which affects mood and bone[17]

07 Night games, early training and time-zone shifts[11]

08 Every performance judged in public and online[4]

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CHAPTER 03

ASSESSMENT

Performance is often the chief complaint.

Athletes rarely open with “I am depressed.” They arrive, or are sent, because performance has changed. The IOC consensus makes two points I repeat to every team: mental and physical health cannot be separated, because symptoms raise injury risk and slow recovery, and diagnosis must separate traits that serve elite sport, such as drive, perfectionism and pain tolerance, from genuine maladaptation.[4] Expect minimization from anyone afraid of losing a roster spot, scholarship or contract.

WHAT YOU HEAR	WHAT MAY BE UNDERNEATH
“I’m in a slump.”	Depression or an anxiety disorder
“I lost my feel.”	A sleep or circadian rhythm disorder
“My body is off.”	Alcohol, cannabis or other substance use
“I just need sleep.”	Energy deficiency or post-concussive symptoms
“Coach doesn’t trust me.”	Adverse effects of stimulants or supplements

Rule out before you rule in

Consensus-informed and coordinated with the team physician; not a validated protocol.

- ☐ TSH, CBC with ferritin, metabolic panel
- ☐ Vital signs and weight trend
- ☐ Menstrual history and energy deficiency screen
- ☐ ECG before stimulants or QT-prolonging drugs when cardiac risk is present
- ☐ Concussion history and current symptoms
- ☐ Snoring and sleep apnea risk in larger athletes
- ☐ Supplements, pre-workouts and caffeine
- ☐ Nicotine pouches, snus, anabolic steroids

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CONSENSUS STATEMENTS

The differential sport creates

This is the differential I find most useful and least taught. The three overlap, can co-occur, and are managed differently.

	OVERTRAINING SYNDROME	MAJOR DEPRESSION	ENERGY DEFICIENCY (REDS)
CORE	Maladaptive response to training load	Pervasive mood disorder	Problematic low energy availability
PERFORMANCE	Decline that persists for months despite rest	May fall; unrelated to training load	Falls; injury and bone stress risk rise
MOOD	Disturbance common, often load-linked	Anhedonia beyond sport, guilt, possible suicidal ideation	Mood symptoms; disordered eating may coexist
HOW TO SORT	Diagnosis of exclusion after training and medical review	Symptoms outside sport; PHQ-9 and interview	IOC REDs assessment tool; nutrition and menstrual history

Meeusen R, et al. ECSS and ACSM consensus, 2013[18] · Mountjoy M, et al. IOC REDs consensus, 2023[17]

IOC TOOL · MODIFIED DELPHI

The IOC screening pathway

The SMHAT-1 is built for athletes 16 and older at the professional, Olympic, Paralympic or collegiate level. Its companion, the SMHRT-1, helps coaches, family and teammates recognize symptoms and refer.[6]

1

Triage

Athlete Psychological Strain Questionnaire (APSQ), 10 items, positive at 17 or higher

Negative: no further screening

→

2

Six screens

GAD-7, PHQ-9, ASSQ (sleep), AUDIT-C, CAGE-AID, BEDA-Q (eating)

Negative: brief intervention

→

3

Clinical care

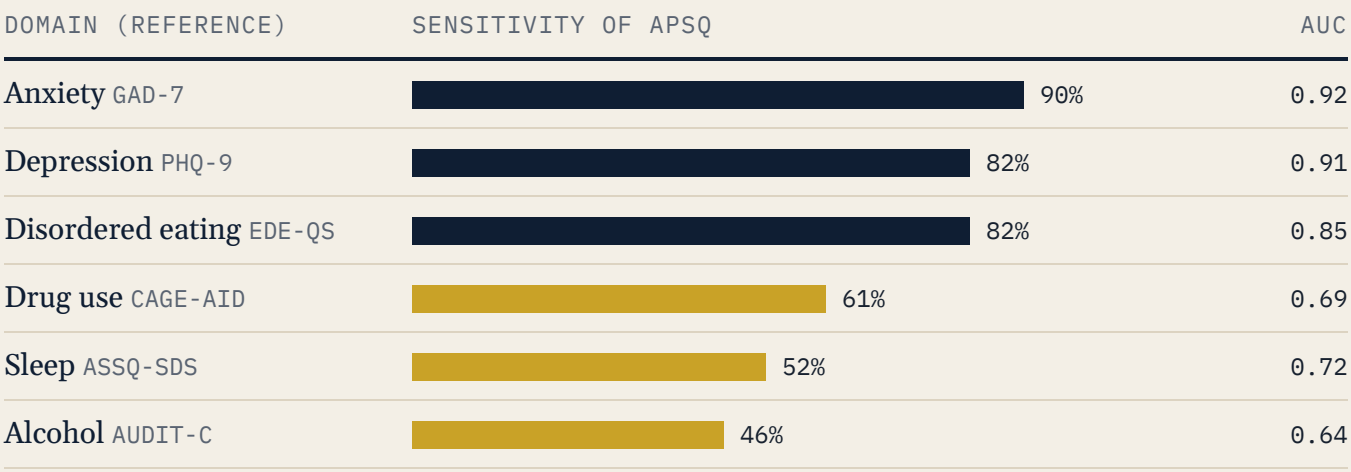
Assessment and management by a sports medicine physician or licensed mental health professional

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CROSS-SECTIONAL · N = 2,758

Triage catches mood and misses sleep and alcohol

Against each disorder-specific screen, the APSQ was very good for anxiety and depression and weak for sleep, drug use and alcohol. It has no suicide item, yet 3.1% of the same athletes endorsed suicidal ideation on PHQ-9 item 9.[12]



Whelan BM, et al. Br J Sports Med. 2026. Reference standards were other screens, not clinical diagnoses.

PRACTICAL FIX

Keep the APSQ for its brevity and always add PHQ-9 item 9 plus brief sleep and alcohol questions. A negative triage starts the conversation.

Six additions to the standard interview

A full psychiatric evaluation plus a sport history, the core of Kamm's sport psychiatry examination.[19]

Sport context

Level, position, minutes, contract or scholarship, season phase

Body and load

Training load, injuries, concussions, weight cutting, eating

Substances

Supplements, caffeine, alcohol pattern, cannabis, nicotine, steroids

Rules and testing

Who tests this athlete, and does an exemption already exist?

Identity

Who are you outside your sport, and what comes after it?

Information flow

Who referred, who expects updates, what will the athlete share?

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CHAPTER 04

TREATMENT

Athletes should receive the same evidence-based treatments as everyone else, adapted for schedules, physical demands and rules.[4] Psychotherapy trials in athletes are sparse and largely anecdotal, so our confidence rests on general-population evidence;[20] I keep therapy brief and skills-based, and I start or change medications in the off-season or practice weeks when I can.

THREE QUESTIONS BEFORE EVERY PRESCRIPTION[21]

1 **Could it impair performance?**
Sedation, weight gain, tremor, slowed reaction time, heat intolerance.

2 **Could it enhance performance or break a rule?**
Anti-doping status, therapeutic use exemption, league or NCAA policy.

3 **Could it harm this athlete in this sport?**
Cardiac effects in endurance sport, heat illness in August, sedation around collisions or heights.

What sports psychiatrists reach for first

SURVEY · N = 75

CONDITION	MOST COMMON FIRST CHOICE
Depression without anxiety	**Bupropion**
Depression with anxiety; generalized and social anxiety	**Escitalopram**
OCD, panic disorder, PTSD	**Sertraline**
Insomnia	**Melatonin** (off-label; a supplement in the US)
ADHD	**Methylphenidate ER (OROS)**
Bipolar, manic phase; psychotic disorders	**Aripiprazole**
Bipolar, depressive and maintenance phases	**Lamotrigine**

Reardon CL, et al. 2025.[22] Preferences of 75 psychiatrists who treated athletes; no comparative efficacy trials exist.

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POLICY · CURRENT AS OF NOVEMBER 2026

First question: who tests this athlete?

The moment you prescribe to someone who competes, rules apply that most of us were never taught, and they differ by who governs the athlete.

WADA CODE	PRO LEAGUES	NCAA
Olympic and international sport. A therapeutic use exemption is required for prohibited medications.	Collectively bargained programs with their own lists and approval processes.	Banned-drug classes, with medical exception documentation held by the school.

Stimulants

PROHIBITED IN COMPETITION

Under the Code, a TUE supported by a documented diagnosis.[23] The NCAA file includes the diagnostic evaluation, collateral information such as rating scales, dose history, non-banned alternatives tried or the reason not, and a follow-up plan.[24]

Beta-blockers

PROHIBITED IN PRECISION SPORTS

In competition in automobile, billiards, darts, golf and mini-golf; in and out of competition in archery, shooting and underwater sports.[23] Elsewhere permitted, but evidence does not support routine propranolol for anxiety disorders.[25]

Bupropion

MONITORED, NOT PROHIBITED

On the 2026 Monitoring Program for in-competition use, which means its use is tracked.[23]

Supplements

STRICT LIABILITY

Athletes answer for whatever is found in their bodies, and contaminated products cause positive tests.[26] Third-party certification lowers the risk without removing it.

BEFORE YOU WRITE THE PRESCRIPTION

- ☐ Check status on Global DRO (globaldro.com), the league policy or the NCAA list.
- ☐ File the exemption or medical exception before competition, never after a positive test.
- ☐ When efficacy is similar, choose the weight-neutral, non-sedating option.

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THE ATHLETE IS THE PATIENT

The team may be your employer, your payer and your referral source at once, with a legitimate interest in whether a player can play on Saturday. Your duty of care still runs to one person. Glick and colleagues' 2012 review offers practical guidance along these lines that I give to every trainee who works with a team.[27]



FOUR PRACTICES THAT PROTECT EVERYONE

1. **Disclose your role at the first visit**
   Who pays you, who you report to, and what you will and will not share.

2. **Put consent in writing**
   Name what is shared, with whom and why; know the collective bargaining agreement and team policy first.

3. **Make return to play a joint decision**
   Decide with the team physician, and include the athlete.

4. **Name the pressures out loud**
   Quick clearance, contract timing and fandom are predictable forces, and VIP status should never lower the standard of care. With minors, agree with the family in advance what the coach and school will hear.

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CHAPTER 06 · COMPOSITE CASE, DETAILS CHANGED

J.R., CLUTCH TIME

PATIENT
24, professional guard

CONTEXT
Contract year; back 3 weeks from ankle sprain

SLEEP
4 to 5 hours after games and flights

MEDICATION
Amphetamine XR, plus a self-added afternoon IR dose

APSQ
15 (cut-off 17)

His shooting has fallen off for six weeks and he is missing free throws late in close games. He drinks “to come down,” feels replaceable, is irritable with teammates and denies depression.

The general manager calls: “Is he okay? Can he play Saturday?”

QUESTION 1

What is the differential?

Insufficient sleep and circadian disruption, a self-added stimulant dose worsening insomnia and anxiety, alcohol used to come down, and post-injury depression or adjustment disorder. Check iron studies and thyroid function, and ask about head impacts.

QUESTION 2

Is he cleared by a negative triage?

No. Against reference screens, the APSQ caught 52% of positive sleep screens and 46% of positive alcohol screens, and it never asks about suicide.[12] Add PHQ-9 with item 9, GAD-7, a sleep screen and AUDIT-C.

QUESTION 3

What can the team hear?

With his written consent, availability and any restrictions. Diagnosis, history and therapy content stay private unless he agrees or safety requires otherwise, and I tell him that at the first visit.

QUESTION 4

What would you prescribe?

Subtract first: stop the extra dose and re-time the stimulant within league rules and any exemption, build a sleep and travel plan, and address the alcohol. For depression with anxiety, escitalopram is the most common first choice;[22] I hold bupropion while he drinks heavily.

Performance should recover if we treat him well, but his health is the outcome I measure.

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FINAL BUZZER

SIX THINGS TO USE TOMORROW

1. **A young, defined field** with a 2024 consensus and no ABMS certification yet.
2. **Fitness does not protect,** and suicide is a rising share of college athlete deaths.
3. **Falling performance is the chief complaint:** rule out energy deficiency, iron, thyroid, concussion and substances.
4. **Screen with athlete tools,** then add suicide, sleep and alcohol.
5. **Three questions before every prescription:** impairment, enhancement or rules, sport-specific harm.
6. **The athlete is the patient.** Set the information rules before the first crisis.

Bookmark: sportspsychiatry.org · IOC SMHAT-1 and SMHRT-1 · NCAA Sport Science Institute · globaldro.com · 988 Suicide and Crisis Lifeline (call or text 988)

GO DEEPER

THE CLUTCH TIME CLINICAL FIELD GUIDE

The reference I wish I had when I started treating athletes.

Prescribing, class by class
Including the heat, hydration and lithium data most clinicians have never seen

Anti-doping, step by step
Exemptions, NCAA files, league programs, cannabis and supplements

Special populations
Youth, women and REDs, concussion, retirement, performers

Ethics and systems
Consent elements, emergency plans, licensure on the road

Four worked cases
From a college distance runner to a touring musician

Clinic-ready tools
Sport history, pre-prescription checklist, travel sleep plan

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QUESTIONS OR CORRECTIONS · CONTACT@DRMIRHOM.COM

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