The promise of mental health and well-being in elite and professional golf
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Introduction

Participation in sport is often promoted on the basis of the physical and mental health benefits it provides (Paluska and Schwenk, 2000). Such reasoning, Bär and Markser (2013) suggest, may underlie an assumption that individuals who compete at the highest levels in sport will be immune to mental illnesses. The suicides of German national goal-keeper Robert Enke in 2009, and Wales’ most capped footballer and national team manager Gary Speed in 2011, are two incidents which reveal this assumption to be flawed. Enke’s death was followed by news that for some time he had been receiving treatment for depression. That few people knew about this is an illustration of how mental illness within sport is shrouded in silence.

Silence around mental illness is just one of the challenges likely to face an athlete struggling with mental health difficulties. Others include; clinicians who may not understand diagnostic and therapeutic issues unique to sport (Reardon and Factor, 2010), lack of interest, care, provision and support from governing organisations and stigma and discrimination (Schwenk, 2000). Further, stress and anxiety surrounding competition, a loss of autonomy due to the typical policing policies associated with contemporary high performance sport, along with lifestyle challenges unique to sport, may increase athletes’ susceptibility to mental illnesses (Reardon and Factor, 2010). Reflecting on these issues Schwenk (2000, p. 4) notes:

“The current conceptualisation of, and approach to mental illness in athletes is fraught with stigmatisation, denial, and dichotomous paradigms of ‘psychological’ versus ‘physical’ disease, which are inaccurate, unhelpful, and deprive the athlete of effective care”.

A number of high profile sports people have recently began to talk publically about their experiences of serious mental illnesses (for example, boxer Frank Bruno, New York Jets receiver Brandon Marshall, gymnast Gloria Viseras and golfer David Feherty). It seems timely therefore that in golf, like other sports, we begin to become more educated and aware about mental illness, understand the risks to mental health in high performance sport, and begin to challenge stigma and discrimination in our ‘back-yard’.

In this chapter, therefore, we would like to draw attention to how mental health and well-being can be compromised in pursuit of sporting excellence. With a better understanding we hope that it becomes possible to identify and adopt strategies that support the positive mental health and well-being of golfers.

Mental health, mental illness and well-being

A number of contrasting perspectives and definitions exist within the literature concerning mental health, mental illness and well-being. Mental illness is a serious
health condition commonly studied within the discipline of psychiatry, and refers to a range of disorders that include bi-polar disorder, schizophrenia, attention-deficit hyperactivity disorder (ADHD), post-traumatic stress disorder (PTSD) and clinical depression (Dodge et al., 2012). Mental health and illness have traditionally been portrayed as existing along a continuum with mental health referring to an absence of illness, as illustrated below:

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Mental health ← Mental illness
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More recently, it has been suggested that an individual who has been diagnosed with a mental illness (for example, clinical depression, a mood disorder or schizophrenia) can also, at the same time, experience positive well-being (Davidson and Roe, 2007). This understanding has given rise to mental health and illness, and mental well-being and loss of well-being existing on different continuums, as illustrated below:

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Mental health ← Mental illness
Positive well-being ← Negative well-being
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This conceptualisation allows for the possibility that a person can live with or manage a mental illness, and achieve or maintain positive levels of well-being despite their diagnosis. This fits with definitions of mental health which we have found helpful in our own work, such as the following:

“the emotional and spiritual resilience which enables us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well-being and an underlying belief in our own and others’ dignity and worth” (Department of Health, 2003, p.8).

*Well-being*, for Pollard and Lee (2003, p. 60), is “a complex, multi-faceted construct that has continued to elude researchers”. In part, this is down to ‘wellness’, ‘well-being’ and ‘health’ being used interchangeably and secondly that “what it means to be mentally healthy is subject to many different interpretations that are rooted in value judgements that may vary across cultures” (USDHS, 1999, p.5). Definitions of well-being include:

“a global assessment of a person’s quality of life according to his own chosen criteria (Shin and Johnson 1978, p. 478).
“A measure of life satisfaction consisting of three interrelated components ‘life satisfaction’ (a cognitive awareness of satisfaction with life) along with, ‘pleasant’ and ‘unpleasant’ affect (meaning moods and emotions)” (Diener and Suh 1997, p. 200).

In the development of more accurate terminology well-being has, in different eras, included the ability to fulfil goals and experience life satisfaction (Foresight Mental Capital and Wellbeing Project, 2008), and to maintain homeostasis while responding to challenges (Cummins, 2010). Recently Dodge et al., (2012) described well-being as a state where an individual has the psychological, social and physical resources to meet the challenges. Using the analogy of a see-saw, if an individual has the resources
to meet psychological, physical or social demands then the individual’s well-being is in a state of equilibrium. However, when demands (or challenges) outstrip resources, well-being dips.

An additional important consideration is the distress that can experienced due to stigma that is associated with mental illnesses. Critically, stigma and discrimination are sociocultural forms of oppression, located in others rather than the person diagnosed with a mental illness. Thus, no medical ‘treatment’ can eradicate stigma or discrimination – the required change is societal. In recognition of this, the mental health charity MIND have called on sport organisations to instigate policies and practices to challenge stigma and discrimination more vociferously, as these issues lie beyond the control of the individual athlete.

Mental illness in sport

In their review of mental illness and diagnosis among athletes, Reardon and Factor (2010) note that the most frequently diagnosed mental illnesses among athletes are clinical depression, overtraining syndrome, and eating and mood disorders. We provide an overview of these below.

Clinical depression (also referred to as major mood disorder) refers to depressed mood and loss of interest or pleasure in daily activities that occurs for more than two consecutive weeks (American Psychiatric Association, 2013). In current times, clinical depression is typically treated with medication, yet there are increasing concerns over the dominance of pharmacological interventions. The ‘biopsychosocial model’ (Engel, 1978) makes the case that because biological, psychological and social factors can all contribute to the development of a mental illness, an interdisciplinary approach is required to support recovery. A less expected depressive disorder found among athletes is grief, experienced by up to 10–20% of athletes, which mirrors the response to bereavement, and has resulted in attempted suicide and warranted clinical intervention (Walker et al., 2007). As with overtraining, grief has been linked to the experience of losing, deselection and the transitional phase out of high-level sport (Carless and Douglas, 2009).

Overtraining syndrome describes an imbalance between the stress and recovery pathways effecting neurohormonal changes, the central nervous system, and

Figure adapted from Dodge et al. (2012, p.230)
mood (Lehmann et al., 1999) and is often linked with injury, losing, ageing, retirement from sport and increased training loads (Reardon and Factor, 2010). A challenge for practitioners is the difficulty of distinguishing overtraining syndrome from other mood disorders (such as depression and bi-polar disorder) due to the many similarities. The lack of differentiation, Schwenk (2000) notes, can lead to an increased risk of misdiagnosis:

“the stigmatisation of and denial by athletes with OT, similar to the behaviour of patients with clinical depression, are preventing sports doctors and scientists from a proper study and treatment of overtrained athletes.”

(Schwenk 2000, p. 4).

Diagnostic challenges also exist in distinguishing overtraining syndrome from burnout. Research into burnout in sport has been heavily influenced by research within occupational settings where Schaufeli and Enzmann (1998, p. 36) defined burnout syndrome as:

“a persistent, negative, work-related state of mind in ‘normal’ individuals that is primarily characterized by exhaustion, which is accompanied by distress, a sense of reduced accomplishment, decreased motivation and the development of dysfunctional attitudes and behaviors at work.”

In sport, burnout is regarded as a multidimensional syndrome incorporating energy depletion, depressed mood, and exhaustion, yet, unlike overtraining syndrome the symptoms usually include a devaluation of sport and a sense of reduced accomplishment (Gustaffson, 2007).

To our minds, the symptoms and experiences of overtraining and burnout are very similar. It seems the main difference between the two is the types of research they produce. For example, research exploring overtraining syndrome has tended to focus on symptoms of maladaptive physiological training responses, whereas research exploring burnout has focused more on the psychosocial precursors of exhaustion and depressed mood which include loss of agency, and social and familial pressure to excel (Gustaffson, 2007). Coakley (1992), for example, theorised from his research that coupled with competitive stress, burnout is in part due to the way sport is socially organised resulting in the individual losing agency.

Given that many athletes treat their sport as ‘work’ and are often encouraged to respond to setbacks, poor performance or deselection by increasing training and commitment, it is unsurprising that researchers in the areas of both overtraining and burnout report athletes to be affected. Peluso and deAndrade (2005) reported that overtraining affects between 20 and 60% of athletes, with distance runners being most affected, while Cresswell and Eklund (2007) suggested 10% of athletes to be affected by burnout.

Eating disorders refer to a range of pathologies that include anorexia (refusal to maintain minimal body weight) and bulimia (episodes of binge eating followed by compensatory behaviours such as fasting, self-induced vomiting or excessive exercise). While some research suggests eating disorders affect 10% of elite athletes – and in high intensity sports up to 17.2% for males and 32% for females (Sundgot-Borgen and Torstveit, 2010) – other research among male rowers and wrestlers has reported much lower levels (Hausenblas and McNally, 2004), with prevalence similar between males and females (Thiel et al, 1993).

In sports where weight, aesthetic appearance, and/or a lean body mass are considered important (such as women’s gymnastics, swimming and distance running), Smolak et al (2000) suggests there is an elevated risk of developing an eating disorder. Elevated risks of eating disorders have also been linked with the intense scrutiny that
Mental health and well-being in sport

Moving beyond the most frequently diagnosed mental illnesses among athletes identified by Reardon and Factor, mental health and well-being are also issues of considerable importance. For example, athletes who create and sustain a strong or exclusive athletic identity (Brewer et al, 1993) appear to be at greater risk of mental health problems. Although developing an athletic identity can result in greater adherence to training, improved motivation and expanded social networks (Horton and Mack, 2000), research suggests a strong and exclusive athletic identity frequently leads to under-developed career and lifestyle planning, and emotional and psychological distress upon withdrawal from sport (Douglas and Carless, 2015; Murphy et al, 1996; Stephan et al, 2003).

Understanding identity development and mental health;
The role of narrative theory.

Narrative theory has made an important contribution to better understanding the links between identity development and mental health illustrating how the process is sociocultural as well as individual (Crossley, 2000). Narrative theory shows how creating and sharing stories about one’s life and self makes it possible not only to create and develop an identity, but also for others to recognise and validate that identity. Validation brings acceptance, and an opportunity to become a valued member of one’s community (Bruner, 1986; Crossley, 2000; McLeod, 1997).

This being the case the opposite can also occur – that is, some stories may be rejected, disbelieved, or devalued, and the individual silenced, shamed and/or stigmatised. In narrative terms risks to mental health are most likely when (a) stories and actions do not align, (b) when a story cannot be told or shared for fear it would bring shame, (c) when the individual’s story runs counter to what is expected and valued and, (d) when the individual has no means to communicate their experiences.

These processes have been illuminated through an analysis of narratives (Carless and Douglas, 2013a, 2013b; Douglas and Carless, 2006a, 2015) which showed there to be three different narratives in elite sport: the performance, discovery and relational narrative types. The first-the performance narrative-is a story of single-minded dedication to sport performance where winning is valued above all other aspects of sport and life. The second-the discovery narrative—is the antithesis to the performance narrative revealing it is possible to reach the very top of sport without sacrificing interests, relationships or a multidimensional identity and sense of self. The third type-the relational narrative-has as its axis the people who the individual makes the journey with, and the special bonds that are possible through sport.

For athletes whose lives align with the performance narrative, life is commonly described as a ‘rollercoaster’ as self-worth and mental well-being rise and fall with success and failure. For these athletes, who tell a ‘winning is everything’ story, emotional trauma ensues when they are no longer able to sustain their winning identity and story (such as after injury, deselection and retirement). In longitudinal research (Douglas and Carless, 2015) participants whose lives aligned with the performance narrative all experienced a loss of mental health following retirement from sport, which included feeling worthless, depression, emotional and...
psychological trauma, and in one case attempted suicide.

The dominance of performance stories has consequences for athletes whose lives align with the discovery or relational narrative. Within sport contexts these individuals have their lives, values and actions judged from the perspective of the performance narrative where they are expected to change their stories (and the actions that go with them) to performance outcomes – i.e., winning – as their priority. The process of denying what is valued (such as a relationship, faith or desire to explore) is likely to elicit emotional distress, risks mental health and well-being (see Carless and Douglas, 2015). However, for these individuals no transitional difficulties were observed during retirement or withdrawal from sport.

Mental illness among golfers

“‘There are advantages to having a mental illness. You know, I tell people I don’t suffer from bipolar disorder, I live with it.’ (golfer David Feherty, cited in Bonner, 2015)

Having outlined some of the ways mental health and well-being have been conceptualised in sport, we now turn to research among elite and professional golfers. It is difficult to gain an accurate picture regarding the prevalence of mental illnesses given there have been no scoping studies to establish pervasiveness. Further, given that stigma and discrimination act to silence those who develop a mental illness, seldom do people talk about it publically. An exception is former European tour golfer David Feherty (cited above), who has spoken about his alcohol and pain-killer addictions, and about his depression and bi-polar disorder. In the course of doing so he also hints that ‘others’ frequently ‘story’ mental illness as something that is ‘suffered’. This is likely to invite negative responses or even pity, as opposed to the less stigmatising way David Feherty states that he ‘lives’ with it.

While research among golfers is necessary to gain a better understating about both prevalence and support strategies, research among elite and professional female tour golfers has provided some insights into the links between playing golf at the highest level and the onset and development of depression and bi-polar disorder. This research also documents attempted suicide and self-harming, and some of the contributing factors to these behaviours, which include sexual abuse and rape, sexual bullying, and the negative and traumatic aspects of motherhood (Carless & Douglas 2009; Douglas & Carless 2015).

Alongside the above, the longitudinal methodology made it possible to document the recovery processes using the examples of two tour players, Bernie and Debbie (Douglas & Carless, 2009a, 2015). These cases illustrate a point Schwenk (2000) made regarding the difficulty of gaining an accurate diagnosis when ‘mood swings’ (joy to sadness) are common and expected responses to winning and losing and the expectations within sport culture where requires an athlete needs to ‘look’ ‘hurt’, shameful’ or ‘devastated’ after losing, or risk being accused of ‘not caring enough’ (Douglas & Carless, 2015). Such was the case for Debbie, who was diagnosed initially with post-natal depression by her general practitioner. Later, and only after she had tried to commit suicide, was she diagnosed with bi-polar disorder which required psychiatric intervention and sectioning (under the United Kingdom 1983 Mental Health Act), followed by medication and counselling support. Bernie, the second female tour player, successfully negotiated a return to mental health without clinical intervention, but before leaving the tour disclosed feelings of
worthlessness and unexplained physical health issues (Douglas and Carless 2009a, 2015).

A number of factors were essential for recovery. Firstly, each woman needed protection (in the form of asylum) from the expectations and values of those in golf culture (where what is valued is winning and being competitive). Secondly, each required a significant period of time away from this culture, along with access to alternative activities in order to develop a different life story. Through taking on different (non-golf related) roles and activities each woman too was able to rebuild a different yet valued identity and a sense of hope about the future (Douglas and Carless 2009a, 2015).

These studies reveal that through ‘doing’ and ‘talking about’ non-golf related activities, and having them validated by others, an individual has the potential to expand their identity repertoire in ways that maintain mental health.

Given most practitioners in sport are very positive about the benefits of sport participation Reardon and Factor (2010) ask us to hold in mind that the development of a mental illness may come about, or be exacerbated by, participation in high performance sport. We see this evidenced in several of the women in the above research where playing golf was implicated in self-harming, cheating, or the onset of depression and bi-polar disorder. Alongside this, Reardon and Factor (2010) also make the point that performing at this level may have nothing to do with the development of a particular mental illness and, further, that playing golf at a high level may be a way to cope with a mental illness.

Mental health and well-being among elite and professional golfers

The majority of research in golf has, as its focus, some aspect of performance enhancement –such as peak performance (Cohn, 1991), athlete development, or factors leading to performance decrement (Hill et al., 2010). Thus mental health and well-being are typically only considered in terms of their effect on performance. For example, Cotterill et al (2010) note that stress has a potentially debilitating effect upon preparation and performance which is perhaps why a great deal of golf research investigates some dimension of stress. Examples include choking (Hill et al, 2011), the use of pre-shot routines (Cotterill, et al., 2010), effective and ineffective coping strategies (Nicholls et al., 2010) and perfectionism (Kang et al., 2016). These studies reveal stressors in golf, like other sports, are complex and multifaceted, but mental health and well-being beyond the performance environment has not been addressed.

Other areas of research that have explored dimensions of mental health or well-being in elite golf include research into transitions and burnout. Factors that facilitate successful transition among tour players include the ability to meet financial challenges and having the motivation and desire to be successful (Douglas, 2004; Pitkanen and Toms, in press). A common theme among both tour players and amateur elite golfers is receiving psychological and emotional support from family, friends and coaches (Hayman et al, 2014). Important as it may be to have parental support, few studies have examined tensions or problems within these parent/athlete relationships. For example, when parents ‘take-over’ roles and responsibilities from young people (to allow a young person to dedicate their time to sport) it can result in the young person failing to develop important life skills. When family, officials or coaches rigorously police behaviour and training, it can reduce opportunities for self-discovery and self-direction. Other problems arise when family members place undue expectations on the golfer. Hayman et al.’s (2014) research illustrates that despite
these threats to well-being, parents and youth golfers had no understanding or awareness about the risks to mental health associated with an exclusive athletic identity and performance narrative. Without recognition and awareness of these potential hazards young golfers remain at risk.

Research has documented both supportive and problematic aspects of relationships. For example, when expectations of close relatives exert extreme pressure it can lead to the individual attempting to remove themselves from the competitive environment by what ever means possible- including cheating by purposefully playing badly. These types of actions have been illustrated in two multiple-winning female tour golfers. The first, during the World Amateur Team Championships, and the second, in an important season ending professional tournament (see Douglas, 2004; Douglas and Carless, 2015). In both cases, cheating brought a degree of agency. In one case, the golfer had self-harmed for several years, yet this was undetected by family members, coaches or other officials.

The above research also showed different ways governing organisations can respond (see Douglas & Carless, 2015). Schwenk (2000) suggested governing organisations often show a lack of care and support for athletes. When the above research was presented at a conference representatives from the English Golf Union (EGU) and English Ladies Golf Association (ELGA) wanted to identify the young golfer, yet showed no interest in her well-being, or what may have caused her to self-harm and cheat, thereby avoiding interrogating the potential role of golf culture. In contrast, when the research was presented in Holland, Dutch Golf Federation officials wanted to explore ways to change the culture within golf in their country to minimise the risks of self-harming and cheating.

Along with stress, burnout (as defined earlier) has been examined amongst women golfers of the Korean Ladies Professional Association (KLPGA), non-tour members (Kang et al., 2016) and among college students (Cohn, 1990). These studies suggest pre-curser of burnout were anxiety and self-doubt, and associated with the demands of competition and relationship. Like the research above, a common source of stress for all participants was striving to meet self-expectations, and those of parents and coaches.

Loss of well-being, exhaustion and burnout, emotional and psychological stress (such as sexist behaviour) have been explored through a number of autoethnographies (Douglas 2009, 2014a, 2014b, 2014c). Here, the aim was to take the reader behind the scenes of high performance golf using a storytelling methodology, thus providing unique insights into the ‘lived experience’ of an elite amateur and tour professional. These stories at times run counter to what is expected in high performance sport. For example, preparation for competition is typically storied as ‘training’, repetitive, demanding, arduous ‘hard work’ that often increases stress (e.g., Cohn, 1991; Crosset, 1995; Therberge, 1980). In contrast, these studies show it possibly for preparation to be storied as ‘play’ even at the professional level—and as something that can be joyous, fun, and creative, when an individual has agency and autonomy (Douglas 2009, 2012).

Implications for the game

In the previous sections we identified some of the risks and threats to mental health and well-being for golfers. One of the risks identified was developing an exclusive athletic identity or performance narrative. In this regard the research made the case that others (parents, coaches, relatives, performance directors and fans) play an
important role in either contributing to the development of a performance narrative or equally can contribute to the development of a discovery or relationship narrative type. One implication of this relates to the responsibility ‘others’ have to invite conversations and stories about non-golf related activities, as these legitimise and value alternative actions, behaviours and stories upon which the building blocks of a multidimensional identity are established. That is, if we ask questions about non-performance related things (such as, the countries visited, people, politics, food, fashion, or wine) it demonstrates these ‘other things’ are important, of interest to us, valuable activities, and that time invested in them is well spent. Over time, it is these types of actions (and the opportunity to have them validated through sharing stories) that helps develop ‘the person’ as opposed to ‘the golfer’ and makes the telling of discovery stories possible. Those golfers who had a multidimensional identity were less effected by poor performances, losses and transition, yet performed equally well. In contrast, if members of golf clubs, journalists, researchers, coaches, and relatives only ever ask the golfer about performance related issues (such as how did you do, what’s the next event, how did you play that shot) it demonstrates that these things are only what is valued and of worth. It is likely in doing so the golfer will continue to feel their self is on the line every time he or she steps on the golf course, and that during performance dips it is the whole ‘self’ that is failing and losing and not just one aspect of life, and that the self that is valued is lost at retirement.

A second implication of the research cited above relates to the limited awareness about mental health, mental illness and mental well-being within golf culture, and the recognition that stigma silences people. In this regard governing organisations might play a more central and active role in informing and educating the golfing community (and especially performers, parents, selectors, and coaches) about what mental illness is and the different ways it can develop. Education of this type can pave the way for golfers who are experience a loss of mental health to begin to share their concerns or feel able to ask for help when facing difficulties.

We would like to conclude with some suggestions to give impetus to these developments.

Summary and future directions

Taken together the research presented above shows that mental illness is something any of us might experience. It also showed that should we become unwell, we will cope more effectively if others around us are informed and supportive. When others are informed and educated it opens the way to talk more candidly without fear of oppression and stigma. The research presented also revealed the fragile nature of mental well being and the many factors that threaten positive mental health. In light of these severe consequences of mental health problems for individuals and their families outlined above, it seems greater attention needs to be paid to ‘early warning’ signs of mental health problems among golfers of all ages and abilities. We would advocate that in the future increased specialist support (from mental health professionals such as counsellors, psychotherapists, and clinical psychologists) should be made available.

As mentioned above, stigma and discrimination can be traced to fear and ignorance of mental health and illness. Both are associated with an assumption that mental health problems are down to the individual, rather than being a collective responsibility we
all share. Overcoming stigma and discrimination will necessitate greater awareness, understanding, sensitivity, care and empathy for those who are, or may be experiencing mental distress.

A third area for future research relates to the absence of research which reveals how male golfer’s might experiences the development of a mental illness, or recovery, or symptoms of self-harming or cheating. By presenting only stories about female golfers it may misleadingly appear that it is only women who experience problems such as cheating, self-harming, heterosexism or homophobia, or abuse. Is it the case that male golfers do not share these experiences? Or is it the case that the research community has thus far been unable to support the telling and sharing of these types of stories among male cohorts? Recent studies (Douglas and Carless, 2012a, 2012b) show how researching taboo issues requires not only long term investments and close trusting relationships, but a different researcher/participant dynamic than is often the case in sport research. The use of innovative research methodologies may help overcome this hurdle.

Finally, too often, in our view, the horizon of interest amongst the research community is limited to performance enhancement. Under these conditions, ‘taboo’ issues – such as mental health and illness – will be unlikely to be voiced or witnessed. Broadening our horizon of interest in future research will move underexplored issues higher up the agenda.

References


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