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1 **A season long investigation into the effects of injury, match selection and training load on**

2 **mental wellbeing in professional under 23 soccer players: a team case study**

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28 **Key words:** Wellbeing; mental health; football; injuries; depression.

29 **Abstract**

30 This study examined the influence of injury, match selection and training load on mental wellbeing

31 (MW) in a squad of professional soccer players. Using a longitudinal design, twenty-five male

32 soccer players (age, 20 ± 1 years, height, 1.80 ± 5.79 m, body mass 76.33 ± 7.52 kg) from the

33 under 23 squad playing in the Premier League 2 division in the UK completed the Warwick-

34 Edinburgh Mental Well-being Scale (WEMWBS) each week of the 2017/2018 season (37 weeks

35 in total). Injury and non-selection for the match squad were the only significant predictors of MW

36 (P<0.05). Injury had the biggest influence on MW that was lower when injured vs. not injured

37 (43.6 ± 5.0 vs. 49.9 ± 3.5, respectively, $P = 0.001$, ES $= 1.48$), accounting for 40% of the variation

38 in MW. This increased to 50% when not being selected to play games was also considered. Weekly

39 training loads measured by GPS (total distance, sprint distance and total duration) and individual

40 player win rate did not influence MW ($P > 0.05$). These findings highlight the importance of

41 monitoring MW in professional soccer players and suggest that injured players and those rarely

42 selected for the match squad should be educated on the strategies available for managing their

43 mental health and wellbeing.

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51 **Key words:** Wellbeing; mental health; football; injuries; depression.

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Introduction

Recent studies have indicated that there is a high prevalence of mental health disorders amongst professional soccer players (Gouttebarge et al., 2015a; 2015b; Junge & Feddermann-Demont, 2016; Junge & Prinz, 2018). For example, in a study of over 500 professional male soccer players from Europe, 25-43% of players reported symptoms of anxiety and depression, 11-18% of distress, and 47-74% of adverse eating behaviors (Gouttebarge et al., 2015a). In a similar study from the same research group, in which the prevalence of adverse mental health disorders in 149 professional soccer players was assessed, 26% of respondents reported suffering from anxiety and depression related symptoms (Gouttebarge et al., 2015b). Similarly, high rates of mental health concerns, specifically anxiety disorders and depressive symptoms, have also been reported in professional female soccer players (Junge & Prinz, 2018).

Although the number of studies examining mental health in elite soccer players is still limited; especially in comparison to those assessing physical health (e.g., fitness levels and injury states) (Rice et al., 2016), the aforementioned findings suggest that the prevalence of mental health disorders might be greater in professional soccer than other sports (Gouttebarge et al., 2015b). These findings suggest that the daily pressures associated with their sport could be negatively affecting their mental health and wellbeing (e.g., ability to cope with stress, undertake daily tasks and contribute to their community and relationships positively; WHO, 2001). This highlights the need for a more concerted research effort to understand the causes and consequences of mental health problems in professional soccer players (Gouttebarge & Aoki, 2014).

Drawing on research across all sports it appears that physical challenges such as training load and injuries, and environmental factors such as low social support, major life events, match experience and career transitions are the main risk factors for developing mental health problems in elite athletes (Schinke et al., 2017; Rice et al., 2017; Junge & Prinz, 2018; Junge & Feddermann-Demont, 2016; Gouttebarge et al., 2015a; 2015b). Of these, injury is often singled out as having the greatest influence on an athlete's mental health and wellbeing (Pearson & Jones, 1992; Schinke et al., 2017). Indeed, a number of studies have found that injured athletes experience a sequelae of negative emotions associated with poor mental health, including frustration, depression, boredom, low mood, low self-esteem, and anxiety (Pearson & Jones, 1992; Leddy et al., 1994; Appaneal et al., 2009; Podlog et al., 2010).

90   Notwithstanding, there has been little attempt to examine the effect of injury or other potential risk

91   factors (e.g., high training loads and match selection) on mental health in professional male soccer

92   players (Gouttebarge et al., 2015a; 2015b Junge & Feddermann-Demont, 2016). Furthermore, the

93   studies to date have rarely considered the mental health of youth players, who might actually be at

94   a greater risk for developing mental health disorders than senior players (Junge & Feddermann-

95   Demont, 2016; Gouttebarge et al., 2015b; Schinke et al., 2017). Additionally, none of the studies

96   to date have employed a longitudinal design in which mental health was measured more than once

97   and where the players acted as their own control.

98   Consequently, the aim of the present study was to examine the influence of some common physical

99   and environmental stressors on mental wellbeing (MW) in a squad of professional under 23 soccer

100 players across a full season. We were specifically interested in the effects injury, training load,

101 match selection and match results had on MW throughout the season. While the effects of injury

102 have been investigated previously, no other studies have attempted to examine the effects of

103 training load and not being selected to play games on any aspect of mental health in professional

104 male soccer players. We hypothesized that injury, not being selected to play games and high

105 training loads would negatively affect the players MW.

106 **Methods**

107 *Participants*

108 Twenty-five professional male soccer players (see Table 1 for physical characteristics) competing

109 in the second tier of the under 23 championships in England took part in this study. Newcastle

110 University Ethics Review board granted ethical approval. All players provided written informed

111 consent for this study.

112 *Experimental procedure*

113 The players completed a questionnaire to assess MW on a weekly basis. The time of day (before

114 training ~09:30) and the day of the week this was completed on was kept consistent (Thursday)

115 throughout the study. This day of the week was selected because matches are typically scheduled

116 for a Monday evening, and therefore it was felt that the player's MW would be less influenced by

117 the preceding/upcoming match on this day. Nonetheless, we still analyzed the effect of match

118 result to see if this did in fact influence MW. The first questionnaire was completed on August

119   14th 2017 during pre-season and the last on April 23rd 2018 at the end of the season (37 weeks in

120   total). Figure 1 displays a longitudinal overview of the study timeline and the periodized training

121   program the players followed during the study.

122   An injury was defined as a period of being unable to complete at least 1 week of training (Appaneal

123   et al., 2009) and not being selected to play games was defined as being named in the match-day

124   squad of 16 players (11 outfield and 5 substitutions). This data was recorded by the Head of Sports

125   Science in conjunction with the medical team at the club. External load measures were calculated

126   from GPS units (OptimEye S5B, Version 7.18; Catapult Innovations, Melbourne, Australia) worn

127   during matches and training sessions (10-Hz GPS and 100-Hz accelerometer devices). Specific

128   data collected are displayed in Table 1, and include weekly training duration, weekly training

129   distance and weekly high-speed running distance. The mean number of satellites during data

130   collection was 16 ± 1, and mean horizontal dilution of position was 0.8 ± 0.1. Previous research

131   has suggested above 6 satellites are required for adequate data quality (Malone et al., 2017).

132   However following conversations with the manufacturer, data was excluded if the number of

133   satellites decreased below 12. If horizontal dilution of position was >1, data was excluded (Malone

134   et al., 2017). Catapult Sprint software was used for data analysis (Catapult Sprint 5.1.5, Catapult

135   Innovations, Melbourne, Australia).

136   *Mental wellbeing measure*

137   Mental wellbeing was assessed using the Warwick-Edinburgh Mental Well-being Scale

138   (WEMWBS). The WEMWBS is a valid and reliable measure of MW in the general population,

139   including young adults, and sensitive to change in response to interventions at the individual and

140   group level (Stewart-Brown et al., 2009; Maheswaran et al., 2012). It has also been used to evaluate

141   MW in several European populations, including the UK, and thus population norms were available

142   for comparison (Tennant et al., 2007; Stewarffft-Brown et al., 2009; Haver et al., 2015). The

143   WEMWBS has also been shown to be highly inversely correlated with psychiatric scales of

144   depression (Bianca, 2012; Zadow et al., 2017). Finally, it is short and freely available and therefore

145   easily accessible for sports clubs who may wish to use it with their athletes.

146   The WEMWBS consist of 14 positive statements about an individual's thoughts and feelings. In

147   the present study, we asked the players to score the questionnaire based on their thoughts and

148   feelings in the preceding 7 days. Each item is scored on a 1 – 5 Likert scale (1 = none of the time,

149   5 = all of the time); the minimum and maximum scores that can be obtained are 14 and 70,

150   respectively. A copy of the WEMWBS used in the present study is provided in the supplementary

151   material.

152   It is important to highlight that we chose to look specifically at MW as opposed to the psychiatric

153   scales favored by other studies, and this was for several reasons. Firstly, because MW, which is

154   concerned with feelings, functioning and life satisfaction, is closely associated with both physical

155   and mental health (Huppert et al., 2009; Stranges et al., 2014). Secondly, psychiatric scales used

156   to assess depression, anxiety and other adverse mental disorders tend to be negatively worded and,

157   when discussing mental health, it has been shown that individuals prefer to answer positively

158   framed questions (Bianca, 2012). Because the players were required to answer questions weekly,

159   we therefore felt that compliance would be higher with a MW questionnaire that contained

160   positively worded questions. Lastly, many psychiatric scales are hidden behind paywalls. We

161   wanted to test the utility of a freely available scale so that our study could be easily implemented

162   and replicated in the elite sporting environment.

163   *Data analysis*

164   All data analysis was performed with SPSS for Windows (SPSS version 24.0) and statistical

165   significance was set to $P < 0.05$ a *priori*. Normality was checked and considered normally

166   distributed if the Shapiro-Wilk test was $P > 0.05$. Individual win rates (win percentage from the

167   number of games selected for), match selection rate (percentage of matches selected for), time out

168   with injury (injury percentage from time at the club) and training load (weekly sum of duration,

169   distance and high-speed running distance) were calculated for each player and used as independent

170   predictors of average weekly MW (see Table 2). The effects of each variable on MW (dependent

171   variable) was analyzed using stepwise multivariate regression. Differences in average MW scores

172   for injured vs. not injured, selected vs. not selected were also analyzed using multiple paired

173   samples T-tests. Differences in MW for preceding match result (win, lose or draw; only including

174   matches selected for) was calculated with a one-way analysis of variance. To estimate the

175   magnitude of change in MW, Cohen's d effect sizes (ES) were calculated with the magnitude of

176   effects considered either small (0.20–0.49), medium (0.50–0.79) or large (>0.80).

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Results

Table 1 displays the descriptive statistics for the player's physical characteristics, independent predictor variables and average WEMWBS scores.

Average MW, as assessed with the WEMWBS, was significantly lower when injured vs. not-injured (43.6 ± 5.0 vs. 49.9 ± 3.5; $P = 0.001$; ES = 1.48; Figure 2) but was unaffected by the preceding match result (win: 50.0 ± 4.0, draw: 50.5 ± 5.0, loss: 49.1 ± 4.8; $P = 1.000$; ES all ≤ 0.28). There were no differences in MW scores when selected vs. not selected (48.9 ± 3.4, vs. 46.9 ± 5.9; $P = 0.134$; ES = 0.43).

The number of days missed to injury and not being selected for the games were the only variables found to be significant predictors of MW in the multivariate regression model (Table 2). The length of time spent injured throughout the season had a significant negative effect on MW, and accounted for the biggest variance in MW (40%). When considered together, the length of time spent injured and not being selected to play games accounted for 50% of the variation in MW scores (Table 2). Multicollinearity between the predictor variables was considered acceptable as Variation Inflation Factors were below 1.5 (Kutner et al., 2005).

The coefficient of variation for week to week changes in total distance (m), weekly total duration (min) and weekly total high speed running distance throughout the data collection period of this study was 12, 10 and 32%, respectively. As shown in Table 2, the players individual training loads did not significantly influence their MW scores.

Discussion

The main findings of this study were that time out injured and not being selected to play games significantly affected MW in a squad of under 23 professional soccer players during the course of a season. Time out injured had the strongest influence on MW; the average WEMWBS when injured was much lower than the average score in the general population (43.6 vs. 50.1; Health Survey for England, 2016), and just below the suggested cut-off for depression (44.5; Bianca, 2012) and marginally above the lowest 15th quartile for MW (42; Stranges et al., 2014). The ≥ 3 point change in MW when injured is also considered to be a clinically meaningful decrease (Maheswaran et al., 2012). This is the first study to longitudinally track MW in a squad of

207 professional soccer players of any age group, and provides new information on the factors that
208 affect MW.

209 As this is the first study to assess the effects of injury on MW in professional male soccer players
210 there are no other studies available for direct comparisons. However, given the close relationship
211 between WEBWMS and clinical depression scales (Stranges et al., 2018) we can make some
212 tentative comparisons to studies assessing the effects of injury on depression symptoms in
213 professional soccer players. Similar to our findings, Junge & Fedderman-demont, (2016) observed
214 that players from the top leagues in Switzerland reported higher levels of anxiety and depression
215 when they were injured (Junge & Fedderman-demont, 2016). Interestingly, male under-21 players
216 had significantly higher depression scores than the senior players. However, in two studies from
217 Gouttebarge et al., (2015a, 2015b) neither depression nor anxiety symptoms were associated with
218 severe injury, despite the fact that depression rates were significantly higher than in other sports
219 (25–44%). The discrepancy in findings between these studies could be due to the different study
220 designs. Junge & Fedderman-demont, (2016) compared depression and anxiety symptoms in
221 players currently injured or not in a cross sectional design, whereas the studies of Goutterbarge et
222 al., (2015a, 2015b) assessed whether the number of previous injuries influenced the players *current*
223 mental state. It is possible that the latter studies failed to detect any association between injury and
224 mental health because the data was not collected when the players were actively suffering from an
225 injury. Assessing mental health while injured might be more sensitive for detecting mental health
226 problems and should be encouraged in future studies.

227 Examining the possible ways in which injury could have affected the players MW was beyond the
228 scope of the present study. However, if MW is considered in relation to an individual's flourishing,
229 that is, whether they are functioning effectively, be it physically, emotionally or socially (Huppert,
230 2009), then anything that disrupts this state will likely affect MW. When injured, their day-to-day
231 functioning (e.g., ability carry out tasks), and identity as a soccer player, is disturbed, as they are
232 not able to train or compete. This change of circumstance has been reported to evoke a wide array
233 of emotional responses such as boredom, frustration and anger, all of which could affect MW
234 (Pearson & Jones, 1992). It has also been suggested by Podlog et al., (2007), in a return from sport
235 injury context, that MW is related to competence, autonomy and social connectedness (e.g., self-
236 determination theory). In this scenario, the loss of autonomy (little control over rate of recovery)

237 competence (inability to perform) and connectedness (isolation from teammates and coaches)
238 could significantly affect MW, and this could help to explain the findings of the present study. To
239 counter this, Podlog et al., (2010) recommend that interventions designed to promote feelings of
240 autonomy, connectedness and competence (e.g., performance on physical tests) should be
241 encouraged during the rehabilitation process. The present study's findings further highlight the
242 need to monitor the mental health of injured soccer players so that the relevant interventions and
243 support can be provided to ensure health and performance are not negatively affected.

244 It is important to note, however, that we cannot discern a cause and effect relationship between
245 injury and lowered MW, only an association between the two. Thus, we cannot rule out that
246 lowered MW is actually a risk factor for injuries and this could help to, at least in part, explain our
247 findings. Although we are not aware of any research assessing MW on injury risk, a recent study
248 by Watson et al., (2017) found that lowered mood increased injury risk in youth female soccer
249 players, suggesting a potential relationship between emotional responses and injury risk in athletic
250 populations. The relationship between MW and injury risk clearly needs further exploration.

251 Neither training load nor match result influenced the players MW; however, in our regression
252 model, not being selected for the match squad had a moderate negative influence on players MW.
253 Whilst this is the first study to assess the effects of match selection on MW, a recent study
254 examined the influence of match selection on anxiety and depression symptoms in professional
255 female soccer players (Junge & Prinz, 2018). In contrast to our findings, they found that not being
256 selected to play games did not significantly influence depression or anxiety with no differences in
257 symptoms between players who played *almost always* to *rarely* or *never.* The discrepancy in
258 findings between the present and the aforementioned study could be due to several reasons; player
259 differences (male under 23 players in England vs. senior female players in Germany), mental
260 health scales used (WEMWBS vs. anxiety and depression scales) and method of collection
261 (longitudinal throughout the season vs. cross sectional at a single time point).

262 As to why not being selected to play games might affect MW, we speculate that not being able to
263 play can result in significant psychological distress for the athlete and, similar to injury, this is
264 possibly due to a loss of autonomy, connectedness and competence, as suggested by Podlog et al.,
265 (2007, 2010). Such psychological distress could be even more pertinent at the under 23 level than
266 the senior level, as their career trajectory is still uncertain. If a player is not playing, either due to

267   injury or due to not being selected, then they are unable to impress coaches and support staff who

268   ultimately decide whether they receive a senior contract with the club or are promoted to the senior

269   squad. It has been shown that youth players who are released from soccer clubs in the UK often

270   suffer from high levels of psychological distress compared to their retained counterparts

271   (Blakelock et al., 2016). It would be reasonable to assume that the looming threat of being released

272   from their contract, or not making it to senior level, is heightened when they are not playing. Or it

273   could simply be the fact that younger players have yet to develop appropriate coping strategies to

274   help them deal with such psychological stress. Future research should examine the psychological

275   distress associated with not being selected in soccer players to better understand how their mental

276   health can be managed.

277   This study has several limitations that need to be acknowledged. Firstly, the sample size was low

278   ($n = 25$) and the population studied relatively homogenous. Thus, these findings might not be

279   representative of senior level soccer players, female players, or those from other countries, as

280   cultural differences in mental health have been observed (Schinke et al., 2017). As such, we

281   caution that these findings may only be relevant to young professional soccer players in the UK.

282   Future studies on MW in soccer players should include players from several different teams and

283   countries. Secondly, there are several other variables that could have affected MW other than those

284   examined in the present study. Our primary outcome measures were injury and not being selected

285   to play games; however, adverse life events and social support could also affect MW (Goutterbarge

286   et al., 2015a) and should be included in future studies. It is important to highlight, though, that

287   Arnold and Fletcher, (2012) identified over 640 different psychological stressors for elite athletes

288   and clearly not all of these can be accounted for in studies of this nature. Another potential

289   limitation is that we did not collect a baseline value to calculate standardized individual changes

290   in MW values. This was partly because it is very difficult to collect a true baseline that is not

291   influenced by training load and performance to some degree, unless we were to collect the baseline

292   value right at the outset of the season, which we were unable to do in this study. Also, some players

293   started the season injured, and therefore getting a baseline MW score would not have been as

294   simple as assessing MW at the start of the season. Nonetheless, this should be considered in future

295   research. Lastly, future studies might experiment with different days the questionnaire is

296   completed. We opted for match day + 3, at which point we expected recovery to be sufficient

297   enough to not significantly interfere with the MW scores. If we had collected these scores on match

298   day, for example, we might have got different results; therefore, future studies might wish to

299   measure MW across a weekly cycle to see if this influences these values. The key strength here, is

300   that we kept the day the survey was completed consistent. Another strength of the present study is

301   the longitudinal design. This is the first study to track MW over a full season, with all previous

302   studies collecting mental health data either retrospectively (Goutterbarge et al., 2015a, 2015b) or

303   with a cross sectional design (Junge & Fedderman-demont, 2016). The present study is also the

304   first to use each player as their own control. We believe our design strengthens the validity and

305   reliability of the findings, as the player's scores were not subjected to recall bias or reliant on a

306   single measure. Lastly, this is the first study to demonstrate that the freely available WEMWBS is

307   a simple and easy to administer questionnaire to monitor changes in MW in soccer players and

308   might serve as a useful tool for sports medicine professionals. It is important to note, however, that

309   WEMWBS is yet to be validated as a measure of MW specifically in soccer players and this should

310   be explored in future work.

311   **Conclusion**

312   In conclusion, this study demonstrates that injury and not being selected to play games can

313   significantly influence MW in under 23 soccer players. These findings add to the scant literature

314   available on mental health in professional soccer players, further highlighting the need to better

315   understand the causes and consequences of psychological distress in this population. From a

316   practical perspective, these findings indicate that soccer players should be educated on strategies

317   to better manage their mental health when injured and not selected. Of the available strategies for

318   coping with common stressors, a recent position stand on the topic (Schinke et al., 2017) suggested

319   that mindfulness based interventions incorporating resilience training might be effective for

320   managing sub-clinical mental health concerns in athletes. Lastly, these findings demonstrate that

321   the WEMWBS is a simple and cost-effective way to detect and monitor for potential mental health

322   disturbances in a squad of professional male soccer players.

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408 **Figure 1** – Longitudinal design of the data collection period, including a detailed overview of the
409 players training cycles throughout season. WEMWBS, Warwick-Edinbugh Mental Wellbeing
410 Scale; Cond, conditioning; St, strength; Spd, speed; Bas, basic; CD, change of direction; Pro,
411 production; Mech, mechanics; Accel, acceleration; Pow, power; Med, medium; Dist, distance; H,
412 high intensity; M, medium intensity; L, low intensity; End, endurance; HIIT, high intensity
413 interval training; PBC, pitch-based conditioning.

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415 **Figure 2** – Average WEMWBS score when injured vs. not injured ($n = 18$) and selected vs. not-
416 selected for the match squad ($n = 25$). *Represents difference in WEMWBS scores; $P < 0.05$.
417 Boxplots show median, 25–75th percentiles, and minimum to maximum scores.

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Table 1 – Descriptive statistics for players age, height, mass, WEBWBS scores, training load
(total duration, total distance, total sprint distance) and the % of time spent out injured, % of
matches they were selected for, and % of matches won.

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Variable	Mean ± SD
Age (years)	20 ± 1
Height (m)	1.80 ± 5.79
Mass (kg)	76.33 ± 7.52
Weekly WEMWBS score (14 - 70)	48.0 ± 3.9
Time out with injury (%)	24.3 ± 23.6
Weekly training duration (minutes)*	272.7 ± 28.0
Weekly training distance (m)*	21249.5 ± 2565.6
Weekly high-speed running distance (m)*#	600.6 ± 193.9
Player match selection (%)**	60.1± 27.9
Player win percentage (%)**	56.1± 17.6

*Includes matches, if selected. **Only for matches in which the players were available for selection.
#high-speed running distance is the distance travelled at ≥60% of maximum speed ($km·h^{-1}$).

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449   **Table 2 –** Results from stepwise multiple regression analysis of the independent predictors on

450   the dependent variable, mental wellbeing.

Predictor	B	SE (B)	ß
Step 1			
Days missed to injury	-.105	.27	-.632*
Step 2			
Days missed to injury	-.091	.26	-.545*
Not selected to play games	.53	.24	.336*

451   Step 1 R^2 = .399, Step 2 R^2 = .505, ΔR^2 = .0.106. *P < .05.

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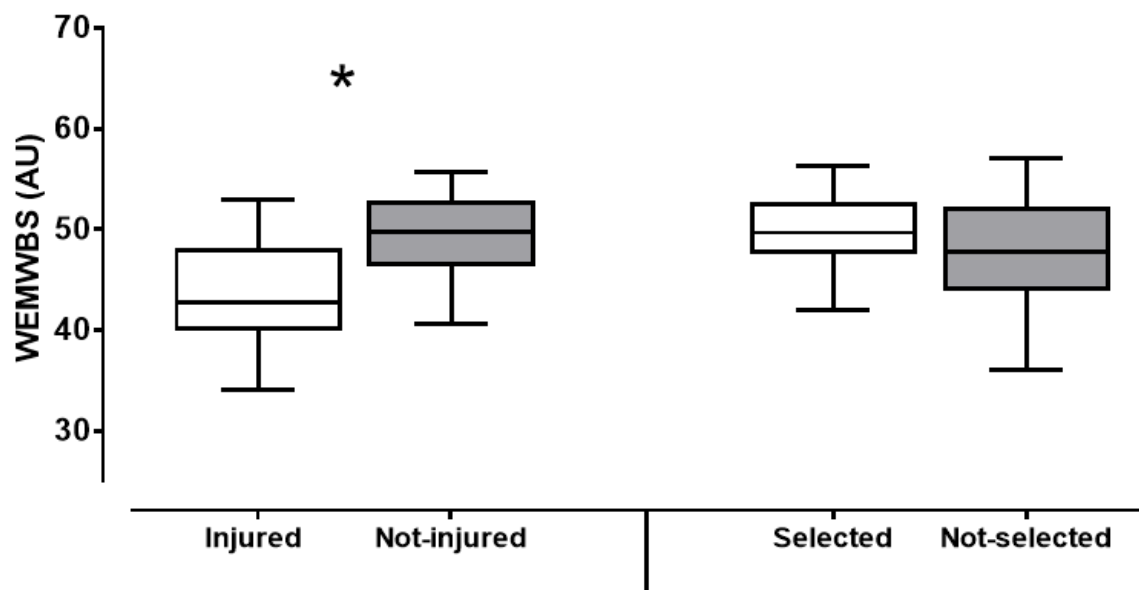454

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Section	Metric	14	21	28	4	11	18	25	2	9	16	23	30	6	13	20	27	4	11	18	25	1	8	15	22	29	5	12	19	26	5	12	19	26	2	9	16	23
Dates	Months	August			September				October					November				December				January					February				March				April			
	WEMWBS	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Gym based cond	Primary focus	Physical Maintanence																			Recovery		Physical Maintanence															
	Sessions	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	0	0	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	Hypertrophy	L	L	L	L	L	L	M	M	M	L	L	L	L	L	L	M	M	M	M	L	L	M	M	M	L	L	L	L	L	L	M	M	M	L	L	L	L
	Bas Strength	L	L	L	L	L	L	H	H	H	L	L	L	L	L	L	H	H	H	H	L	L	H	H	H	L	L	L	L	L	L	H	H	H	L	L	L	L
	Max Strength	M	M	M	L	L	L	H	H	H	M	M	M	L	L	L	H	H	H	H	L	L	H	H	H	M	M	M	L	L	L	H	H	H	M	M	M	L
	St-Spd	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	L	L	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Spd-St	M	M	M	H	H	H	L	L	L	M	M	M	H	H	H	L	L	L	L	L	L	L	L	L	M	M	M	H	H	H	L	L	L	M	M	M	H
PBC	Primary focus	Physical Maintanence																			Recovery		Physical Maintanence															
	Sessions	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	0	0	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Pre-Season Cond	Aerobic Base	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	L	L	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	HIIT Training	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	L	L	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Speed End	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	L	L	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
	Spd pro	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	L	L	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M	M
In Season Cond (Plyos)	Land Mech	L	L	L	L	L	L	H	H	H	L	L	L	L	L	L	H	H	H	H	L	L	H	H	H	L	L	L	L	L	L	H	H	H	L	L	L	L
	Slow SSC	H	H	H	M	M	M	L	L	L	H	H	H	M	M	M	L	L	L	L	L	L	L	L	L	H	H	H	M	M	M	L	L	L	H	H	H	M
	Fast SSC	M	M	M	H	H	H	L	L	L	M	M	M	H	H	H	L	L	L	L	L	L	L	L	L	M	M	M	H	H	H	L	L	L	M	M	M	H
In Season Cond (Spd/CD)	Accel Pow	M	M	M	M	M	M	H	H	H	M	M	M	M	M	M	H	H	H	H	L	L	H	H	H	M	M	M	M	M	M	H	H	H	M	M	M	M
	Med Dist Spd	H	H	H	M	M	M	M	M	M	H	H	H	M	M	M	M	M	M	M	L	L	M	M	M	H	H	H	M	M	M	M	M	M	H	H	H	M
	Long Dist Spd	M	M	M	H	H	H	L	L	L	M	M	M	H	H	H	L	L	L	L	L	L	L	L	L	M	M	M	H	H	H	L	L	L	M	M	M	H