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# Mental Health Literacy and Mental Health in At-Risk Populations

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This thesis is submitted in partial fulfilment of the requirements for the  
degree of Doctor in Clinical Psychology

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## List of Abbreviations

ADHD	Attention Deficit and Hyperactivity Disorder
BBC	British Broadcasting Corporation
BPS	British Psychological Society
CAT	Cognitive Analytic Therapy
CINAHL	Cumulative Index of Nursing and Allied Health Literature
DoH	Department of Health
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, 4 <sup>th</sup> Edition
FA	Football Association
FAD FC	Football's Awareness of Depression Football Community
GP	General Practitioner
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10 <sup>th</sup> Revision
IPA	Interpretative Phenomenological Analysis
MHL	Mental Health Literacy
OCD	Obsessive Compulsive Disorder
PFA	Professional Footballers Association
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
SDR	Sequential Diagrammatic Reformulation
USA	United States of America
WHO	World Health Organisation

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Last, but not least, I would like to thank my family, Olly and friends who have supported me more than they know. For the belief, encouragement, newspaper clippings and welcome distractions I thank you.

## **Declaration**

This thesis has not been submitted for any other degree or to any other institution. This thesis was carried out under the supervision of Lesley Pearson (Clinical Tutor, Coventry University) and Jo Kucharska (Clinical Director, Coventry University). The named supervisors were involved in the initial formulation of research ideas and design. They have provided suggestions and feedback throughout. Validating the coding for my empirical paper was supported by an independent research colleague who was familiar with interpretative phenomenological analysis. Feedback on the reformulation letters for the reflective paper was provided by Dr Chris Laking (Clinical Psychologist, CWPT), who is experienced in Cognitive Analytic Therapy. Apart from the collaborations stated, the content of this thesis is my own work.

Chapter 1: Gender differences in the levels of mental health literacy in young people, has been prepared with the view to submit to the Journal of Child and Adolescent Mental Health. Chapter 2: Male professional footballers' experiences of mental health difficulties and help-seeking, has been prepared for submission to the Journal of Clinical Sport Psychology. The reflective paper in Chapter 3 will be submitted to Reformulation, the journal published by the Association of Cognitive Analytic Therapy.

## **Summary**

This thesis explores mental health literacy (MHL) and mental health difficulties in at-risk populations. Young people, particularly males, are vulnerable to the onset of mental health difficulties, failing to access support and increased risk of suicide. Supporting people with mental health difficulties and improving prognosis is an important area of public health concern.

Chapter one is a systematic review of gender differences in MHL of young people (ages 12-25 years). 14 studies were identified and critically assessed. The nature of gender differences in MHL of young people is complex but most consistently reported in depression. Females tended to have higher levels of MHL than males. The implications for public health interventions and future research are discussed. Methodological components of MHL research, such as the use of case vignettes are also considered.

Chapter two is a qualitative research study of male professional footballers' lived experiences of mental health difficulties and help-seeking using interpretative phenomenological analysis. One superordinate theme emerged from the data; Survival. This is discussed through six subordinate themes and alongside existing literature pertaining to identity, transition, personality and emotional development. The clinical implications of the findings are discussed, as well as suggestions for future research.

Chapter three is a reflective paper considering the use of Cognitive Analytic Therapy as a tool for reflexivity in qualitative research. The opportunities and limitations of this approach are considered, alongside reflections on the research process.

**Overall Word Count: 19,981**

## **Chapter 1: Literature Review**

### **A Systematic Review of Gender Differences in Mental Health**

#### **Literacy of Young People**

In preparation for submission to the Journal Child and Adolescent Mental Health

(See Appendix A for author instructions for submission)

Overall chapter word count (excluding tables, figures and references): 7,994

## Abstract

**Background:** One in five young people (ages 12-25 years) will experience mental health difficulties and this can have a detrimental impact upon their education, development and wellbeing, as well as increasing the risk of suicide. Public health initiatives have targeted mental health literacy (MHL) to try to increase the recognition of symptoms and facilitate access to support in order to improve prognosis. MHL interventions tend to be generic, however, the presence of gender differences in MHL may indicate the need to tailor interventions to increase their effectiveness. This review aimed to identify if there are gender differences in MHL of young people, where these differences lie and how they are investigated. **Method:** A systematic search of the literature identified 14 studies which were critically analysed. **Results:** The presence, absence and inconsistency of gender differences in MHL are reported. Case vignettes and mixed method design were the most prominent methodological approaches. **Conclusions:** Gender differences in MHL are most consistently reported for depression, with females having higher levels of MHL than males, and more likely to recommend seeking help from family, friends and a counsellor.

Key practitioner message:

- Replicability of the research is needed, with a focus at symptom level, particularly for a wider range of mental health difficulties.
- The validity of the methodological approaches to MHL, and the use of case vignettes, requires improvement in subsequent research.
- A cost-benefit analysis of gender-specific interventions should be considered.

*Key Words: Mental health literacy, young people, adolescents, gender differences, sex differences, systematic review.*

## **Introduction**

### ***Mental Health Difficulties in Young People***

Mental health is an important area of public health concern given that at least 1 in 4 people will experience mental health difficulties at some stage in their life (Department of Health [DoH], 2011). Mental health difficulties can have a significant impact on a person's quality of life, wellbeing, physical health, social and occupational functioning (DoH, 2014).

The reported prevalence of mental health difficulties in young people is varied and is influenced by culture, socio-economic status and the criteria used to categorise mental health difficulties. In addition, the age boundaries, and terminology, that define young people are fluid, variable and culturally dependent (Patel, Flisher, Hetrick & McGorry, 2007). For the purpose of this systematic review the definition of young people will incorporate the ages of 12-25 years as outlined in previous literature (e.g. Patel et al., 2007; Rutter & Smith, 1995). This definition was adopted to go beyond the traditionally age-defined concept of adolescence (10-19 years) in order to include the health and developmental needs of young people who are emerging as adults at an age where the risk of onset of mental health difficulties is high (Kessler, Berglund, Demler, et al., 2005; Patel et al., 2007; World Health Organisation [WHO], 2005).

The estimated prevalence of mental health disorders in young people is approximately 1 in 5 (e.g. Costello, Mustillo, Erkanli et al., 2003; Patel, et al., 2007; WHO 2005). Whilst half of all life-time prevalence of mental health difficulties starts before the age of 14 years, three quarters starts by the age of 24 years (Kessler, et al., 2005). For

example the median age for the onset of anxiety disorders is estimated at 7-14 years, and there is a marked increase in prevalence of schizophrenia between the ages of 15-17 years (Kessler, Amminger, Aguilar-Gaxiola, et al., 2007). The most common mental health difficulties experienced by young people are depression, anxiety and impulse control disorders, such as ADHD and conduct disorder (Green, McGinnity, Meltzer, et al., 2005). Of further concern is the increased rate of suicide in young people, currently the third leading cause of death of young people (Center for Disease Control and Prevention, 2013). This is particularly evident in young males with mental health difficulties (Houston, Hawton, & Shepperd, 2001). Depressive disorders and substance abuse are the strongest risk factor of suicide in young people (Beautrais, 2000; Houston, et al., 2001). Therefore, it can be seen how improving the recognition, treatment and management of mental health difficulties has a crucial role in reducing suicide in young people (Beautrais, 2000).

Mental health difficulties can have a significant impact on young people including negative implications such as poor educational achievement due to absenteeism, poor academic productivity, withdrawal and suspension (Andrews & Wilding, 2004). Mental health difficulties can also negatively affect the development of professional and interpersonal skills in young people, thus potentially impacting upon their future career development (Davies, Wardlaw, Morriss & Glazebrook, 2016). Young people who experience mental health difficulties are also at increased risk of substance misuse, violence, poorer sexual health, and disability adjusted life years (Patel et al., 2007).

The ability of young people to recognise mental health difficulties, the attitudes and beliefs they hold about mental health and their knowledge of the support available and how to access this, is central to improving outcomes for the experience of mental health difficulties (Gulliver, Griffiths, & Christensen, 2010; Kelly, Jorm & Wright, 2007; Swami, 2012). These aspects can be incorporated and understood as mental health literacy.

### ***Mental Health Literacy***

The term ‘mental health literacy’ (MHL) was introduced by Jorm et al. (1997). MHL is defined as the ability to recognise specific mental health disorders and the persons’ knowledge about these. This includes aspects such as a person’s beliefs about the causes and risk factors of mental health disorders as well as options for help-seeking (Francis et al., 2002; Jorm, 2000; Jorm et al., 1997). This definition of MHL will be adhered to throughout the systematic review.

MHL is an important area of concern because many young people who experience mental health difficulties are reluctant to seek help and do not access professional support (Reavley, Cvetkovski, Jorm & Lubman, 2010; Rickwood, Deane & Wilson, 2007). Accessing professional help is essential to receiving evidence-based interventions (Meltzer, Bebbington, Brugha et al., 2003; Oliver, Pearson, Coe & Gunnell, 2005). Early intervention helps to minimise the social, occupational and emotional impact of mental health difficulties (Rickwood, Deane, Wilson & Ciarrochi, 2005), reduce the risk of suicide (Appleby et al. 2011; Michelmores & Hindley, 2012) and facilitate wellbeing and recovery (DoH, 2011). In a recent review of help-seeking



in young people with mental health difficulties, a lack of knowledge about mental health was identified as a key obstacle (Gulliver, et al., 2010). Furthermore, when young people do seek help they are more likely to seek support from their friends/peers than adults (Kelly, et al., 2007). MHL, therefore, has a significant role because greater levels of MHL can contribute to the early recognition of mental health symptoms within the young person themselves or in their peers in order to; facilitate intervention through their knowledge of available help and how to access this (Kelly, et al., 2007), improve prognosis and promote less stigmatising attitudes (Cotton et al., 2006; Jorm et al., 1997; Swami, 2012; Wolff, Pathare, Craig & Leff, 1996). Poor levels of MHL are associated with lower rates of service utilisation and help-seeking (Evans-Lacko, Brohan, Mojtabai, & Thornicroft, 2012) because of the inability to recognise and articulate difficulties, as well as the limited awareness of available support (Burns & Rapee, 2006; Jorm, 2000). Furthermore, poor MHL negatively impacts upon willingness to disclose mental health difficulties, ability to make decisions regarding intervention and compliance with treatment (Rusch, Evans-Lacko & Thornicroft, 2011; Swami, 2012).

The levels of MHL in the general population across the world are low and interventions targeting this could improve outcomes for people with mental health difficulties (Jorm, 2000; Kelly, et al., 2007). For example, a vignette describing a person with depression was correctly identified by as few as 39.8% of an adult sample in Switzerland (Lauber, Nordt, Falcato & Rossler, 2003) and 39% in Australia (Jorm et al., 1997). Recognition of schizophrenia is lower at 27% (Jorm et al., 1997). Similar patterns of recognition have been reported in young people. In recent Australian studies, approximately half of the young people surveyed were able to recognise

depression (Burns & Rapee, 2006; Kelly, Jorm & Rodgers, 2006) and less than a quarter recognised psychosis (Wright, McGorry, Harris, et al., 2006). Research indicates a gradual improvement in the recognition of mental health difficulties following public health initiatives targeting MHL (Jorm, Christensen & Griffiths, 2006a). However, the evidence base for mental health education based interventions to enhance MHL and to reduce stigma of young people is limited. Promising findings for improving MHL and help-seeking have been demonstrated (e.g. Pinto-Foltz, Logsdon & Myers, 2011), however, these studies have a number of limitations including small sample sizes and lack of follow up. A recent randomised control trial found that a classroom based intervention, “HeadStrong”, improved adolescent’ MHL for depression with a moderate to large effect immediately after the intervention ( $d=.60$ ) but that this declined at the 6 month follow up ( $d=.37$ ) (Perry, Petrie, Buckley, et al., 2014). Furthermore, although the intervention reduced stigma it did not significantly impact upon participants’ attitudes towards help-seeking (Perry, et al., 2014). This is perhaps indicative of the promise of classroom based interventions but also of the need to refine these with a greater understanding of the components that affect levels of MHL in order to achieve sustainable gains.

### ***Gender Differences in Mental Health Literacy***

Considerable research has identified gender differences in factors associated with mental health, such as; prevalence, diagnosis, prognosis, and mortality (Appleby et al. 2011; Cotton, Wright, Harris, et al., 2006; DoH, 2011; Wilkins, 2010). Given these differences, a number of studies have considered whether gender may be a factor in levels of MHL however the current evidence base is unclear.

Gender differences were identified in a systematic review by Holzineger, Floris, Schomerous, Carta and Angermeyer (2012), which included studies from western countries that examined components of MHL in the general population. The study did not focus on a young people population and age boundaries were not reported. Women were more likely to favour psychosocial explanations of mental health difficulties, more likely to seek psychotherapy/professional help and expect more favourable outcomes. Although the findings were mixed, there did not seem to be gender differences in attitudes towards people with mental health difficulties, or in the response to specific mental health difficulties overall (Holzineger et al., 2012). Females were shown to be more likely to recognise a vignette of depression (e.g. Burns & Rapee, 2006; Swami, 2012) and to identify fatigue, weight loss and diminished interest as symptoms of depression (Burns & Rapee, 2006). There were no significant differences in gender for the recognition of psychosis (e.g. Melas, Tartani, Forsner et al., 2013); however gender differences were found in the forms of support endorsed. Gender, therefore, appears to have some role in explaining differences in levels of MHL however the extent of these differences remains unclear given that no gender differences were found in over half of the studies included in Holzineger et al.'s (2012) review.

No systematic review of gender differences in the levels of MHL in young people has been identified. Gender differences in the levels of MHL in young people have been reported, with young females typically having higher levels of MHL for depression and social anxiety (e.g. Cotton et al., 2006; Furnham, Annis & Cleridou, 2014). However the picture is mixed and gender differences in young people's ability to

recognise mental health difficulties or recommend professional help are not always reported (e.g. Byrne, Swords & Nixon, 2015). A recent study suggested that gender differences in the levels of MHL in young people may not be as great as previously thought and that age, experience of mental health and education about mental health were more positively correlated with the levels of MHL (Furnham, et al., 2014).

### ***Rationale***

There is a considerable need to address the growing levels of mental health difficulties reported in young people (DoH, 2015), particularly given that the onset of mental health difficulties is high between the ages of 12-25 years (DoH, 2015; Kessler et al., 2005; Kessler et al., 2007; Patel et al., 2007) and that the presence of mental health difficulties is the most significant risk factor for suicide (Beautrais, 2000; Houston, et al., 2001). MHL is an important component of recognising mental health difficulties, facilitating access to professional support, providing peer support, and improving prognosis (Cotton et al., 2006; Kaneko & Motohasi, 2007). Hence intervention aimed at enhancing MHL in young people is an important agenda for public health.

Gender differences in MHL are often, albeit not always, reported in the literature however interventions targeting young people's MHL tend to be generic across genders and there is a call for gender specific intervention programmes (Lauber et al., 2005), given that interventions targeting MHL are most effective when they are tailored for a homogenous group (Kelly, et al., 2007). Therefore, identifying the underlying mechanisms of gender differences in MHL and the impact of these is important because they could impact upon the effectiveness of MHL interventions.

Given the variability in the evidence for gender differences the methodological quality of the studies will also be critically evaluated in order to make recommendations for future research.

### ***Aims of the Review***

This systematic review aims to critically examine empirical studies that have measured gender differences in the levels of MHL amongst young people in the general population. In particular:

1. Are there gender differences in the levels of MHL in young people and where do these gender differences lie?
2. How are these differences investigated?

## **Method**

### ***Search Strategy***

#### **Database Search**

A systematic search of the literature that has examined gender differences in the levels of MHL in young people was carried out between December 2015 and March 2016. The following databases were searched; Cumulative Index of Nursing and Allied Health Literature (CINAHL), MEDLINE, PsycINFO, Scopus, and Web of Science.

## Systematic Review Search Terms

The search terms and Boolean logic used for the systematic database search are outlined in Table 1.1. This systematic review will adhere to Jorm et al.'s (1997) definition of MHL; the ability to recognise specific mental health disorders, knowledge about these disorders and beliefs about help-seeking. Therefore, articles published from 1997 onwards were considered.

Table 1.1: Database search terms for systematic review

Concept	Variations	Location
Mental Health Literacy	Mental Health Literacy	Title, Abstract, Main Text
	Mental Illness Literacy	
Gender Differences	Gender Difference*	Title, Abstract, Main Text
	Sex Difference*	
Young People	Young	Title, Abstract, Main Text
	Child*	
	Adolescen*	
	Student*	

*Note: In order to capture variations of the keywords they were truncated (as shown with an \*).*

*The concepts MHL, gender differences and young people were combined using the 'AND' Boolean operator. The variations within the concepts were searched using the 'OR' Boolean operator.*

## **Manual Search**

After the initial database search, a manual search for additional references was undertaken. The reference list of each identified article was hand searched for other applicable studies, which were then verified in line with the inclusion and exclusion criteria. The process of this systematic review is evidenced in Figure 1.1.

## ***Search Criteria***

The titles and abstracts of the articles were initially screened and retained if they were; written in English Language, were peer reviewed original research, empirically measured levels of MHL in the general population, and the full text was available. Following the initial screening the articles were assessed for inclusion based upon the following criteria.

## Inclusion and Exclusion Criteria

Table 1.2 Inclusion and exclusion criteria of this systematic review.

Criteria	Inclusion	Exclusion
Mental Health Literacy	Encompass definition of MHL (Jorm et al., 1997)	Failure to meet components of the definition
General Population	General Public	*Health care students (e.g. medical, nursing, psychology) Professionals Clinical populations/patients
Mental health difficulties	Mental Health Diagnoses (e.g. depression, psychosis, anxiety, eating disorders etc.)	Neurodevelopmental disorders Physical health difficulties
Gender Differences	Male and Female Gender analysis reported	Male or female only No analysis across gender reported
Young people	Age in sample falls within 12 to 25 years.	No young sample Studies that do not separate the young sample in gender analysis

\*Excluded due to these population groups having increased training, knowledge and exposure to mental health difficulties compared to the general population.



## Systematic Search Results

The systematic procedure for selecting studies was recorded on a ‘Preferred Reporting Items for Systematic Reviews and Meta-analyses’ (PRISMA) diagram (Figure 1.1).

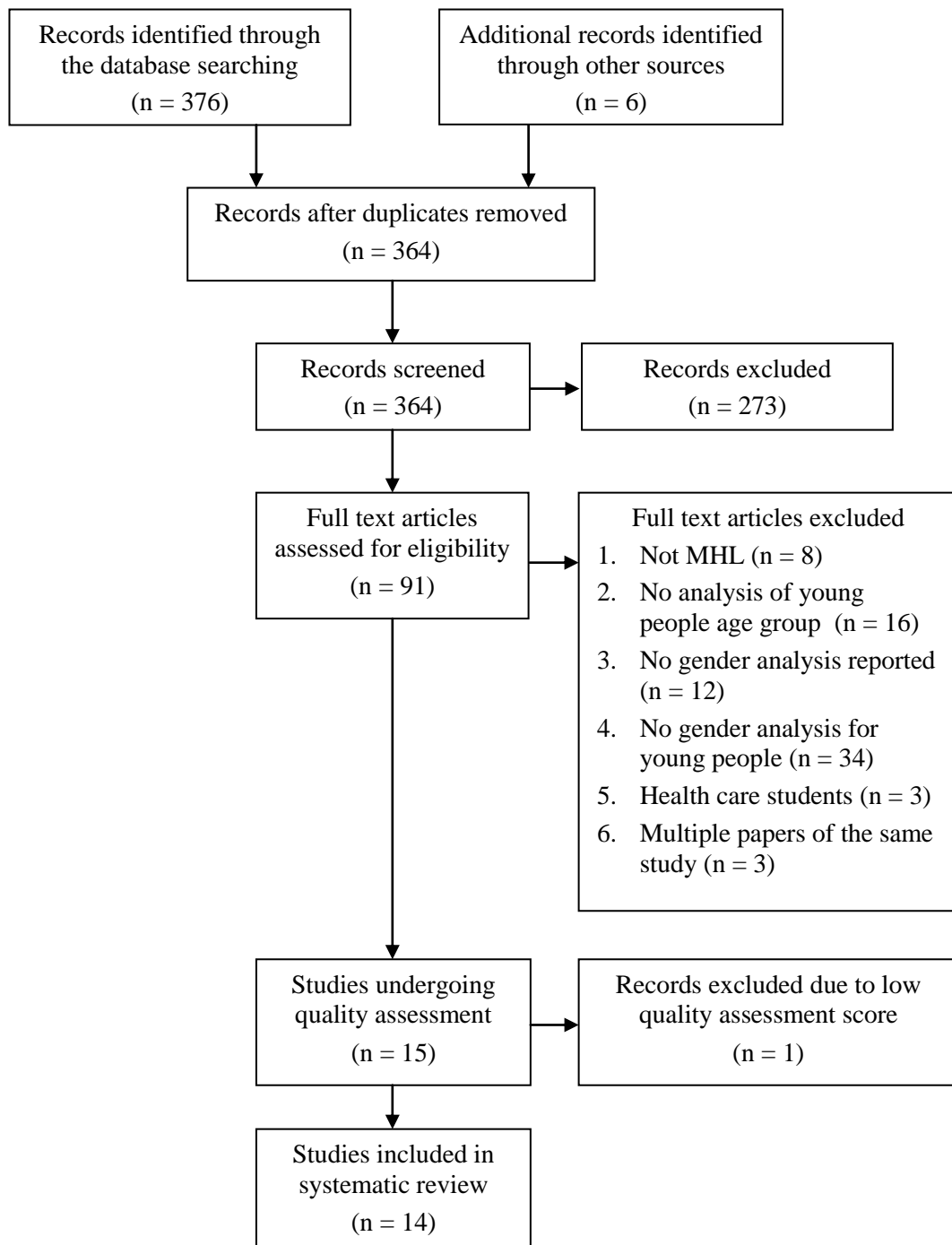


Figure 1.1: The systematic search strategy PRISMA diagram

### *Assessment of Quality*

The quality of the 15 studies identified by the systematic review was assessed using a quality checklist (Appendix B) adapted from the Critical Appraisal Framework (Caldwell, Hensham & Taylor, 2005). This framework was chosen due to its application in health and clinical psychology for both qualitative and quantitative methodologies. Two adaptations were made. The quality area “authors” was removed as a clear description of the criteria to judge author credibility was not provided or justified. The quality area for “hypotheses and variables” was split into two quality areas as they address separate components of research.

The quality of quantitative and qualitative studies was assessed separately. The quantitative and mixed methods studies were scored against 18 areas (maximum score = 36) and for each area the studies were rated as 2 if the criteria were fully met, 1 if partially met or 0 if the criteria was not met or not known. The qualitative studies were scored against 16 areas (maximum score = 32). The quality scores were converted into a percentage to allow for a comparison. Studies which scored below 50% were excluded due to failing to reach a sufficient level in terms of the quality assessment framework.

The quality assessment scores of the studies ranged from 47% to 83%, mean score 66% (Appendix C). In order to increase the reliability of the quality assessment, another independent researcher rated three articles against the quality checklist. Analysis of inter-rater reliability was undertaken using the Kappa Statistic (Appendix D). A score of 0.62 indicated substantial agreement (Landis & Koch, 1977).

One study was excluded based upon the quality assessment. Of the remaining 14 studies the highest quality rating of 83% was awarded to Cotton, et al. (2006) and three studies achieved the second highest rating of 75% (Burns & Rapee, 2006; Furnham, et al., 2014; Mason, Hart, Rossetto & Jorm, 2015). The lowest quality ratings of the studies included were 53% (Droga, Omigbodun, Adedokun, et al., 2011) and 56% (Olsson & Kennedy, 2010). The primary difference between high and low quality studies was the suitability and depth of data collection, analysis, results, discussion and conclusions.

## **Results**

### ***Overview of Results***

A summary of the 14 studies included in this systematic review is presented in Table 1.3. Only the characteristics that are relevant to the aims of this review will be discussed. A total of 11 studies utilised mixed methods, two used quantitative and one used qualitative methods. The studies that were mixed methods primarily collected quantitative data through Likert-type scales, and qualitative data through written/verbal responses to open questions which were coded using content analysis and subsequently analysed quantitatively. The majority of the studies used case vignettes of mental health difficulties to facilitate the exploration of levels of MHL in young people. The following section will address the aims of the systematic review.

Table 1.3: Summary of the key characteristics of the studies reviewed.

Authors, Date & Location	Study Aim	Research Design	Sample	Methodology (Materials & Analysis)	Key Findings for Gender	Quality Score
Burns & Rapee (2006)  Sydney, Australia	To extend knowledge of MHL in adolescent population  To assess declarative knowledge of mental health rather than selecting from multiple choice answers	Quasi-experimental  Cross-sectional  Mixed Methods	202 students (122 male), ages 15-16 years, from two private single sex schools. Mostly middle to upper class Anglo-Saxon backgrounds.	5 vignettes (2 depression & 3 normal life crisis)  Friend in Need Questionnaire  Completed during school  Likert scales & coding of qualitative responses using content analysis.	1. Females more likely to diagnose 'depressed' for depression vignettes ( $p < .001$ ). 2. Both showed greater concern for depressed vignette. Females showed more concern overall which was not dependent on vignette type ( $p < .001$ ). 3. Both report longer 'time until better' for depression. Females reported longer 'time until better' overall which was not dependent of vignette type ( $p < .001$ ). 4. Females more likely to identify symptoms of; fatigue, insomnia, weight and appetite loss, and lost interest in activities ( $p < .01$ ). 5. No gender difference in identifying symptoms of; diminished ability to think and suicidal thoughts. 6. Females more likely to recommend counsellor as source of help ( $p < .01$ ). No difference in other forms of help.	75 %
Byrne, et al. (2015)  Republic of Ireland	To assess MHL of Irish adolescents for depression.  To investigate sex differences in knowledge and help-seeking	Quasi-experimental  Cross-sectional  Mixed Methods	187 students (91 male), ages 15 – 19 years, from 3 secondary schools in rural counties. Mostly White Irish backgrounds.	5 vignettes (2 depression & 3 normal life crisis) from Burns & Rapee (2006) adapted for Irish setting (e.g. Irish names)  Completed web-based questionnaire during school  Likert scales & coding of qualitative responses using content analysis.	1. No difference in identifying depression vignette. 2. Females showed more concern overall, and more concern specifically for depressed vignette ( $p < .001$ ). 3. Both report longer 'time until better' for depression. Females reported longer 'time until better' overall ( $p < .05$ ). 4. Females more likely to identify symptoms of weight loss and fatigue ( $p < .01$ ). 5. Females more likely to recommend help ( $p < .05$ ), but no difference in source of help. 6. Females more likely to help friend access support and to offer multiple forms of help ( $p < .05$ ). No difference in reasons why they help.	69 %

Coles, Ravid, Gibb et al. (2016)  New York, USA	To replicate and extend work examining levels of MHL for depression and social anxiety in US adolescents.	Quasi-experimental  Cross-sectional  Mixed Methods	1104 public high school students (570 male), ages 14-19 years.  85% Caucasian, 4.9% African-American, 3% Hispanic, 2.4% Asian, 5.3% other.	3 vignettes (depression, social anxiety & normal life crisis)  Friends in Need Questionnaire (Burns & Rapee, 2006) completed during school.  Likert scales & coding of qualitative responses using content analysis.	1. Females had higher levels of MHL for depression ( $p<.001$ ). No difference for recognition of social anxiety. 2. Females showed more concern overall ( $p<.001$ ). 3. Females estimated longer 'time to recover' ( $p<.001$ ). 4. Females more likely to endorse seeking treatment for depression and anxiety vignette ( $p<.001$ ). 5. Females more likely to endorse help from a counsellor, friend or family for depression and anxiety vignette ( $p<.001$ ). No difference for psychologist, psychiatrist, teacher, or doctor.	72%
*Cotton, et al. (2006)  Victoria State, Australia	To examine gender differences of MHL in young Australians.	Quasi-experimental  Cross-sectional  Mixed Methods	1207 young Australians (539 male), ages 12-25 years from 4 regions in Victoria.	Randomly presented with 1 of 4 vignettes (depression, psychosis and 2 non-clinical)  MHL Questionnaire adapted from Jorm, et al. (1997) was completed via telephone survey  Coding of qualitative responses using content analysis.	1. Females recognise depression more than psychosis at ages 12-17 and 18-25 years ( $p<.001$ ). 2. Males aged 18-25 years recognise depression more than psychosis ( $p=.001$ ), no difference 12-17 years. 3. Interaction between vignette gender & participant gender <b>Depression</b> 4. Females more likely to correctly recognise ( $p<.001$ ). 5. Males more likely to identify as characteristic of mental illness ( $p=.016$ ), bullying ( $p=.004$ ), or family problems ( $p=.041$ ). 6. No difference in views of sources of help but females more likely to endorse vitamins, minerals & herbal remedies as helpful ( $p=.005$ ), males more likely to endorse sleeping pills ( $p=.04$ ), tranquilizers ( $p=.015$ ) & alcohol ( $p=.002$ ). <b>Psychosis</b> 7. No difference in correct recognition overall or at ages 12-17 years. 8. Females aged 18-25 more likely to recognise ( $p=.014$ ). 9. Females more likely to endorse doctor ( $p=.028$ ) or psychologist/counsellor ( $p=.010$ ), males more likely antibiotics ( $p=.024$ ).	83%

Droga, et al. (2011)  Nigeria	To get baseline data of knowledge, attitudes & social distance towards mental health in Nigerian adolescents.	Non-experimental & cross-sectional  Mixed Methods	145 students (70 male), ages 14-18 years from 2 urban and 2 rural schools.	Questionnaire on knowledge, attitude and social distance towards mental health.  Completed during school.  Likert scales & coding of qualitative responses	1.Males more likely to agree that; there is stigma attached to mental health ( $p=.025$ ), parents transmit their mental illness to their children ( $p=.02$ ), and mental illness cannot be treated ( $p=.042$ ). 2.Females more likely to agree that 1 in 4 people will develop mental illness in their lifetime ( $p=.003$ ), and more likely to respond as 'unsure' to statements. 3.No differences in response to other statements e.g. mental health likely to be cause by stress.	53%
Furnham, et al. (2014)  England	To explore the influence of gender on MHL of young people.	Quasi-experimental  Cross-sectional  Mixed Methods	370 young students (176 male), ages 17-22 years.  46% White British, 18% Chinese, 17% White "other", 6% Mixed British, & 14% Other.	9 vignettes (addiction, anorexia, bulimia, OCD, ADHD, depression, schizophrenia, bipolar disorder and social phobia)  Questionnaires of vignette identification and attitude completed in school and university.  Likert scales & coding of qualitative responses	1.Females more likely to identify; addiction ( $p<.001$ ), anorexia ( $p<.001$ ), bulimia ( $p<.001$ ), OCD ( $p=.003$ ), ADHD ( $p<.001$ ), depression ( $p<.001$ ), bipolar disorder ( $p=.016$ ), and social phobia ( $p<.027$ ). No difference for schizophrenia. 2.There was an interaction between gender of participant and gender of vignette in recognition. 3.Females rated the distress experienced by the vignette characters as higher, the conditions as more difficult to treat (apart from anorexia), and greater levels of sympathy (apart from anorexia, addiction and schizophrenia). 4.Interaction between participant gender and vignette diagnosis for happiness ratings ( $p<.001$ ), successfulness at work ( $p<.05$ ) and relationship satisfaction ( $p<.001$ ) 5. Females more likely to suggest help-seeking ( $p<.05$ ). 6. Males more likely to suggest coping along ( $p<.05$ ), females more likely to suggest other forms of helps such as family ( $p=.01$ ), GP ( $p<.05$ ) and psychiatrist/psychologist ( $p<.001$ ).	75%

Hernan, Philpot, Edmonds & Reddy (2010)	To assess depression recognition, barriers to help and sources of help in rural adolescents.	Quasi-experimental  Cross-sectional  Mixed Methods	74 students (33 male), ages 14-16 years from 2 rural secondary schools.	Male or female depression vignette from Jorm et al (1997).  Likert-scale and open-ended questionnaire coded completed in school.	1. Depression recognised by 75.6% females and 69.7% males. Significance not reported. 2. Females more likely to recommend informal sources of help ( $p<.001$ ). No differences for formal or external sources. 3. No difference in logistical or personal barriers to seeking help from a doctor. 4. No difference in logistical barrier to seeking help from other health professional, but females perceive more personal barriers ( $p<.05$ ).	64%
Leighton (2010)  England	To examine levels of MHL among school based adolescents.	Quasi-experimental  Cross-sectional  Mixed Methods	208 students (96 male), ages 11-18 years, from 4 schools in the West Midlands.  Predominantly White British.	5 vignettes (depression, psychosis and 3 adjustment disorder)  Vignette based questionnaire with likert scale & content analysis for open questions	1. Relationship between gender & form of help-seeking which varied by vignette. 2. Females more flexible in choice of help and perceived benefit of help overall ( $p<.05$ ). 3. Females more likely to have had experience with mental health problems ( $p=.007$ )	69%
MacLean, Hunt & Sweating (2013)  Scotland	To explore age and gender differences in young peoples' understanding of mental health and help-seeking.	Qualitative	90 students (56 males), ages 10-15, from a primary and a secondary school in rural Scotland.	4 vignettes (physical and psychological symptoms)  Task-centred focus groups on symptom recognition & help-seeking.	1. No difference in understanding psychological symptoms as 'painless', 'emotional', 'voluntary' and 'untreatable'. 2. Males more likely to understand psychological symptoms as 'rare', 'weird', 'taboo', 'passing', 'trivial' and 'not an illness'. 3. Females more like to understand psychological symptoms as 'worsening', 'serious' and 'a real illness'.	59 %
Mason, et al. (2015)  Melbourne, Australia	To examine quality and predictors of adolescents first aid intentions to peers with mental health problems.	Quasi-experimental  Cross-sectional  Mixed Methods	518 students (264 males), ages 14-17 years, from a high school in Melbourne.  7% from non-English speaking background.	2 vignettes (depression and social phobia).  MHL questionnaire adapted from Jorm & Wright (2007a), a Personal Stigma Scale, & a Social Distance Scale completed in school.	1. Females scored higher for first aid intentions and actions for both depression & social phobia ( $p=.041$ ). 2. Females more likely to recommend adult help for depression vignette ( $p<.001$ ). No difference for social phobia. 3. No difference in valuing friendship as important for either depression or social phobia. <i>The study did not separate correct identification of problem by gender.</i>	75%

Melas, et al. (2013)	To examine levels of MHL among adolescents.	Quasi-experimental	426 adolescents (154 male), ages 15-19 years, from 2 English speaking high schools in Stockholm.	2 vignettes (depression & schizophrenia) based on Jorm, et al. (1997).  Content analysis of open-ended questions completed in school.	1. Females better at recognising depression ( $p=.006$ ), no difference for schizophrenia. 2. No difference in recommending professional help for depression or schizophrenia. 3. Females more likely to state an intention to help ( $p=.004$ ).	61%
Stockholm, Sweden		Cross-sectional				
		Mixed Methods				
Olsson & Kennedy (2010)	To assess the ability of young people to recognise mental health difficulties and if this is connected with a willingness to take helping action.	Quasi-experimental	217 students (131 male), ages 11-18 years, from a public school in Virginia.	4 vignettes (depression & social phobia from Jorm, et al., 1997; and 2 life stress from Burns & Rapee, 2006)	1. Females more likely to talk to a depressed peer and recommend help ( $p<.05$ ). 2. No difference in recommending professional as best source of help or sharing concerns with school counsellor. 3. No difference in help recommendations for social phobia.	56%
Virginia, USA		Cross-sectional				
		Mixed Methods	78.9% White, 21.1% Non-white	MHL questionnaire with open and closed questions completed during school.	<i>The study did not separate correct identification of problem by gender.</i>	
Williams & Pow (2007)	To explore levels of knowledge and attitudes towards mental health and if there are gender differences.	Non-experimental	496 pupils (245 male), ages 15-16 years, from three Scottish schools.	30 item questionnaire measuring attitudes and perceptions	1. No difference in experience of mental health 2. Females self-reported more knowledge of; depression ( $p=.03$ ), eating disorders, self-harm, & panic attacks ( $p<.001$ ) 3. No difference in self-reported knowledge of; severe stress, nervous breakdown, schizophrenia, personality disorders, anxiety disorders and manic depression. 4. No difference in request for more information about mental health conditions. 5. Males more likely to believe that; public should be protected from people with mental health problems ( $p<.001$ ), it is hard to talk about mental health problems ( $p<.001$ ), and less likely to recover ( $p=.016$ )	69%
Scotland		Cross-sectional		Completed in school.		
		Quantitative				



Yamawaki, Riley, Sato & Omori (2015)	To compare patterns of MHL between United States and Japan university students.	Quasi-experimental  Cross-sectional  Quantitative	**289 Americans students (102 male), ages 18-60 years, studying History & 298 Japanese (143 male), ages 18-53 years, studying Agriculture.	1 vignette (Depression, modified from Jorm, et al., 1997).  Subscales from MHL scale from Jorm, et al., (1997)	1. Females more likely to recognise depression ( $p<.001$ ). 2. No interaction for recognition of depression between country and gender. 3. Males more likely to underestimate prevalence of depression ( $p<.001$ ). 4. Females more likely to recommend counselling and consulting with the family ( $p<.001$ ) 5. Females more likely to have experience of depression or know someone with depression ( $p<.05$ ).	58%
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\*Cotton, et al. (2006) was part of a large cross-sectional survey and three other papers reporting on this study were identified in the literature search; Jorm, et al. (2006b), Kelly, et al. (2006), and Wright, et al. (2005). For the purpose of this review, the Cotton, et al.'s (2006) paper is referenced as this paper focused on reporting gender differences in the levels of MHL in young people.

\*\*Despite the age range of 18-60 years from the American sample and 18-53 years for the Japanese sample the study was retained in this systematic review because the mean ages were 18.8 years and 19.4 years indicating that very few participants were outside of the defined young people age of 12-25 years.

### ***Are There Gender Differences in Levels of MHL in Young People?***

In order to address the first aim of this review this results section will at first look to identify if there are gender differences in levels of MHL of specific mental health difficulties, and where these differences lie. How gender differences in levels of MHL of young people are investigated will be reported in the second section.

#### **Depression**

Depression was the most researched difficulty and gender differences in MHL were examined by 11 studies. With the exception of one study of Irish adolescents (Byrne, et al., 2015), females were found to be significantly more likely to correctly identify and recognise depression (see Table 1.3 for significance levels). In addition, higher levels of self-reported knowledge for depression in females were found by Williams and Pow (2007). Gender differences in the identification of specific symptoms of depression were explored by both Burns and Rapee (2006) and Byrne, et al. (2015). Consistent across the two studies, both of which achieved good quality scores, was that females were more likely to identify symptoms of weight loss and fatigue, as well as expecting it to take a 'longer time until better'. Burns and Rapee (2006) also found that females were more likely to identify symptoms of insomnia, appetite loss and lost interest in activities but no gender differences were found for suicidal thoughts or diminished ability to think.

Gender differences in help-seeking and treatment recommendations were less conclusive. In three of the studies, females were more likely to recommend help-

seeking overall (Byrne, et al., 2015; Furnham, et al., 2014; Mason, et al., 2015), whilst males were more likely to recommend coping alone (Furnham, et al. 2014). In two studies, females were more likely to express the intention to support a friend in accessing support (Melas, et al., 2013; Olsson & Kennedy, 2010). These studies achieved moderate quality scores and therefore replication in future research can strengthen the reliability of these findings.

The presence of gender differences in the type of help recommended was inconsistent and complicated by how this aspect was examined differently in terms of how the types of help were grouped together. For example, Hernam, et al. (2010) compared informal sources of help with formal and external sources of help, whilst Burns and Rapee (2006) considered different forms of help, such as family, friends, counsellor, psychologist, psychiatrist, teacher and GP independently. These inconsistencies were not easily explained by differences in quality scores. The most notable, albeit limited, convergence in findings was that in three studies, females were more likely to recommend seeking family support (Coles, et al., 2016; Furnham, et al., 2014; Yamawak, et al., 2015) and in three studies, recommend seeking help from a counsellor (Burns & Rapee, 2006; Coles, et al., 2016; Yamawaki, et al., 2015). Overall gender differences in the types of help recommended were either not found, or when they were, reported higher recommendations by females but with limited replicability. In one study where young people were asked to indicate the reasons why they would seek help, no gender differences were found in the reasons identified (Byrne, et al., 2015). In addition, no gender differences were found in valuing friendship as important in supporting someone with a mental health difficulty (Mason, et al., 2015).

## **Social Anxiety and Social Phobia**

Four studies explored levels of MHL for social anxiety or social phobia (Coles, et al., 2016; Furnham, et al., 2014; Mason, et al., 2015; Olsson & Kennedy, 2010). Literature on the effect of gender on the recognition of social anxiety or social phobia is sparse. One study found that females were more likely to correctly identify social phobia (Furnham, et al., 2014), whilst no difference was found by Coles, et al. (2016). Both studies achieved similar quality scores, and a possible explanation for these differences is not obviously apparent, other than cultural differences between British (Furnham, et al., 2014) and American young people (Coles, et al., 2016). The two further studies did not report on correct recognition across the genders.

Minimal gender differences were found in help-seeking and treatment recommendations. Olsson and Kennedy (2010) found no gender differences in help recommendations. Furthermore, no differences were found in the recommendation of adult help or valuing friendships as important (Mason, et al., 2015). Coles, et al. (2016) identified some gender differences; females were more like to endorse seeking treatment, either help from a counsellor, friends or family, but there was no difference in endorsing help from a psychologist, psychiatrist, teacher or doctor.

## **Psychosis and Schizophrenia**

Four studies explored MHL for psychosis or schizophrenia. Both genders recognised psychosis less than depression (Cotton, et al., 2006) and no gender differences were found in self-reported knowledge of schizophrenia (Williams & Pow, 2007). As opposed to depression, gender differences in the recognition of psychosis were rarely

reported and no gender differences in the correct identification of a vignette depicting psychosis were found in three studies (Furnham, et al., 2014; Leighton, 2010; Melas, et al., 2013). In contrast, one study found that females aged between 18-25 years were better at recognising psychosis than males of the same age range, but no gender difference was found between males and females aged 12-17 years (Cotton et al., 2006). No gender difference was found in the likelihood of recommending help-seeking for psychosis (Melas, et al., 2013), but females were more likely to endorse professional help and be more flexible in the sources of help recommended (Cotton, et al., 2006; Leighton, 2010).

### **Other Mental Health Difficulties**

One study included in the review examined young people's MHL for other mental health difficulties, such as; addiction, anorexia, bulimia, OCD and bipolar disorder. Females were found to be more likely to correctly identify the vignette difficulties (Furnham, et al., 2014). This study achieved a good quality score of 75% and may therefore serve as a marker for comparison with future research for gender differences in levels of MHL for less studied difficulties. In addition, Williams and Pow (2007) found that females demonstrated higher levels of self-reported knowledge for eating disorders and self-harm. However, no gender differences were found in levels of self-reported knowledge for severe stress, anxiety disorders, personality disorder or manic depression (Williams & Pow, 2007).

## **General Differences in Gender**

In comparison to males, females reported more concern for the person in the vignette, estimated it would take a long time until the person was better (Burns & Rapee, 2006; Byrne, et al., 2015; Coles, et al., 2016), identified higher levels of distress, indicated the person would be more difficult to treat and had greater sympathy (Furnham, et al., 2014). Droga, et al. (2011) found that males were more likely to identify mental health problems as difficult to treat. In two studies, females demonstrated more accurate estimation of the prevalence of mental health difficulties (Droga, et al., 2011; Yamawaki, et al., 2015).

## ***How Are Gender Differences in MHL of Young People Investigated?***

In order to address the second aim of this review, this section will report information on the sample, research design, materials and measures and the methods of analysis in the studies reviewed.

## **Sample**

How well the samples reflected the individual study's target population was questionable. The age of the sample varied and was predominantly based upon convenience sampling methods. Nine studies identified 'adolescents' as their target population although the sample recruited often did not reflect the age span of adolescence, for example Burns and Rapee (2006) sample included just 15 and 16 year olds compared to Leighton (2010) who included adolescents aged 11-18 years. A further four studies identified 'young people' as their target population, with

Cotton, et al. (2006) achieving an encompassing sample of 12-25 year olds, whereas the ‘young people’ sample of 11-18 year olds in the Olsson and Kennedy study (2010) is better reflective of adolescents. This variance is perhaps demonstrative of the lack of agreement in defining this sample. The remaining study included a university student sample with mean age of 19.1 years (Yamawaki, et al., 2015).

Four studies included samples from Australia, three from the USA, two from England and Scotland and one from Ireland, Japan, Sweden and Nigeria (see Table 1.3). Demographic diversities such as social, cultural, and ethnic variables within the samples were rarely stated by the studies or reported in the analysis. The exceptions included an analysis across rural compared to urban participants (Droga, et al., 2011), educational programmes (Melas, et al., 2013) and race (Olsson & Kennedy, 2010). Where demographic diversity was analysed the variable of gender was no longer considered. The analysis of MHL across gender and culture occurred in one study which compared American and Japanese students (Yamawaki, et al., 2015). American students were significantly more likely to recognise depression ( $p<.001$ ), and Japanese students were more likely to underestimate the prevalence of depression, ( $p<.001$ ). Gender analysis was only reported overall and not within or between American and Japanese students.

Access to young people was primarily through their place of study, typically schools. It is worth noting that there is an under-representation of university samples in this review due to the exclusion criteria (Table 1.2). Access to young people was also achieved by one study through using a large-scale computer assisted telephone survey of listed household numbers (Cotton, et al., 2006).

## **Research Design**

The majority of studies used a quasi-experimental or non-experimental cross sectional survey design. This is indicative of the need to strengthen the quality of research design in exploring gender differences of MHL, however this also reflects the suitability and practicality of research exploring gender differences. Two studies used purely quantitative methodology (Williams & Pow, 2007; Yamawaki et al., 2015). Only one study used a qualitative design (MacLean, et al., 2013), which makes comparison of their findings difficult. However having task-centred focus groups and using case vignettes helped retain the focus on MHL and allowed for some comparison of the findings with questionnaire based vignettes.

The remaining studies utilised a mixed methods design whereby MHL was examined using a questionnaire which included both closed and open questions. The closed questions typically adopted a Likert-type scale and were analysed quantitatively. The open questions collected written or verbal qualitative data that was then coded using content analysis and subsequently the generated codes were analysed quantitatively. This approach was intended to improve the ecological validity of the study by requiring the participants to generate responses rather than select from a response repertoire provided. However, there were low completion rates of open-ended questions reported by one study (Furnham, et al., 2014) and the quantitative analysis of qualitative data ultimately loses some of the depth of the responses and may therefore not be the most appropriate method.



## **Materials and Measures**

### *Development of Case Vignettes*

In all of the studies utilising the vignettes, these were adapted to match the age group of the participants. Furthermore, cultural adaptations were made to existing research vignettes to increase ecological validity; using an Irish adolescent sample (Byrne, et al., 2015) and comparing an American sample with a Japanese sample (Yamawaki, et al., 2015).

Very little information was given about the development of non-clinical vignettes depicting normal life stress. Typically the development of clinical case vignettes was based upon clinical criteria for mental health difficulties as outlined in the DSM-IV or ICD-10. Burns and Rapee (2006) did not include the symptom of psychomotor agitation as this is evidenced to not be present in the adolescent population. The vignettes from Burns and Rapee (2006) were used in two other studies and adapted for their target population by, for example changing names to suit an Irish setting (Byrne, et al., 2015; Coles et al., 2016). In one study the vignettes were derived from unidentified other studies and case study textbooks (Furnham, et al., 2014) and in another, the criteria used to develop the vignette was not described (MacLean, et al., 2013). The remaining studies utilised the vignettes from three other published sources (Jorm, et al, 1997; Jorm & Wright, 2007a; Jorm, Wright & Morgan, 2007b). The validation of the case studies by mental health professionals was reported in two studies (Byrne, et al., 2015; Leighton, 2010). The case vignettes used were provided in the article by only six studies (Burns & Rapee, 2006; Byrne, et al., 2015; Cotton et al., 2006; Leighton, 2010; Olsson & Kennedy, 2010; Yamawaki et al., 2015).

### *Case Vignettes*

A total of 12 of the 14 studies utilised written case vignettes in order to facilitate the exploration of levels of MHL. The remaining two studies (Droga, et al., 2011; Williams & Pow, 2007) relied solely on questionnaires. The number of vignettes used in a study ranged from one (Yamawaki, et al., 2015) to nine (Furnham, et al., 2014), with the average being four. The type of mental health difficulty characterised in the vignette also varied (see Table 1.3), however depression was represented in all of the studies using vignettes, whilst psychosis/schizophrenia was represented in four studies (Cotton et al., 2006; Furnham, et al., 2014; Leighton, 2010; Melas et al., 2013) and social anxiety/social phobia was represented in four studies (Coles et al., 2016; Furnham, et al., 2014; Mason et al., 2015; Olsson & Kennedy, 2010). Furnham, et al. (2014) also included vignettes for anorexia, bulimia, obsessive compulsive disorder, ADHD, and bipolar disorder. In addition, six studies used vignettes depicting a normal life crisis or stress to determine whether young people could distinguish between clinical and non-clinical difficulties.

The majority of studies presented participants with each vignette. Only one study controlled for the possible effects of the order that the vignettes were presented in, using counterbalancing (Coles, et al., 2006), whilst the random allocation of vignette type was also undertaken in one study (Cotton, et al. 2006). The possible interaction between gender of participant and gender of vignette was considered in three studies (Cotton, et al., 2006; Furnham, et al., 2014; Hernam, et al., 2010; Leighton, 2010).

### *Measures of MHL*

The majority of studies utilised questionnaires to measure levels of MHL, with the exception of one study which used a task-orientated focus group (MacLean, et al., 2013). Four studies used an adapted MHL based questionnaire from previous research into adult MHL undertaken by Jorm et al., (1997) and Jorm and Wright (2007a). The questionnaires gathered quantitative data, through closed questions with Likert scale responses. The questionnaires also obtained qualitative responses, through open-ended questions, which were then converted into quantitative data through coding and content analysis. Although the MHL questionnaire demonstrates good face validity, the tool has not been validated. This is similar to the Friend in Need questionnaire, developed and used by Burns and Rapee (2006) and also used by Coles et al. (2016) as a measure of MHL. The Personal Stigma Scale and Social Distance Scale were used as secondary measures to a MHL questionnaire by Mason, et al. (2015). The remaining seven studies appeared to construct their own questionnaire to measure levels of MHL. Limited information about the content of these questionnaires was provided, with the exception of Droga, et al. (2011) and Leighton (2010) who included a copy of the questionnaire in the appendices.

The measures of MHL were primarily completed in hand-written form, with the exception of Byrne, Swords and Nixon (2015) who used web-based questionnaires completed during school, and the large scale telephone survey undertaken by Cotton, et al (2006).

## **Discussion**

The aim of this systematic review was to critically examine empirical studies that have measured gender differences in the levels of MHL amongst young people (aged 12-25 years) in the general population. The review attempted to identify whether gender differences exist, and if present, where the gender differences were found. In addition, the review examined how these differences in MHL were investigated.

### ***Summary of Main Findings***

#### **Are There Gender Differences in the Levels of MHL in Young People?**

The finding of gender differences in the levels of MHL in young people was mixed and complex. The existence of gender differences was influenced by the diagnosis of the vignette, specific symptoms and treatment recommendations. More generally, females reported more concern/sympathy, estimated longer time until recovery, and more accurate estimation of prevalence of mental health difficulties compared to males.

#### ***Depression***

The most frequently studied and most consistent reporting of gender differences in levels of MHL was for depression. Females appeared to be more likely to be able to correctly identify and recognise depression than males. This difference may be explained by increased exposure to depression amongst females through personal or peer group experience (Hankin, Mermelstein, & Roesch, 2007; Kessler, 2003; Kessler, et al., 2005; Rudolph, 2002) which is associated with increased recognition

(Coles & Coleman, 2010; Yamawaki, et al. 2015). This review also highlighted that there appear to be gender differences in the identification of specific symptoms of depression, which has important implications for the delivery of interventions targeting improving levels of MHL in young people. Females are more likely to identify symptoms of weight loss and fatigue (Burns & Rapee, 2006; Bryne, et al., 2015), as well as appetite loss, insomnia and lost interest in activities (Burns & Rapee, 2006) as part of depression. Both genders displayed good identification of suicidal thoughts and poor identification of diminished ability to think. Young females appeared more likely to recommend help-seeking for depression overall which is consistent with existing adult MHL literature (e.g. Holzineger, et al., 2012; Oliver, et al., 2005). There was also an indication that females were more likely to express the intention to help a friend access support (Melas, et al., 2013; Olsson & Kennedy, 2010), which may be explained by different levels of intimacy and expectation in young females' peer groups (Rudolph, Flynn & Abaied, 2008).

Less conclusive were the findings pertaining to gender differences in treatment recommendations. The inconsistencies in findings could not be accounted for by differences in the quality scores of the articles. Interpretation of this component was complicated by treatment recommendations being examined differently across the studies in terms of the choices provided to the participants and how they were grouped together. Overall, gender differences in the types of help recommended were either not found, or when they were, reported higher recommendations by females but with limited replicability. The most consistent findings were that females were more likely to recommend seeking family or friend support and help from a counsellor (Burns & Rapee, 2006; Coles, et al., 2016; Furnham, et al., 2014;

Yamawak, et al., 2015). This difference may be explained by females being more likely to favour psycho-social explanations of depression (Holzineger, et al., 2012) and the influence of gender roles, such as the expectation for males to be independent and in control, inhibiting help-seeking (Vogel, Wester & Larson, 2007).

### *Social Anxiety and Social Phobia*

The literature exploring the effect of gender on levels of MHL for social anxiety was sparse and further research is clearly needed in this area. Gender differences in the recognition of social anxiety were not definitive, but a tentative trend towards greater recognition by young females is noted. This finding is replicated in the adult population with females reported to have greater recognition for social anxiety and other anxiety disorders (Coles & Coleman, 2010). Minimal gender differences were found in help-seeking and treatment recommendations. Only one study identified gender differences with young females being more likely to endorse seeking treatment, help from a counsellor, friend or family (Coles, et al., 2016) in line with evidence in the adult literature for anxiety disorders (Coles & Coleman, 2010; Susuloda, Mojtabai & Mendelson, 2015).

### *Psychosis and Schizophrenia*

The studies exploring the role of gender in levels of MHL for psychosis and schizophrenia were also limited, but more consistent than social anxiety/social phobia. Both genders recognised psychosis less than depression or anxiety disorder and this may be accounted for the greater prevalence and exposure to depression and anxiety disorders than psychosis (Gibbons, Thorsteinsson & Loi, 2015). In addition,

the recognition of psychosis requires knowledge of a more specific set of symptoms compared to the broader symptoms of depression and anxiety (Gibbons, et al., 2015). This is particularly concerning given the importance of recognising signs of mental illness in order to reduce the duration of untreated psychosis and improving prognosis (Apeldoorn, Sterk, Van Den Heuvel, et al., 2014; Marshall, Lewis, Lockwood, et al. 2005). Gender differences in the recognition of psychosis or treatment recommendations were not typically identified in the studies reviewed, or in adult MHL findings (Lauber et al, 2005; Sai & Furnha, 2013). An interesting exception was found by Cotton et al. (2006), whereby females aged 18-25 years demonstrated better recognition of psychosis than males, but no gender differences was found between ages 12–17 years. Further research is needed to help explain the age-gender interaction for the recognition of psychosis.

#### *Other Mental Health Difficulties*

The rare inclusion of other mental health difficulties and lack of replicability in the studies reviewed inhibits drawing conclusions about gender differences in this area. Females were found to be more likely to identify vignettes depicting; addiction, anorexia, bulimia, OCD and bipolar disorder (Furnham, et al., 2014), and record higher levels of self-reported knowledge for eating disorders (Williams & Pow, 2007) compared to males. In the interest of public health, replication of the Furnham et al. (2014) study is needed, given the good quality score of the study and the scarcity of literature looking at gender differences in levels of MHL in young people for other mental health difficulties.

## **How Are Gender Differences in MHL Investigated?**

This section will firstly discuss issues with the research sample and design used by the studies reviewed and secondly, with case vignettes, given that they were the predominant material used. Finally, the measures of MHL will be considered.

### *Research Sample and Design*

The age range of the samples varied and was limited in their generalisability to the target population. This was reflective of both limitations in convenience sampling methods (Farrokhi & Mahmoudi-Hamidabad, 2012; Mackey & Gass, 2005) and inconsistencies in age bound definitions of concepts such as adolescence and of young people (Patel, et al., 2007). Of concern, is that demographic diversities such as social, cultural, and ethnic variables were rarely controlled for, in the analysis, despite evidence of these factors being correlated with variability in the levels of MHL (e.g. Droga, et al., 2011; Kaneko & Motohashi, 2007; Yamawaki, et al., 2015).

Quasi-experimental designs were largely adopted in the studies reviewed. This method was both practical and appropriate for research exploring gender differences, as gender is not a true independent variable that can be randomly assigned. The use of a mixed methods design by the majority of studies allowed for increased ecological validity of the research, with young people being required to generate responses indicative of their levels of MHL rather than selecting from available options in a Likert-type scale (Burns & Rapee, 2006). However a loss of depth to the data occurs when qualitative responses are coded quantitatively in content analysis (Driscoll, Appiah-Yeboah, Salib & Rupert, 2007). In addition, the need to collect



and analyse qualitative data can lead to researchers reducing the sample size (Driscoll, et al., 2007), which has implications when the concept, such as gender differences in MHL, has a small effect size (e.g. Swami, 2012) and most psychological gender differences have relatively small effect sizes (Hyde, 2005). Therefore this increases the risk of type II errors as small but significant gender differences in MHL may have been unidentified. It is important that future research incorporates estimates of effect size for gender difference in levels of MHL in order to include an adequate sample size to achieve sufficient statistical power. In addition, future research should consider using mixed methods where the data is not transformed (Driscoll, et al., 2007).

### *The Use of Case Vignettes*

Vignette research enables sensitive topics to be evaluated, and has been shown to elicit responses similar to how the participant would respond in real life (Leighton, 2010; Ganong & Coleman, 2006; Hughes & Huby, 2004). However, the generalisability of behaviours and responses, and the accurate prediction of how a participant would respond in real life situations, are limited and requires characters and scenarios that feel real (Burns & Rapee, 2006; Leighton, 2010). The case vignettes were commonly developed using clinical criteria from the DSM-IV or ICD-10, or replicated from previously used research vignettes. Of concern is that only two studies reported that the vignettes were validated by a mental health professional. Positively, case vignettes were adapted to match the age and culture of the participant groups. However, mental health difficulties, particularly depression, can present differently across males and females (Bennett, Ambrosini Kudes, et al.,

2002; Carder, Joyce, Mulder, et al., 2000). It is therefore necessary for future research to consider adapting the case vignettes to match the gender specific presentation of depression to strengthen construct validity. The validation from local mental health professionals is likely to have greater importance when using vignettes developed for other populations, to account for cultural differences in presentations of mental health difficulties. Gould (1996) suggested that the internal validity of vignettes research can be enhanced through; 1) developing vignettes from the literature/clinical cases, 2) a panel of experts reviewing the vignettes, and 3) pretesting to remove questions that are ambiguous.

Additional limitations of the methodology of the studies reviewed are that the use of counterbalancing for the order of the vignettes or random allocation of vignette type was rarely undertaken in the studies reviewed. Furthermore, the possible interaction between the gender of participant and gender of vignette on levels of MHL was considered in only three studies (Cotton, et al., 2006; Furnham, et al., 2014; Hernam, et al., 2010; Leighton, 2010). Therefore, the presence of these potential extraneous variables is a threat to the reliability and validity of the conclusions drawn in a number of the studies.

### *Measures of MHL*

The lack of standardised and validated tools to measure levels of MHL was evident across the studies reviewed. This highlights the need to formally develop a measure of MHL that demonstrates both construct validity and internal consistency to enhance the area of research. Half of the studies used or adapted the MHL based questionnaire from previous research in adult MHL (Jorm et al., 1997; Jorm &

Wright, 2007a) or the Friend in Need Questionnaire (Burns & Rapee, 2006), The remaining studies appeared to construct their own questionnaire. Although there were some exceptions (Droga et al., 2011; Leighton, 2010), limited information about these constructed questionnaires was provided which challenges the ability for both critical analysis and replicability.

Given the applicability and simplicity of using technology in research (Jewitt, 2012; Riva, Teruzzi & Anolli, 2003), it is somewhat surprising that the large majority of studies used written materials for both vignettes and data collection. Young people are familiar with technology and the use of web-based questionnaires would arguably be a more efficient research tool with the exception of when these resources aren't available. Furthermore, the use of video based vignettes could help enhance the realism of the character and scenarios, which is necessary for improving the ecological validity of the research (e.g. Leighton, 2010).

### ***Limitations***

A number of the studies excluded from this systematic review were excluded due to either the analysis between gender and MHL not being reported, or when gender analysis of levels of MHL occurred this did not distinguish a young people sample. This raises two limitations. Firstly, if the studies that did not report an analysis between gender and MHL actually found no gender differences then the results of the literature review reflect a positive bias. Secondly, as highlighted in the introduction, the age boundaries that define young people vary across research. This means that relevant data, for example in a sample of 18-30 years olds has been excluded in order to maintain the homogeneity of the studies included in the review.

The analysis of inter-rater reliability achieved a level indicative of a substantial agreement (Landis & Koch, 1977). This is somewhat concerning given that for 38% of the ratings there was disagreement between the researcher and the independent researcher for the quality assessment scores. This reflects both the limitations of using Kappa as a measure of inter-rater reliability, as well as the subjectivity and variance in interpretation of quality assessment frameworks. The judgment about what level of Kappa is acceptable and its usefulness in research is an ongoing debate (McHugh, 2012)

### ***Clinical Implications and Research Recommendations***

The findings from this systematic review have implications for the area of public health. Firstly, gender differences, particularly in levels of MHL for depression exist, with females more likely to recognise depression and specific symptoms of depression, compared to males. Therefore, the design and delivery of gender specific targeted interventions for improving levels of MHL and analysing possible gender differences in outcomes, is important (Kelly, et al., 2007; Lauber et al., 2005). Secondly, the replication of studies exploring gender and cultural differences in the levels of MHL for young people is needed, particularly for mental health difficulties that have been under represented in the research. This should also take into account similarities and differences between genders at a symptom recognition level, which could further help to tailor intervention programmes.

The research into MHL would be enhanced by the development of a standardised and validated measure of MHL appropriate for the target population. This would also help to facilitate a commonality in the range of treatment recommendation options provided to participants to enable clear comparison across genders. In addition, revising the leading questions, such as “what do you think is wrong?” from the questionnaires will also help minimise the risk of overestimating the levels of MHL by priming the participants that there is a difficulty. Research using video vignettes may also enhance the ecological validity of the research.

It is also important that future studies continue to undertake and report gender analysis, even if gender differences have not been found. Furthermore, in order to improve the quality of the research, counterbalancing the order of presentation of the vignettes and controlling for the complexity of interactions between participant gender and vignette gender is required (Davies, et al., 2016; Sai & Furnham, 2013).

## ***Conclusion***

The picture of gender differences in the levels of MHL of young people is complex. Gender differences are most consistently reported in levels of MHL for depression, with females found to have higher levels of MHL than males, and more likely to recommend seeking help from family, friends and a counsellor. Greater replicability of the research is needed, with a focus at symptom level, particularly for a wider range of mental health difficulties. The validity of the methodological approaches to MHL, and the use of case vignettes, requires improvement in subsequent research. Furthermore, a cost-benefit and outcomes analysis of developing gender-specific interventions should be considered.

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## **Chapter 2: Empirical Paper**

### **Male Professional Footballers' Experiences of Mental Health Difficulties and Help-Seeking**

In preparation for submission to Journal of Clinical Sport Psychology

(See Appendix E for author instructions for submission).

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## **Abstract**

Male professional footballers represent a population that is at-risk of developing mental health difficulties and not accessing professional support. The prevalence of mental health difficulties in male professional football is similar to the general population. Little is known about professional footballers' experiences of mental health difficulties and help-seeking. This qualitative study provides in-depth insight into male professional footballers' lived experiences of mental health difficulties and how this impacts upon their willingness to seek support. Seven participants undertook a semi-structured interview and data was analysed using interpretative phenomenological analysis. One superordinate theme emerged; Survival. This related to survival in the professional football world, of mental health difficulties and after transition into the 'real world'. This is discussed through six subordinate themes and alongside existing literature pertaining to identity, transition, personality, emotional development and emotional regulation. Recommendations are made for the provision of mental health education and support. Directions for future research are identified.

*Key Words: Professional football, soccer, athletes, mental health difficulties, help seeking, male mental health, interpretative phenomenological analysis.*

## **Introduction**

### ***Mental Health Difficulties and Help-Seeking***

One in four people will experience mental health difficulties during their life (Department of Health [DoH], 2011). The level of mental health stigma is high (Corrigan, 2004; Corry, 2008) and this can negatively impact wellbeing because people who could benefit from mental health services do not access them (Corrigan, 2004; Evans-Lacko, Henderson & Thornicroft, 2013; Zartaloudi & Medianos, 2010). Personal attitudes towards mental health can be barriers to accessing support (Reynders, Kerkhof, Molenberghs & Audenhove, 2014) and shame and stigma towards help-seeking are associated with a passive coping style; whereby individuals do nothing, hoping that their difficulties will alleviate (Reynders, et al., 2014).

Professional help is important for receiving evidence-based interventions to manage mental health difficulties (Meltzer, Bebbington, Brugha et al., 2003; Oliver, Pearson, Coe & Gunnell, 2005). These interventions can facilitate improved wellbeing, symptom reduction, recovery and quality of life (Appleby, Kapur, Shaw, et al., 2011; Rickwood, Deane, Wilson & Ciarrochi, 2005), as well as reduce the risk of suicide (Deisenhammer, Huber, Kemmler et al., 2007; Michelmores & Hindley, 2012; Reynders, et al., 2014). Help-seeking behaviour is also important for receiving early intervention to minimise the impact of mental health difficulties and improve prognosis (DoH, 2011). A concern for public health is that men display higher levels of stigma (Howerton, Byng, Campbell, et al., 2007; Golberstein, Eisenberg & Gollust, 2008), negative attitudes towards mental health (DoH, 2011; Evans-Lacko, et al., 2013) and less help-seeking behaviour (Mansfield, Addis & Courtenay, 2005;

Richwood, Dean & Wilson, 2007; Vaswani, 2011). Furthermore, men are at higher risk of suicide (Appleby et al., 2011), alcohol dependency and being detained in psychiatric hospitals (Wilkins, 2010).

### ***Mental Health Difficulties in Sport***

The onset and prevalence of mental health difficulties in young people and young adults (16-34 year olds) is higher than in other age groups (Appleby et al., 2011; Gulliver, Griffiths & Christensen, 2012; Kessler, Amminger, Aguilar-Gaxiola, et al., 2007). It is concerning that, whilst young people are at-risk of developing mental health difficulties, they are the least likely group to access support (Rickwood, et al., 2007). Professional and elite sports people typically fall within this at-risk age group. The average retirement age across a range of sports is 34 years indicating that most sports people fall into the at-risk age group during participation (North & Lavalley, 2004), however they are underrepresented in the mental health literature. This may be due to difficulties in accessing elite sports people for research or because exercise and participating in sports has widely been regarded as a protective factor against mental health difficulties (Hughes & Leavey, 2012).

Research into mental health difficulties in sport is a relatively new area of study. Substantial gaps exist in understanding diagnostic and therapeutic issues, risk factors, prognosis and the unique experiences of this sub-population (Hughes & Leavey, 2012; Reardon & Factor, 2010). Mental health difficulties exist among sports people. Eating disorders and substance misuse have been the most studied and appear common in athletes (Reardon & Factor, 2010). A recent Australian study of



elite athletes (Olympic/Paralympic, professional, state-, national-, or international-level athletes) found a similar prevalence of mental health difficulties to community epidemiological studies (Gulliver, Griffiths, Mackinnon, et al., 2015). A total of 46% of elite athletes were experiencing symptoms of at least one mental health difficulty. Depression was the highest reported difficulty (27.2%), followed by eating disorders (22.8%), social anxiety (14.7%), generalized anxiety (7.1%) and panic (4.5%).

Understanding what factors influence help-seeking for mental health difficulties is important. A qualitative study by Gulliver, et al. (2012) identified stigma as the most important barrier to young elite athletes seeking support. This included negative self-appraisal, embarrassment and fear of negative appraisal, particularly for male athletes. Athletes considered seeking support for mental health as embarrassing. It was more acceptable to seek help for performance. The lack of mental health literacy (MHL), concerns about confidentiality, and past negative experiences of help-seeking were also barriers. MHL is the ability to recognise mental health difficulties, beliefs about these, and awareness of support (Jorm et al, 1997). Positive relationships with help providers and coaches were facilitators to accessing support (Gulliver, et al. 2012).

Research has started to explore mental health difficulties in high level sport (e.g. Gouttebarga, Frings-Dresen & Sluiter, 2015; Gulliver, et al., 2012; Gulliver, et al., 2015; Reardon & Factor, 2010). This has coincided with increased social media reports of mental health difficulties in sport and former professionals sharing their experiences through, for example the BBC documentary 'Football's Suicide Secret' (DeHaney, 2013) and endorsing specialist clinics, such as Sporting Chance.

## ***Mental Health Difficulties in Professional Football***

Mental health in professional football remains an understudied area due to the high profile nature of the sport and a lack of investment into mental health by the governing bodies. This is surprising because the majority of footballers fall into the category of young males who are at-risk of experiencing mental health difficulties and suicide (Appleby et al. 2011; Gulliver, et al., 2012) and do not engage in help-seeking behaviour (Richwood, et al., 2007; Vaswani, 2011). Professional footballers also fall into the at-risk age group for onset of mental health difficulties with the average age of signing their first professional contract, 18.2 years, and average age of retirement, 32.5 years (Drawer & Fuller, 2002). Professional footballers are subject to a number of stress factors that could contribute to mental health difficulties and hinder help-seeking behaviour. These include severe or recurrent injury (Gouttebarga, et al., 2015; Gulliver et al., 2015), osteoarthritis (Gouttebarga, Inklaar & Frings-Dresen, 2014), football organisational and financial pressure and the loss of public and media interest following retirement (Gouttebarga, et al., 2015; Kristiansen, Halvari & Roberts, 2012).

### **Prevalence**

The prevalence of mental health difficulties in professional football is only recently being explored. Gouttebarga, et al. (2015) found that 26% of current footballers reported experiencing anxiety and/or depression, 10% experienced distress, 5% low self-esteem, 7% adverse smoking habits, and 19% adverse alcohol behaviours. The reported prevalence of mental health difficulties increases following retirement (Gouttebarga, Aoki, & Kerkhoffs, In Press), such that 35% of former footballers

experienced anxiety and/or depression, 18% experienced distress, 24% adverse alcohol behaviour, 28% sleep disturbance and 65% adverse nutrition behaviour. Footballers' experiences of mental health difficulties were significantly associated with severe injury, low social support and recent life events (Gouttebarga, et al. 2015).

Professional footballers are in a unique position in society and are held in the position of role models. Their methods of coping as well as their willingness to discuss and break down the stigma associated with mental health could impact upon the general population. For example, following the railway suicide of German international goalkeeper Robert Enke there was a significant increase in the number of 'copycat' railway suicides in the general population, despite media sensitivity and preventative measures (Ladwig, Kunrath, Luckaschek & Baumert, 2012).

The provision of thorough mental health support within professional clubs appears to be limited. For example, only 7% of Dutch professional football clubs undertook mental health investigations (Gouttebarga & Sluiter 2014). Young footballers have also been critical of the support offered for the emotional and psychological disturbances experienced during transitions, such as being released from their club (Brown & Potrac, 2009). Clinical levels of psychological distress have been reported in young footballers after deselection (Blakelock, Chen & Prescott, 2016) and the transition out of professional football alongside a breakdown of athletic identity is associated with considerable emotional distress, including feelings of anxiety, fear, depression, anger, humiliation, and rejection (Brown & Potrac, 2009; Brownrigg, Burr, Locke, Bridger, 2012). Research has emphasised the need for pre-planning of

transition, providing support and actively encouraging help-seeking to support the footballers' life-long wellbeing (Brownrigg, et al., 2012; Gouttebarga, et al., 2015). However, support offered by professional football clubs is considered inadequate, particularly by footballers forced to retire through injury (Drawer & Fuller, 2002).

### ***Aims of Current Research***

Mental health is a growing area of interest and concern for football's governing bodies. Male professional footballers are at-risk of mental health difficulties (Appleby et al. 2011; Gulliver, et al., 2012) and evidence suggests that the prevalence of mental health difficulties is similar to the general population (Gouttebarga, et al., 2015; Gouttebarga, et al., In Press). Young male professional footballers are likely to experience higher levels of stigma and low levels of MHL, which might limit the likelihood of seeking support if they experience mental health difficulties (Richwood, et al., 2007; Vaswani, 2011). Currently there is a lack of qualitative research exploring the lived experiences of mental health difficulties and help-seeking in professional footballers. Advancing research and understanding in this area is important for educating and supporting this at-risk population.

The present study aims to expand upon the knowledge and understanding of male professional footballers' experiences of mental health difficulties and help-seeking. Using an in-depth idiographic approach, this study elicits the opportunity to inform future research and policy, mental health education and support within professional football. Focusing on personal meaning, experiences and perceptions enables this to be informed through the voice of footballers as experts by experience.

## **Methodology**

### ***Research Design***

A qualitative research design was adopted. The research aimed to gain an in-depth understanding of male professional footballers' experiences of mental health difficulties and help-seeking, therefore interpretative phenomenological analysis (IPA) was considered appropriate (Smith & Osborn 2008; Smith; Flowers & Larkin, 2009). IPA is an idiographic approach and therefore focuses on personal meaning and how people, in a given context and with shared experiences, perceive their experiences and make sense of them (Smith & Osborn, 2008; Smith, et al., 2009). IPA is not hypothesis driven, therefore the research sought to inquire and generate meaning from the participants' experiences and adopt the stance of flexible and open enquiry to encourage personal depth to the data (Smith & Osborn, 2008). IPA encourages the researcher to reflect upon their own beliefs and preconceptions to allow the focus to remain on the participants' experiential world (Smith & Osborn, 2008).

An alternative method, such as Grounded Theory (Glaser & Strauss, 1967) may have been appropriate. However, Grounded Theory is best suited to an explanatory research question to build an inductive theory or model to account for the participants' experiences (Chamaz, 2003). IPA was chosen because of the potential to produce rich thematic descriptions and insights into lived experiences (Starks & Trinidad, 2007) which, would help address the scarcity of knowledge and understanding of professional footballers' experiences of mental health difficulties.

## *Participants*

In line with IPA methodology and consistent with an idiographic approach, a small homogenous sample was purposively recruited (Smith, et al., 2009). Seven male professional footballers were recruited. The participant inclusion and exclusion criteria are detailed in Table 2.1.

Table 2.1: Participant inclusion and exclusion criteria

Inclusion Criteria	1) Has held a professional football contract
	2) Acknowledged experiencing mental health difficulties
	3) At least 18 years old
Exclusion Criteria	1) Retired from football for more the 10 years
	2) Non-English speaking

## Demographic Information

The participants were aged between 32 to 41 years (mean =37.2 years). One participant declined to provide his age. Four participants identified themselves as of White British ethnic origin, two of Mixed/Multiple ethnicities and one of Black/Caribbean British ethnic origin.

Six of the participants were retired. One participant was playing football part-time. Two participants were involved in football coaching a professional clubs. All participants reported experiencing an injury of greater than six weeks during their career. The number of professional clubs played for ranged from 2 to 6 (mean = 4.5 clubs). The highest playing level ranged from Premiership (n = 3), Championship (n = 1), League 1 (n = 1) and former League 1\* (n = 2). Two participants had also played at youth international level.

A form of professional support was accessed by three participants. One participant accessed a sport psychologist during their professional football career. One participant accessed the PFA and NHS, and one participant accessed a private clinic after their professional career. All participants identified contact with another professional footballer who has experienced mental health difficulties. Contact with family and friends who have experienced mental health difficulties were also identified by the participants.

*\* Played with a club in the second level of the England football tier system and formerly called League 1 (Renamed as League Championship in 2004/2005).*

## ***Materials***

A semi-structured interview schedule (Appendix F) was developed in line with IPA methodology (Smith, et al., 2009). The questions were constructed through consultation with the research team and centred upon the research aims. The participants were held in the position of experts by experience, therefore the interview schedule was designed to be open and flexible in order to guide possible questions and prompts whilst being led by the participants.

## ***Procedure***

### **Ethical procedure**

Ethical approval was granted by Coventry University (Appendix G). The research adhered to the British Psychological Society (BPS) Code of Human Research Ethics (BPS, 2011) and BPS Code of Ethics and Conduct (BPS, 2009) guidelines.

## ***Recruitment***

A snowballing sampling method was adopted due to the difficult to access population. Participants were recruited through the Professional Footballers Association (PFA), former player associations and FAD FC (Football's Awareness of Depression Football Community). Gatekeepers informed potential participants about the research and shared the participant information sheet (Appendix H) and researcher's contact details. The researcher contacted footballers who expressed an interest in participating to arrange an interview. Participants who expressed an interest but did not disclose difficulties with mental health were not recruited.



## **Interview procedure**

Interviews were conducted in a private room near to each participants' location, such as an office at the local county FA. Participants were asked to read the information sheet and were given the opportunity to ask questions or express any concerns. Participants then provided written consent (Appendix I). Demographic information was collected (Appendix J). The interviews were audio recorded using a Dictaphone. The duration of interview ranged from 65 to 110 minutes (mean duration of 83 minutes). Participants were given the Debrief Information Sheet upon completion (Appendix K).

## ***Analysis***

Upon completion of each interview, the audio recordings were transcribed in verbatim. Identifying information was removed. The data was analysed following Smith, et al.'s (2009) procedure for IPA (Appendix L). Excerpts from three participants' transcripts are included in Appendix M to demonstrate the initial noting and emergent themes. Connections between emergent themes and participants were explored through dynamic visual mapping to help identify superordinate and subordinate themes (Appendix N).

## **Validity of study**

Validity and quality of qualitative research can be supported through the use of guidelines and credibility criteria (Smith, 2003). Yardley (2000) outlined four broad principles which were applied to this research; sensitivity to context,

commitment and rigour, transparency and coherence, and impact and importance (Smith, 2003; Smith, et al., 2009; Yardley, 2000). The initial coding, emergent themes and final themes were discussed with the research team. An independent researcher coded excerpts from two transcripts and similarities and discrepancies in coding were discussed.

### **The researcher's position**

The researcher was a 27 year old, female, White British, Trainee Clinical Psychologist. The researcher currently participates in Women's Football and previously represented the England international youth teams. A bracketing interview was undertaken to explore and identify the researchers pre-existing beliefs (Smith, et al., 2009). The researchers' beliefs incorporated the notion that talking about feelings is hard, and a curiosity around the attachment relationship between the footballer and the manager. The researcher was also more attentive to aspects about loss. The process of making these beliefs explicit enabled the researcher to be mindful of these beliefs throughout data collection and analysis. Reflective practice alongside the support of the research team was used throughout the research process.

## Results

The study explored male professional footballers' experiences of mental health difficulties and help-seeking. One superordinate theme emerged; 'Survival'. This superordinate theme contained six subordinate themes which are presented in Table 2.3. Convergence and divergence within the themes is discussed. To maintain confidentiality pseudonyms are used in for the quotations and all identifying information has been removed

Table 2.3: Superordinate and subordinate themes.

Superordinate Theme	Subordinate Themes
<b>Survival</b>	<ol style="list-style-type: none"><li>1) "It resembles a kind of battle field, just constant challenge and fight"</li><li>2) "They must have seen me as a golden nugget...now I was like a dead duck"</li><li>3) "I was struggling and this show, this outwards show, wasn't the reality"</li><li>4) "I need somewhere to go and talk about this but I don't feel like I can go anywhere with it"</li><li>5) "I had fallen out of love with the game"</li><li>6) "Playing stops and that's it"</li></ol>

### ***Superordinate Theme: Survival***

All of the participants communicated a strong sense of their struggles and fight to survive within and outside of the football world. The superordinate theme was identified from the participant's description of an environment that encapsulated the notion that the fittest and strongest survive. The football field was analogous to the battle field. Participants perceived signs of vulnerability or weakness, particularly emotional struggles or injury, as a threat to their survival as a professional footballer. The power behind the superordinate theme is reflective of the importance that being a professional footballer held for the participants; being a footballer was as valued as life. Like animals in the wild, footballers who could adapt to their niche environment had better chances of surviving. Learning new adaptations to survive in the real world was more natural for some participants than others and was facilitated by personal and professional support. This superordinate theme emerged in the context of six subordinate themes (Table 2.3).

#### **Theme 1: "It resembles a kind of battle field, just constant challenge and fight"**

The quotation encapsulates the levels of; challenge, focus, dedication, and fight communicated by the participants' experiences of becoming a professional footballer. The words "battle field" and "fight" are perhaps indicative of the brutality and hurt, winning and losing, or more primitively, the sense of life and death as a footballer. This image was furthered by participants referring to the football world as "cut throat", "ruthless" and "brutal" as they faced challenges such as team selection and earning professional contracts.

“I just kept working and working and working. I was very obsessive over it, over football. [ ]. I was the one who was just constantly focus focus focus.” (Edward, lines 48-51)

“It’s just so ruthless. You’re just constantly on trial really. If things go well on a Saturday, you play and you win, you just kind of dodge the bullet because it’s coming round the corner next Saturday.” (Graham, lines 200-204)

There seemed to be a perceived cost to the level of sacrifice, focus and dedication expended in becoming a professional footballer. There was an expectation from the participants that these sacrifices and narrow focus were necessary, or had felt necessary, to improve their performances and football career. With the exception of expanding identity brought by fatherhood, it was as if they saw their whole identity as a footballer and nothing else.

“I had an epiphany that it’s just become that everything I do is related to football; where we’re eating, what we’re eating, can I take the kids to the park? No I’ve got a game tomorrow. Everything, every decision I made had a foot hole in being a footballer and I was just so so narrow, assuming that being narrow would help my performance. I was just completely wrong looking back.” (Benjamin, lines 793-798)

The quotation below, expresses the primitive nature of this fight for survival against an opponent, which in contrast to a traditional battle field, could also be within the same team competing for selection.

“If you’re on a football field I would say that the other person is prepared to do almost anything to beat you. The nature of it is either; I’m going to eat or you’re going to eat, my family is going to eat or your family is going to eat.” (Dwayne, lines 333-336)

“I don’t care what anybody says, you don’t want to be nasty, but you want them to have a bad game and you want them to get injured because I want to get in the team” (Dwayne, lines 110-112)

This experience seemed to be shared by other participants (i.e. Benjamin; Edward & Freddy) who reflected a sense of confusion and conflict about forming friendships in the football world. In addition, Aaron described feeling as if the football world were like a “character assassination”, whilst the use of metaphors such as “you’re on a tight rope” communicated a sense of just how high the risk of ‘falling’ out of the professional football world felt for the participants.

This subordinate theme highlights the survival instincts evoked for the participants in their experience of fighting for survival in the football world. For the participants, football was clearly more than just a game, it was their life. This left an unanswered question for the research of just how far would professional footballers be willing to go to survive and preserve football as their life.

**Theme 2: “They must have seen me as a golden nugget...now I was like a dead duck”**

The quotation exemplifies the commoditised self expressed by the participants. It appeared difficult for participants to move from feeling like a “golden nugget” that everybody wanted a piece of, to a “dead duck”, to be eaten or discarded. The participants spoke of the realisation that the football world was like a business, where they felt as if they were treated like an asset with conditional value. This appeared to reflect the experience of dehumanisation as a professional footballer.

“No one says how are you feeling...they’re not bothered how you’re feeling, they’re bothered about making...being injured you realise you’re commodity really quickly, that they want you for what you can deliver. They don’t want you because it’s you, [Benjamin]. They want you to do that job for them. This like loyalty in football is the biggest load of rubbish ever. There’s none. There’s absolutely none, you’re a tradable commodity.” (Benjamin, lines 996-1001)

The sense of value was often expressed as a dichotomy of valuable to dispensable. In particular, injury highlighted a sense of devalued worth and being classed as a “non-producer”, “disabled”, and “worthless”. This sense of self is incongruent to surviving in the football world with the perceived physical and mental expectations of the environment and may have added to the participants’ distress.

“What they want is this robust you know performance machine. Performance machines don’t have erm...issues and insecurities, and problems, they get on with it.” (Benjamin, lines 310-312)

The perception of being a commodity with changeable value, exposed participants to vulnerabilities, particularly at times of injury or poor performance, which may have contributed to difficulties with mental health. The subsequent subtheme outlines the perceived need to hide these difficulties.

### **Theme 3: “I was struggling and this show, this outwards show, wasn’t the reality”**

Edward’s quotation above reflects his perception of the “stage character” he used to mask his true experience of struggling. Descriptors such as “bravado”, “actor” and “brave face” were used to illustrate the shield the participants hid behind as a defence to conceal emotional vulnerability. This appeared to be fuelled by the perceived pressure to be tough and cope, both as footballers and as men. To be tough and to cope were like rules for living in the language used by participants. For example, “you” in “you don’t show that you’re struggling” appears like an authoritative or parental instruction of what to do with emotional difficulties.

“Everybody else looked like they were dealing with stuff, but internally I wasn’t. I think it was a case of being out of sync in terms of coping with life and it manifested itself in an outwards show of ‘oh yeah I’ve got it together’. I was overcompensating with a bit of show, and it was pushing people away cause if you get to what’s really going down for me; that I’m struggling with stuff, I don’t feel that I’m good enough, I don’t feel that I should be here, I don’t feel like I deserve to be here, then you’re going to find that I’m a bit of a fraud.” (Edward, lines 129-136)



There was a fear that if their true, and arguably, human vulnerabilities were revealed that this would be a “straight ticket out of football” and a shared perception that as a footballer you couldn’t be vulnerable and survive. Mental health difficulties were not perceived as acceptable or compatible within the football world. Language such as “admittance” or “confessing” may indicate the belief that difficulties with mental health were considered as wrong or bad.

Although participants referred fondly to the togetherness and camaraderie of the dressing room they also acknowledged a fear of rejection from their team mates and the football world if they revealed mental health difficulties. This reflected the level of stigma and intolerance towards mental health in the football world.

“I think you’d have been, ‘black balled’ I suppose, so an admittance to me at that time would have felt like erm you know he don’t fit in with the culture, he’s not tough enough, just being shunned and probably found myself out the game” (Aaron, lines 770-774)

Mental health difficulties were experienced at varying levels by the participants, with depression, anxiety and substance misuse being the most referred to difficulties. Aaron, Edward and Freddy described difficulties both during and after being a footballer. Benjamin and Dwayne reported difficulties whilst being a footballer. Craig and Graham reported difficulties following the transition out of football. The experience of mental health difficulties seemed to be heightened during injury and these periods were often described by participants as the “lowest point” and that their “world is shattered”.

The struggle with mental health and the pressure to hide difficulties to survive as a footballer appeared to be linked with seeking escapism from their internal and external world. This included alcohol and substance misuse, gambling, women and partying, aggression, and withdrawal. The risk of a more permanent form of escapism was communicated by Aaron and Freddy who experienced suicidal ideation and Edward who described feeling fortunate to have survived a serious suicide attempt.

“I’d been out the game for about two years and I saw no way out. My drinking, drug taking everything else had materialized, escalated heavily. I had no structure, I wasn’t training every day, my relationships were bad and this aspect of not knowing a way out and it wasn’t a cry for, or there weren’t many cries for help at the time, I wanted out because I didn’t see any other way cause I was really struggling, really struggling. Yeah so I was really really struggling and I saw that as the only option really, which is sad looking back but fortunately I’m here to tell the tale.”

(Edward, lines 690-698)

The participants’ appeared to use language as a way to create emotional distance and disconnection from their internal experience, for example through the use of “you feel” rather than owning their emotional response with “I feel”.

“You’re stuck in bed weeks at a time and your knee feels like it’s going to explode or someone’s stuck in a hot poker which was just...I can’t explain the pain and you’ve got to try to learn to walk again. Never mind run, sprint, kick a ball, head it and tackle. It was hard. It was hard and I think that’s why I turned to the drink. It just helps you get away from everything, a bit of escapism.”

(Freddy, lines 417-422)

The participants’ emotional difficulties alongside the pressure to hide their struggles left them feeling trapped, needing to escape their experiences. The next subordinate theme reflects the participants’ dilemma of whether it felt safe to seek support for these experiences.

#### **Theme 4: “I need somewhere to go and talk about this but I don’t feel like I can go anywhere with it”**

The quotation reflects a dilemma experienced by participants as they sought to manage their experiences. This may be connected with trying to survive the internal experience of mental health whilst trying to survive externally in the football world. A number of barriers to seeking support were expressed, including; internal obstacles such as feelings of shame, believing help was for those “at their wits end”, and a fear of rejection from others. In addition, a lack of MHL, reflected in the lack of recognition of mental health difficulties and awareness of support, also contributed to a delay in help-seeking.

“At the time I wasn’t aware enough or I suppose I didn’t wanna accept where I was you know. I wanted to be isolated, not wanting people to find out how I was feeling cause at that point I didn’t want to talk about it cause I didn’t understand it. I thought I was...for want of a better word abnormal. I suppose I took it as part of the game and I had to find a way round it and toughen up.” (Aaron, lines 470-476)

The disclosure of mental health difficulties appeared to feel threatening to the participants and the perceived lack of a safe containing space to share their experiences may have contributed to the feelings of helplessness, isolation and a sense of being trapped.

“I think it’s one of the things why I suffered more than probably what I should have done is because I didn’t have anyone to talk to.....not just about the injuries but about the ways that it affects you.....it erm...made life a lot more difficult.”  
(Freddy, lines 720-725)

The participants spoke about valuing support from their family, in particular female partners and mothers. They may have been drawn to females for emotional support due to the perception of females being nurturing and caring, in contrast to the competitive, macho culture associated with their experience of males in the football world. The experience of more formal help-seeking was viewed positively by the participants who accessed support.

“[Sport Psychologist] was like the biggest influence on my career both professionally as a footballer and personally as a man really. Straight away we got to work on how cause I was more anxious there was increased injury risk because I was constantly looking and searching for things that might be wrong and then obviously you’re not playing with any freedom because you’re already tighter and anxious. Then coming back I’d set my expectations at perfection and anything other than perfection in how my body was feeling was a negative and that would set it off. Just understanding myself and I suppose that outlet of being able to talk to someone who wasn’t judging you as a footballer, just trying to help you as a person.” (Benjamin, lines 59-69)

It appeared to be important for participants to access support from someone outside of their football world but who had an understanding of football culture. This may be the position that the participants held the researcher in, and they assumed a shared experience of some aspects of football which was expressed in language symbolising a collective identity such as “we”, referring to all footballers, and “you know yourself”.

#### **Theme 5: “I had fallen out of love with the game”**

All participants communicated a love for football and it appeared integral to fuelling their drive, passion and commitment needed to survive and thrive as a professional footballer. This love was described with analogies of childhood passions, and romantic relationships. It appeared to be maintained by winning,

success and team camaraderie. At times, the love for football was presented as a blind fantasy, where the participants were unable to acknowledge the reality of professional football; that some experiences were special but that others were physically and emotionally hard, such as the “torture” and “hard miles” to survive as footballer. Sadness was evident for the participants whose love for football had died. It may be that this blind fantasy developed as a defence to help footballers do what is demanded of them to survive in the football world.

“I wanted to get out, but being so far in it that you’ve got to continue. It felt a bit like when you’ve made a choice to kind of jump off something or do something and you change your mind and you’ve got to carry on doing it you know. It’s like you got to keep going despite the fact you’re like shit I don’t want to do this no more and that’s how it felt. I think from that my drinking, my drug taking, my gambling got worse you know.” (Edward, lines 451-457)

Through reflecting on being in and out of love for football, the participants communicated a concern for the next generation of young footballers, how they would survive the intense relationship with football, and an emphasis on the need for education around mental wellbeing and support. It seemed like the participants had not felt forewarned or prepared for the death and loss of their football fantasy.

“They’re living the dream and they want people to know they’re living the dream, unfortunately they’re building it on quicksand aren’t they.” (Dwayne, lines 403 – 404)

### **Theme 6: “Playing stops and that’s it”**

With the exception of Dwayne, who returned to the family business, the participants described football as their whole world and they faced several losses at transition into the “real world”. This included the loss of the team environment, attention, adulation, escapism, structure, purpose, and identity. Feelings of loneliness, sadness, failure and fear were apparent at this time. The transition seemed to be synonymous with the death of the footballer/athlete identity and the need to construct a new sense of self to survive in the real world.

“It’s buzzing, you’ve got loads of people to interact with, you’re part of your team mates and obviously the banter in the dressing room and you’ve got a purpose, a focus...to retiring and having nothing really. Not having a career I was looking forward to, no focus, no motivation...just retired and that was it.” (Craig, lines 75-79)

“You have to reinvent yourself; personality, the way you conduct yourself, sometimes the way you talk, the language you use...it’s a...it’s a different world, a different world.” (Freddy, lines 857-860).

“I feel like that’s me, the piece of paper, and I just sort of like keep tearing little pieces away and not getting anything done, not growing in size but actually shrinking in size.” (Graham, lines 453-455)

When playing stopped, or was threatened to stop, by a career threatening injury, the emotional impact of the sudden and potential loss of football was evident. Choice and readiness seemed to be related to adjustment. Greater emotional distress was associated with less control over factors influencing retirement, such as injury. The powerful grief, sadness, anger and murderous rage towards the perceived perpetrator that was expressed by Freddy may have been reflective of the perceived ‘murder’ of his football career, hopes and dreams.

“One of the hardest things as well is that the player that caused my injury [ ]...and erm.....you know you have silly thoughts like you want to go round and slaughter his wife and kids...just to fuck his life up as well, but erm.....fortunately like I say we live in a civilized society so you don’t do it... [ ]...and you just think have you not got any bollocks. Do you think you should have kicked his head in...put him in a wheelchair...but there’d just be no point.”

(Freddy, lines 874-892)

The participants spoke about the challenges of adjustment from a football world where they experienced their life as “mapped out” and “other people take care of things”. It was as if the development of autonomy was arrested and this presented challenges in decision making, task-management and longer-term planning.



“For a lot of your life you know your main thing is just to go out and play football and other people take care of other things for you. Then when you come out and you haven’t got those things it’s a massive...a massive challenge to erm... to sort of fit in and try and readjust.” (Aaron, lines 1390 – 1394)

The metaphor; like a “rabbit in the headlights”, communicates a sense of feeling stunned, scared and in danger of becoming road kill as they started a new journey in which Craig, Freddy and Graham described feeling lost and not knowing which way to turn.

“My wife would go to me; what’s your plan, what you going to do, she was in tears getting frustrated at me and I was getting frustrated back saying I don’t know what I want to do. I had no idea, absolutely no idea. I didn’t have a clue what I was going to do. So yeah it was quite fraught at times.” (Craig, lines 340–344)

In contrast, Benjamin and Dwayne described coping well with transition although the decision to leave football had initially felt difficult. This was facilitated by personal and professional support and engaging in a new passion. Being able to apply football values into a new career also appeared to ease transition.

“I was so into the content [University Degree] and I was ready for it and it was my decision to do it. I just took to it like a duck to water and it was...it was amazing.” (Benjamin, lines 837-839)

The contrast of moving to a position of acceptance verses being stuck in regret was a central factor to how the participants were surviving in the real world. It was sad and frustrating for Craig, Edward, and Freddy to imagine what might have been if their decisions and experiences had been different.

“Looking back now I should have, I wish I’d, I wish I’d carried on.

Wish I carried on now but at the time I thought I was ready.”

(Craig, lines 120-121).

The acceptance of mental health difficulties and of new roles outside of football was associated with better mental wellbeing. Holding onto the regret reflected an emotional dissonance that Craig and Freddy seemed to feel within themselves.

“If you dwell on it, it will just eat you up, eat you up.....I still have the thoughts, you know, what if...what if? (Freddy, lines 876-877).

## **Discussion**

This study explored male professional footballers' experiences of mental health difficulties and help-seeking using IPA. One superordinate theme, "Survival", emerged. The survival narrative was carried throughout six subordinate themes. This is discussed in the context of relevant theory and literature and limitations of the study are considered, alongside clinical implications and future research.

### ***Discussion of Findings***

The nature of survival as a professional footballer was built around the notion that the fittest, strongest and best adapted, survived. Consistent with previous research, physical, mental and emotional difficulties were seen as weakness and threats to survival (Anderson, 2011; Gulliver et al., 2012). Charles Darwin's theory of evolution has a fitting application in understanding the functions of the participants' survival in the niche environment of professional football and in adjusting to the new demands of the real world. The level of challenge and fight alongside football being described as a battle field and cut throat was reflective of the primitive survival nature of sport from its roots in warlike sports in early Western cultures to Spartans in Ancient Greece (Freeman, 2015).

The sense of being a commodity with conditional value reflected the experience of dehumanisation as a professional footballer. The participants' value could be externally and conditionally constructed by stakeholders in football. This seemed to contribute to the ongoing sense of threat to a footballer's survival. This prolonged sense of fear is counterintuitive to performance as the consequences of

altered focus of attention and muscle tension increase the risk of injury (Junge, 2000). A focus on externally and conditionally applied value, such as praise or attainment, can have negative implications for self-esteem (Crocker, 2002), as well as higher levels of anxiety and depression in elite sports people which is detrimental to performance (Koivula, Hassmen & Fallby, 2002). Furthermore, low self-esteem is a risk factor for developing mental health difficulties (Mann, Hosman, Schaalma & Vries, 2004; World Health Organisation, 2012).

The dichotomised sense of self as a valuable or dispensable asset overlaps with traits of narcissism, for example the narcissistic split of seeing oneself as either special/grandiose or vulnerable/worthless (Miller, Hoffman, Gaughan et al., 2011; Zeigler-Hill & Jordan, 2011). Narcissism can develop when the child (young footballer) exists to fulfil the parents' (football stakeholders) wishes and needs (Cramer, 2011). Higher traits of narcissism have been found in sports people and can be linked with increased effort in performance focused climates (Elman & McKelvie, 2003; Roberts, Woodman, Lofthouse & Williams, 2015). However, the narcissism defense is fragile (Zeigler-Hill & Jordan, 2011) and is correlated with mental health difficulties and substance misuse in men (Stinson, Dawson, Goldstein, et al., 2008) and violence in sports people (Welch, 1997)

An embodied metaphor was used to express the dichotomy of relating to a body that was “a robust performance machine” compared to “disabled”. The experience of anger, sadness, vulnerability, worthlessness and adjustment following injury is consistent with the sport injury literature and may reflect the psychological distress associated with the breakdown of the athlete identity (Sparkes, 1998;

Sparkes & Smith, 2005). This is an important area of concern given the increased risk of mental health difficulties and suicidal tendencies of injured athletes (Gouttebarga, et al. 2015; Gulliver et al., 2015; Walker, Thatcher & Lavallee, 2007; Wiese-Bjornstal, Smith, Shaffer & Morrey, 1998).

Consistent with male mental health literature, the participants felt the need to conceal their emotional vulnerability and experience of mental health difficulties behind a stage character and brave face (Addis & Mahalik, 2003; Mansfield, et al., 2005; Rickwood, et al., 2007; Vaswani, 2011). This appeared to be driven by the fear that revealing human vulnerabilities was not congruent with survival as a professional footballer. Forms of escapism, such as alcohol, substances and gambling, were used as a means to gain emotional distance from difficult feelings (Mullen, Watson, Swift & Black, 2007; Reid, Desiree, Lopez et al., 2011). This way of coping left the participants feeling isolated and trapped, which are risk factors for mental health difficulties and suicide (Appleby, et al., 2011; Bryan & Rudd, 2005). The shared perception that footballers must cope and not show they are struggling, may be introjections absorbed by the participants from their environment (Mann, 2010) as well as reflective of the social-cultural pressures of being a man (Addis & Mahalik, 2003). Introjections are not always negative, however, this example is debilitating to their wellbeing because it reduces their ability to access support that is important to mental wellbeing (Appleby et al. 2011; Rickwood et al., 2005), treating mental health (Meltzer et al., 2003; Oliver et al., 2005) and reducing suicide risk (Deisenhammer et al., 2007; Michelmore & Hindley, 2012; Reynders et al., 2014).

Low levels of MHL was a barrier to accessing support and is consistent with male MHL research (Burns & Rapee, 2006; Richwood, et al., 2007; Swami, 2012; Vaswani, 2011). Feelings of shame and stigma also hindered participants help-seeking. Addressing these beliefs is important in facilitating help-seeking and recovery (DoH, 2011; Reynders, et al., 2014).

The passionate relationship with football appeared to be like a blind fantasy where at times participants were unable to acknowledge an integrated reality of the positive and negative experiences of professional football. This relationship may have some parallels to the addictive quality and compulsion to repeat abusive relationships (Nicholas, 2013). Detecting violations in social contracts when one is at-risk of being harmed enables a person to withdraw (DePrince, 2005). However this is counterproductive if the ‘victim’ is dependent on the ‘perpetrator’, as the footballer is on their employer, because withdrawal threatens their survival goals (DePrince, 2005). Dissociation through the decreased awareness of betrayals contributes to maintaining this relationship (DePrince, 2005). Therefore the blind fantasy may have developed to help footballers undertake the demands of the football world in order to survive as a professional.

The footballers described a number of losses at transition, feelings of fear and grief. Consistent with sport transition literature; personal and professional support after transition (McKnight, Bernes, Gunn, et al., 2009) and finding a new passion (Wylleman & Lavallee, 2003) was associated with better coping. The greater psychological distress associated with involuntary retirement is also supported by sport transition literature (e.g. Alfermann, 2000; Teitelbaum, 2005).

The participants' narrow professional footballer identity is consistent with athlete identity literature (e.g. Brownrigg et al., 2012; Lavalley & Robinson, 2007), and a limited exploration of other identity roles (North & Lavalley, 2004). Narrow identity in sport is linked with increased confidence and performance (Brown & Potrac, 2009) however it is also associated with adjustment difficulties at transition (Brownrigg et al., 2012; Lally, 2007; Lavalley & Robinson, 2007). Furthermore, the loss of a strong collective group identity (Chow & Feltz, 2007; Zuccheromaglio & Alby, 2011) can lead to the reduced clarity of self-identity (Slotter, Winger & Soto, 2015). Identity formation is an important component of adolescence (Erikson, 1971; Meeus, 2011) and football may not have been a secure and nurturing environment for the participants to develop a sense of self and autonomy. Therefore, arrested emotional development may have contributed to difficulties with self-esteem, mental health and maladaptive coping (Cabaniss, Cherry, Douglas, & Schwartz 2011). The 'death' of the footballer identity was challenging as participants attempted to construct a new sense of self for the real world. The experience at transition was analogous to that of military personnel for whom the experience of a unique subculture, masculine environment, banter, and loss, particularly of identity at transition, has also been identified (Brunger, Serrato, & Ogden, 2013; Green, Emslie, O'Neil, Hunt, & Walker, 2010). Having left 'the battle field', footballers too had to learn how to adjust to 'civilian' life.

### ***Methodological Limitations***

It is important to consider the findings of this study in light of its limitations. Firstly, the validity of this study could have been improved by undertaking respondent validation of the themes. Attention to reflexivity, supervision and inter-rater reliability of coding helped to address this limitation. Secondly, the inclusion criteria relied upon self-identified mental health difficulties. A clinical diagnosis was not undertaken and may therefore reduce the construct validity of the inferences made. However, the participants' transcripts and experiences demonstrated good face validity for the experience of mental health difficulties. This also meant that participants' had to accept that they experienced mental health difficulties, which may represent a subgroup of the target population.

### ***Areas for Future Research***

The findings from this study, alongside the limited literature, indicate the opportunities and need for further research, for example:

- 1) To replicate prevalence studies of mental health difficulties in the British footballer population using standardised and validated assessment tools.
- 2) To assess levels of MHL and the effectiveness of interventions targeting MHL in footballers and their immediate support networks.
- 3) To assess the prevalence of mental health difficulties and levels of MHL in the growing domain of women's professional football.
- 4) To evaluate the effectiveness of clinical models, such as Acceptance and Commitment Therapy, at transition points.



### ***Clinical and Organisational Implications***

Football is at the start of a culture shift in recognising mental health but as the participants identified “there is a long way to go”. An awareness of the lived-experience of mental health difficulties has implications for understanding difficulties in professional football and for the delivery of interventions targeting mental health by the FA, PFA, and third sector organisations. Furthermore, footballers are role models in society and talking to young males about mental health may help to address stigma and encourage others to access support.

Providing access to professional support, with knowledge of football but outside the footballers’ immediate world, is important. The PFA counselling network is an important step but more needs to be done to promote confidence in accessing support. In addition, several clinical models exist for managing responses to injury and trauma (Walker, et al., 2007) and access to professionals qualified in such interventions is important. Collaboration between musculoskeletal professionals and clinical professionals may facilitate this. Attending to the personal development of a footballer, including self-esteem, alongside educational development may increase the footballers’ resources to cope with the emotional demands of football and transition (Miller & Kerr, 2002). The overlap in components of transition with military personnel suggests that football organisations would benefit from consulting military literature and professionals experienced with military transition. Supporting young footballers to overcome the barriers to early planning for career transition will also improve psychological

wellbeing and adjustment (Drawer & Fuller, 2002; Martin, Fogarty & Albion, 2014; North & Lavalley, 2004).

### ***Conclusion***

This study explored male professional footballers' experiences of mental health difficulties and help-seeking. The powerful sense of trying to survive in the professional football world and the real world emerged. Injury and transition were linked to experiences of mental health difficulties. Shame, stigma, fear and lack of MHL were prominent barriers to accessing support, whilst maladaptive forms of escapism were used to try to manage difficult emotional experiences. Football has continued to evolve; players are more skilful, quicker and stronger. The evolution of the mental health side of football is slowly beginning and further attention and research is needed to provide adequate support for professional footballers' mental wellbeing.

“Some people think football is a matter of life  
and death. I assure you, it's much more serious  
than that” Bill Shankly (1913-1981)

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## **Chapter 3: Reflective Paper**

### **Cognitive Analytic Therapy to Support Reflexivity in Qualitative Research: A Collaboration between the Self as Clinician and Researcher**

Overall chapter word count (excluding tables, figures and references): 3,991

## **Introduction**

Personal and professional development is central to training and practicing as a clinical psychologist (British Psychological Society (BPS), 2013). A core component of this is reflective practice which incorporates critical observation and evaluation, abstract conceptualisation and committed action (BPS, 2013; Health and Care Professions Council, 2012; Kennedy, Llewelyn & Beinart, 2009). It can occur in the present moment, on past experiences, on others and on the self (Llewelyn, Beinart & Kennedy, 2009). Throughout my journey on clinical training and the research process I have held the position of reflective-practitioner in high regard. The reflections shared in this paper are taken from my reflective journal and supervisory discussions.

The term reflection refers to the self-awareness of, and attention to, thoughts, memories, emotions and bodily sensations arising in-the-moment (Dallos & Stedman, 2009). Reflexivity is the conscious process of applying knowledge and theory to further scrutinise episodes of reflection (Dallos & Stedman, 2009). In this paper I will firstly outline what is meant by reflexivity in qualitative research and then reflect upon my epistemological stance. I will then share reflections upon the application of a clinical model; Cognitive Analytic Therapy (CAT) to qualitative research with Interpretative Phenomenological Analysis (IPA). The conflict between the role of clinician and researcher is often expressed (Lanza & Satz, 1995; Yanos & Ziedonis, 2006) however this reflective paper considers whether the unique clinical skills of a psychologist can be enhancing to the profession's role in research rather than act as a barrier. Further applications of applying CAT to qualitative research will also be considered.

## **Reflexivity: To Bend Back Upon Oneself**

“The challenge of reflexivity for an experiential qualitative researcher is to first identify fore-understandings and their routes and then to ensure they do not denigrate the research process, either in terms of the social event that is the research interview or the interpretative activity of analysing experiential data” (Shaw, 2010)

Reflexivity has an important role in qualitative research and its application is driven by both the aims of the reflexive process and my theoretical position as the researcher (Finlay, 2008). Reflexivity assumes a co-construction of meaning between the researcher and the researched of the same order, human beings (Shaw, 2010). Similarly, the grounding of IPA in hermeneutics and phenomenology means that as the researcher, I was trying to make sense of how the footballers made sense of their world and experiences (Shaw, 2010; Smith & Larkin, 2009). This sense-making is situated, emergent and negotiated in the research encounter through conscious and unconscious processes with both researcher and participant subject to projections and introjections (Finlay, 2008). Typically, reflexivity involves the self-aware analysis of the intersubjective processes between the researcher and the researched to allow the researcher to attend to how these dynamics can transform the research (Finlay, 2008).

### *An Insider or an Outsider?*

The stories shared by participants and the way they are told are influenced by my position as a researcher (Greene, 2014). In qualitative research, an insider-researcher studies a group with which they share membership in aspects such as culture, or experience or possess intimate a priori knowledge (Dwyer & Buckle, 2009; Greene, 2014). An outsider-researcher studies a group that they do not share commonalities, experience or prior knowledge of (Breen, 2007; Dwyer & Buckle, 2009). There are a number of advantages and disadvantages to both positions (Breen, 2007; Dwyer & Buckle, 2009; Greene, 2014) however this is beyond the scope of this paper.

As a football fan and a female footballer playing at national level, I initially struggled with identifying my position. From an insider-perspective I have observed, participated and coached within the football world, experiencing teams, managers, fans, success, graft, failure, injury and selection. Yet I was also aware of the differences between myself and the participant group. Firstly, as a woman my socio-cultural expectations differed, and secondly, football was not my career; I have not lived through the journey of becoming a professional footballer or experienced the media coverage and financial world of the men's game. I was also mindful that the participants' perception of my position was just as significant. On occasions participants perceived me as part of their world assuming a shared knowledge of what it is like to be a footballer evidenced. At other times the participants positioned me outside of their world, distinguishing experiences in the men's football world from the women's game.

As I reflected on my research position, rather than restricting to the dichotomy of insider or outsider, my position became more clearly understood as integrated along the continuum of an insider-outsider (Breen, 2007; Dwyer & Buckle, 2009; Kerstetter, 2012). From this stance I was able to retain a reflexive position on the complexity of both similarities and differences between myself and the participants to better manage the paradox of qualitative research and IPA (Dwyer & Buckle, 2009).

“The qualitative researcher’s perspective is a paradoxical one: it is to be acutely tuned-in to the experiences and meaning systems of others—to indwell—and at the same time to be aware of how one’s own biases and preconceptions may be influencing what one is trying to understand.” (Maykut & Morehouse, 1994, p. 123)

## **Epistemological Position**

As I embarked on the journey of research I was initially drawn towards research questions and methodology that fitted objective ontological inquiry. My enthusiasm for science and deduction fitted more comfortably with a positivist position in an attempt to explain how and why footballers develop mental health difficulties. Having previously found it difficult to accept the uncertainty of subjective ontology, I initially avoided a qualitative methodological approach fearful of my potential failure in interpreting subjective accounts.

The importance of my epistemological position became clearer as my research question was refined. My initial fear of the qualitative methodologies had masked my underlying curiosity to understanding how professional footballers experienced mental health difficulties. In a research area where there was so little knowledge I was seeking a human-led understanding to elucidate footballers' experiences and allow space for complexity and contextual factors. So with the anxiety of lesser certainty of the research process I started to embrace the interpretivist epistemological position to try to build an understanding of footballers' experiences rather than theory testing.

My initial uncertainty with the interpretivist position surprised me given my comfort in trying to understand the meaning clients, as individuals, draw from their experiences in my role as a clinician. However, I also reflected upon the value I hold for the role of neuropsychological and psychometric assessment as tools to facilitate explanation. These assessment approaches are perhaps more congruent with a positivist position. As my understanding of epistemological positions has increased I have a clearer sense of the values I hold in both positions, but also the belief that the quest for knowledge of phenomena requires both explaining and understanding, both positivist and interpretivist drivers.

## **Application of a Clinical Model to Research**

Training as a clinical psychologist requires the development of clinical and research skills, alongside personal growth. At times I found myself feeling split in the different roles, identities, skill sets, and motivations of the clinician, researcher

and self. For example, the clinician who wants to help the participants understand their experiences, the researcher who wants to get quality data and the self who wants to discuss the football match that was on the day before. However through the process of conducting this research I became more conscious of the integration and accumulation of these roles and the curiosity that underlies them all.

The most striking awareness of role integration was when I was conducting the first interview; the balance of the researcher's non-directive exploring alongside the clinician's attentiveness to containment and dynamic processes and the awareness of the reflective self. Accepting that as a researcher I could not deny or remove the clinician and the self, led me to question how I could integrate these processes and roles to enhance the quality and depth of the research. I chose to draw upon the principles of Cognitive Analytic Therapy (CAT), a model that I had applied previously to personal reflection and reflexivity as well as clinical work, to aid with the reflexivity of conducting research with IPA.

## ***Cognitive Analytic Therapy***

### **Introduction**

It is not within the scope of this paper to provide a detailed account of the origins and theory behind CAT, however, the following section is intended to assist the reader in understanding the CAT model.

CAT is an integrative approach to understanding human experiences and their development which incorporates ideas from cognitive, psychoanalytic, object-



relations and Vygotskian theory (Ryle & Kerr, 2002). The sense of self is considered to have been shaped through relationships with others and through the internalised representations of the meaning learnt from these relationships alongside wider cultural values (Ryle & Kerr, 2002). A central component of CAT is that the routine reciprocal role procedures for navigating the world that are learnt in early relationships are repeated in how people relate to the self, others and the world (Murphy & Llewelyn, 2005; Ryle & Kerr, 2002). The internalisation of reciprocal roles means that a child who received loving care and felt loved, also learns how to be loving. Similarly, a child who received neglectful care and felt abandoned also learns how to be neglectful. The learnt reciprocal roles become a repertoire of positions to adopt and shift between. Procedures are narrow choices of behaviour/responses which can be both helpful and unhelpful (Potter & Lloyd, 2005). Of these unhelpful procedures; dilemmas appear as polarised forced choices, traps are self-reinforcing patterns of thought or behaviour and snags which undermine achievable goals (Murphy & Llewelyn, 2007; Ryle & Kerr, 2002).

### **Rationale for Application of CAT to Qualitative Research**

As discussed earlier, in qualitative research such as IPA, it is important for the researcher to attend to the patterns activated between themselves and the participant (Finlay, 2008; Shaw, 2010). CAT may provide a tool, grounded in a theoretical framework, to facilitate greater depth to reflexivity and understanding of the researcher-participant dynamic. The CAT model has been effective in understanding complex organisations and societies and in undertaking dialogical sequence analysis of speech (Potter & Lloyd, 2005).

An awareness of the reciprocal roles and patterns that may have been activated between the participant and their experience of the football world could enable deeper insight into their lived experience. Furthermore, attending to reciprocal processes between the researcher and the data during analysis facilitates further awareness of the researcher's position, emotional and behavioural responses to the research. In addition, CAT can be applied alongside the hermeneutic circle adopted in phenomenological research (Willig & Billon, 2011). For example, as I am trying to understand some of the reciprocal roles in the room (the parts), I look to the context of the reciprocal roles in the football world (the whole), and as I am trying to understand some of the roles within football world, I look to the context of the roles between myself the participant in the room (Smith & Larkin, 2009).

## **The Application of CAT in this Research**

This section reflects upon the process of applying CAT to this research, thoughts about what CAT added, consideration of its limitations and future applications.

### ***Reformulation***

Traditionally, reformulation involves gaining an understanding of the reciprocal roles procedures from a person's early life and using a structured assessment tool. However, reciprocal role procedures can be devised from analysing dialogue and reflection in the present moment of intersubjective processes (Potter & Lloyd, 2005). As a clinician, I wanted to understand more about the participants and how their early experiences may have affected their experiences of the football world

and mental health but this was restricted by my researcher position and holding true to the ethical considerations of the research. The participants had consented to an interview about their experiences, not therapy.

Central to reformulation in CAT is the development of a shared understanding between clinician and client of the client's experiences. A parallel process occurred in this qualitative research as I attempted to develop a shared understanding of the participants' experiences through the interview, albeit under the time limitations of a research interview compared to a course of therapy.

### **Sequential Diagrammatic Reformulation**

The purpose of sequential diagrammatic reformulation (SDR) is to illustrate and describe the reciprocal roles procedures that are active and repeated in unhelpful patterns (Ryle & Kerr, 2002). The SDR is a map and a generalised representation developed from a range of experiences described by the person. To further explore the reflections made and to facilitate reflexivity in this research a SDR was produced after completing the interviews (Appendix O). This SDR is based upon the experiences described by footballers, their perception of the football world and mental health, and an interpretation of the dynamic processes in the interview.

### **Reformulation Letter**

The narrative account in the reformulation letter is an attempt to identify the personal meaning a person gives to their experiences and to describe the problem procedures they are entangled with which are maintaining their distress (Ryle &

Kerr, 2002). The letter offers a global and preliminary understanding. To facilitate reflexivity in this research two reformulation letters were written; one to the footballer (Appendix P) and one to the researcher (Appendix Q). The letter was not written to be sent to the footballer as this was not part of the ethical agreement, but was drafted to facilitate the researcher's reflective process.

### **What Did CAT Reformulation Add?**

The following examples demonstrate what CAT reformulation and understanding added to the reflexivity of the research and to the quality and depth of IPA.

#### *Example 1: Awareness of Overlapping Processes*

The construction of the SDR (Appendix O) highlighted a number of overlapping processes between how the footballers experienced relating to their world and with other high achieving roles, such as the world of clinical psychology. Attending to these processes helped to make conscious the experiences I was bringing with me into the data analysis. As an undergraduate and assistant psychologist I idolised and admired the role models I saw in both trainee and qualified clinical psychologists. This perhaps paralleled how young footballers idolised their professional football heroes. I sought to learn from and even imitated their clinical style in the way that young footballers re-enact their idealised role models. The journey to become a clinical psychologist involved dedication, sacrifice and striving due to the competition for contracts and the demands of the NHS. Similarly, the short lived adulation and the feeling of being special at making it onto clinical training mirrored the footballers' achievements of professional contracts and being revered by their family and peers.

Reflecting upon the SDR of the footballers' experience alongside the conscious awareness of my own reciprocal roles allowed me to be mindful of the reenactments that were more likely to occur. For example, stepping out of a containing interview frame and accepting the offer to extend the time of the interview beyond the participant's originally agreed availability would perhaps be comforting and natural for the striving positions of both me and the footballer. If I had broken the 'contracted' interview framework, the participants may have been left feeling controlled/powerless, commoditised and exploited by me and the research in the way that they had felt from the football world. Furthermore, I am aware of my tendency to fall into the position of being critical and the shared drive with footballers to be the best one can be. Therefore, an awareness of the unconscious invitations by the participants to pull me into being judging or critical of their experiences allowed the interview to remain on its self-directed course.

A marked difference between the two worlds lies in the safety of the environment. I have experienced clinical training as nurturing and actively encouraging of openness with emotions and accessing support. I can cry, feel angry and reflect on worthlessness without the same fear of being rejected, discarded, humiliated or 'killed' as communicated by the footballers. This contrast brought to mind the image of a nourished tree versus a gladiator fighting for survival. Furthermore, although I do at first try to resolve things on my own when I am struggling, I do not feel the need to hide behind an act and bravado or to cope with difficult feelings and experiences in isolation in the way the footballers shared. The social and cultural pressures of being a man and a footballer may account for this difference.

### *Example 2: Reflexivity and Emotional Depth*

The practice of writing the reformulation letters addressed to the hypothetical collective footballer and to myself as the researcher facilitated the greater emotional connectivity to the researched. The process of reformulation in the context of this research can be seen as making explicit the processes of phenomenological research and the hermeneutic circle. The letter to the hypothetical footballer is a narrative of my understanding as a researcher of how they have understood their experiences. Part of this letter may also then be about writing to the understanding of the footballer part of the researcher. Bobvos-Bekefi (2014) described how hermeneutic understanding could enhance the theory and practice of CAT. Figure 3.1 below, adapted from Bobvos-Bekefi (2014) illustrates how hermeneutic-CAT aligns with reflexivity and the interpretivist epistemology of IPA research as well as how it differs from the reciprocal roles of a positivist epistemological position.

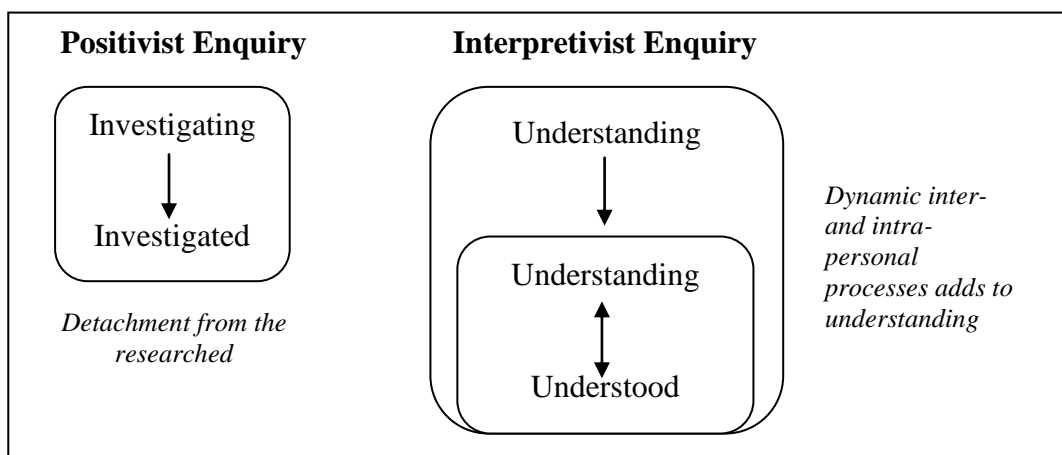


Figure 3.1: Illustration of the reciprocal roles of the positivist and interpretivist epistemological positions and the hermeneutic understanding of understanding.

The letter written to myself as the researcher from the integration of clinician-researcher-self positions created an open invitation to be conscious of, and reflective upon, the competing demands, expectations and drives of my roles and how these might be influencing the step-by-step moments of the research. The narrative of the reformulation letter facilitated reflexivity by making these processes explicit in order to help retain closeness and connectivity with the participants lived experience. This letter was a very challenging concept; to truly try to “bend back upon oneself” and look through the mirror. At times during this process, I identified with the vulnerable position that the research had now placed me in and the desire to want to escape from the uncomfortable feelings that arose from this. Although a certain level of reflection and reflexivity can be achieved by oneself this process only furthered my belief that supervision plays an important role in shedding light on the blind spots and I would argue that this level of reflexive depth and collaboration needs to be applied in qualitative research, particularly of a phenomenological stance.

### ***Interviews***

The activation of reciprocal role repertoires throughout the interviews was evident. The example below illustrates how an understanding of CAT and an integrated attentiveness of the selves of the clinician, researcher and person helped to facilitate the interview and maintain my position as a researcher.

As Freddy described the experience of severe injury, he spoke powerfully and emotionally of the trauma, torture and murderous rage of his experience. The

emotion was raw, unprocessed and I felt pulled into the tempting position of rescuer. This rescuer position was likely to be elicited by both my own set of reciprocal roles, alongside the belief that talking about emotions is hard as identified in my bracketing interview, and those of Freddy, with for example desiring rescue as a form of temporary escape. This position may also have been activated by feelings of guilt that my research had re-exposed him to difficult emotions. My capacity to hold and contain powerful emotions as a clinician-researcher alongside an awareness of my own reciprocal roles allowed me to reflect upon this pull rather than re-enact a reciprocal role procedure. For example, without the knowledge of these roles, by rescuing, even subtly, I may have increased his feelings of vulnerability and prompted anger at being placed in a position that feels scary and intolerable. Alternatively, assuming he needed rescuing may have left him feeling shut down as he felt unable to continue to express himself or him experiencing shame for sharing his emotions. I think that this gave Freddy the space to experience surviving powerful emotions which I hope was a validating experience for him and to share what he had intended to.

### *Analysis*

I noticed that my relationship with the data had parallels with some of the reciprocal role procedures for relating that were familiar to me. For example, the ‘dismissing to dismissed’ reciprocal role can be activated within me in response to my own emotional experiences, and was also evident in the way the football world responds to emotion in footballers. As I progressed through IPA I was more aware of the need to attend to emotionally hot moments in the data to ensure that



my coding did not re-enact this role by minimising and dismissing the participants' emotional experience. This process was also apparent in my early drafts of the reformulation letter and demonstrates the depth of emotional reflexivity required to conduct IPA which can be aided by the CAT model.

Knowledge of my reciprocal roles procedures identified a pull during analysis. My feared place of worthlessness can lead me to fall into the patterns of striving to reach an idealised position to move away from the sense of worthlessness. The awareness of my desire for the research and by extension myself, to be received as impactful, special and significant allowed me to monitor the language I used for coding, and writing, to try to keep it as close to the lived-experience communicated by the participants, rather than using language which was overzealous. The avoidance and disconnection experienced during the analysis paralleled some of the dichotomous feelings I have experienced through clinical training, as well as the dichotomy of the 'highs' and 'lows' of the football world, whereby I could move quickly between the buzz and excitement of the research, to feelings of exhaustion and despair. Recognising this dichotomy enabled me to get back in touch with the stable middle ground.

### ***Limitations and Future Implications***

In contrast to using CAT with clients, whereby reformulation and understanding can be revisited collaboratively across the therapy, conducting research does not afford this more active collaborative understanding in the same way. Therefore caution regarding the interpretative nature of the SDR and reformulation needs to

be maintained and ultimately the researcher must be led by the participants' data. Upon completion of the reformulation letter to the hypothetical footballer I found myself facing the ethical dilemma of wanting to share the letter with the participants to help validate their experiences and acknowledging that this could not happen, as this had not been an ethically agreed part of the research. Furthermore, I was aware of the emotional depth and therapeutic nature of this letter which carried an unethical risk of causing distress. Future qualitative research that is supported with CAT may benefit from seeking ethical approval of sharing letters narrating the researchers understanding of the participants experiences to give the participants the choice of receiving it. This could allow further collaboration with the themes developed in qualitative research.

A further dilemma from using CAT arose in the SDR diagram and whether this invited me as the researcher to start developing a model to explain footballers' mental health difficulties rather than understanding their lived experience through IPA. The application of CAT to aid reflexivity and analysis in qualitative research may therefore have merit in a grounded theory approach to data analysis. However, I think that the CAT model served as a framework to provide greater emotional depth to understanding the participants lived experiences and facilitated the IPA through the reflection on dynamic processes between participant and the researcher-clinician-self.

This reflective paper demonstrates the strengths of integrating the roles of researcher-clinician-self and how CAT may facilitate this process to enhance the quality and depth of IPA. Knowledge and application of clinical models, through

clinicians conducting or supervising research, may contribute to facilitating reflexivity in qualitative research and the research into the effectiveness of these may further the qualitative field.

## **Conclusion**

As I have explored my position as a researcher I have found an enthusiasm for understanding the philosophical underpinnings of research and how my epistemological position influences the research. Throughout this research, CAT served as a valuable tool for greater insight into the emotional depth of the participants' experiences. CAT facilitated reflection and reflexivity by focusing awareness on the intrapersonal process of the integrated researcher-clinician-self as well as the dynamics arising during the interview and analysis. I look forward to further collaborations between the researcher-clinician-self and future participants.

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## Appendices

### Appendix A: Author Guidelines for the Journal *Child and Adolescent Mental Health*



Edited by: Crispin Day, Jane Barlow, Kapil Sayal, Leslie Leve and Paul Harnett

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Author Guidelines

1. Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Measurement Issues; Innovations in Practice.

**Original Articles:** These papers should consist of original research findings.

**Review Articles:** These papers are usually commissioned; they should survey an important area of interest within the general field.

**Measurement Issues:** These are commissioned review papers that aim to evaluate evidence-based measurement issues in child mental health disorders and services.

**Innovations in Practice:** Submission to this section should conform to the specific guidelines, given in full below.

2. Submission of a paper to *Child and Adolescent Mental Health* will be held to imply that it represents an original article, not previously published; that it is not being considered for publication elsewhere; and that if accepted for publication it will not be published elsewhere without the consent of the Editors.

3. Manuscripts should be submitted online. For detailed instructions please go to: [http://mc.manuscriptcentral.com/camh\\_journal](http://mc.manuscriptcentral.com/camh_journal) and *check for existing account* if you have submitted to or reviewed for the journal before, or have forgotten your details. If you are new to the journal *create a new account*. Help with submitting online can be obtained from Piers Allen at ACAMH (e-mail [Piers.Allen@acamh.org.uk](mailto:Piers.Allen@acamh.org.uk))

4. Authors' professional and ethical responsibilities

**Disclosure of interest form:** All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

**Ethics:** Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the *Ethical*

*principles of psychologists and code of conduct* (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (ICJME) and is also a member and subscribes to the principles of the Committee on Publication Ethics (COPE).

*Informed consent and ethics approval:* Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study country. Within the Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

*Recommended guidelines and standards:* The Journal requires authors to conform to CONSORT 2010 (see CONSORT Statement) in relation to the reporting of randomised controlled clinical trials; also recommended is the Extensions of the CONSORT Statement with regard to cluster randomised controlled trials). In particular, authors must include in their paper a flow chart illustrating the progress of subjects through the trial (CONSORT diagram) and the CONSORT checklist. The flow diagram should appear in the main paper, the checklist in the online Appendix. Trial registry name, registration identification number, and the URL for the registry should also be included at the end of the methods section of the Abstract and again in the Methods section of the main text, and in the online manuscript submission.

Manuscripts reporting systematic reviews or meta-analyses should conform to the PRISMA Statement.

The Equator Network is recommended as a resource on the above and other reporting guidelines for which the editors will expect studies of all methodologies to follow. Of particular note are the guidelines on qualitative work <http://www.equator-network.org/reporting-guidelines/evolving-guidelines-for-publication-of-qualitative-research-studies-in-psychology-and-related-fields> and on quasi-experimental <http://www.equator-network.org/reporting-guidelines/the-quality-of-mixed-methods-studies-in-health-services-research> and mixed method designs <http://www.equator-network-or/reporting-guidelines/guidelines-for-conducting-and-reporting-mixed-research-in-the-field-of-counseling-and-beyond>

*CrossCheck:* An initiative started by CrossRef to help its members actively engage in efforts to prevent scholarly and professional plagiarism. The journal to which you are submitting your manuscript employs a plagiarism detection system. By submitting your manuscripts to this journal you accept that your manuscript may be screened for plagiarism against previously published works.

5. Manuscripts should be double spaced and conform to the house style of *CAMH*. The first page of the manuscript should give the title, name(s) and address(es) of author(s), and an abbreviated title (running head) of up to 80 characters. Specify the author to whom correspondence should be addressed and provide their full mailing and email address.

*Summary:* Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

*Keywords:* Please provide 4-6 keywords (use MeSH Browser for suggestions).

*Key Practitioner Message:* (in the form of 3-6 bullet points) should be given below the Abstract, highlighting what's known, what's new and the direct relevance of the reported work to clinical practice in child and adolescent mental health.

6. Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Original Articles should not exceed 5,500 words, including References and Tables. Occasionally, longer articles may be accepted after negotiation with the Editors. Authors should include a word count of their paper.



7. Authors who do not have English as a first language may choose to have their manuscript professionally edited prior to submission; a list of independent suppliers of editing services can be found at [http://authorservices.wiley.com/bauthor/english\\_language.asp](http://authorservices.wiley.com/bauthor/english_language.asp). All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

8. Headings: Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

9. All manuscripts should have an Acknowledgement section at the end of the main text, before the References. This should include statements on the following:

*Study funding:* Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.

*Conflicts of interest:* Please disclose any conflicts of interest of potential relevance to the work reported for each of the authors. If no conflicts of interest exist, please include an explicit declaration of the form: "The author(s) have declared that they have no competing or potential conflicts of interest".

*Contributorships:* Please state any elements of authorship for which particular authors are responsible, where contributions differ between the author group. (All authors must share responsibility for the final version of the work submitted and published; if the study includes original data, at least one author must confirm that he or she had full access to all the data in the study, and takes responsibility for the integrity of the data and the accuracy of the data analysis). Contributions from others outside the author group should also be acknowledged (e.g. study assistance or statistical advice) and collaborators and study participants may also be thanked.

10. For referencing, *CAMH* follows a slightly adapted version of APA Style <http://www.apastyle.org/>. References in running text should be quoted showing author(s) and date. For up to three authors, all surnames should be given on first citation; for subsequent citations or where there are more than three authors, 'et al.' should be used. A full reference list should be given at the end of the article, in alphabetical order.

References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

11. Tables: These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.

12. Figures: Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file. See <http://authorservices.wiley.com/bauthor/illustration.asp> for further guidelines on preparing and submitting artwork. Titles or captions should be clear and easy to read. These should appear at the end of the main text.

13. Footnotes should be avoided, but end notes may be used on a limited basis.

### **Review Articles**

These papers are usually commissioned; they should survey an important area of interest within the general field of child and adolescent mental health disorders and services. Suggestions for topics and proposals (outline and/or draft abstract)

may be sent to the CAMH Editorial Office [camh@acamh.org](mailto:camh@acamh.org)

### **Measurement Issues**

These are commissioned review papers that aim to evaluate evidence-based measurement issues in child mental health disorders and services: if you have a suggestion for a measurement-based overview article, please contact the CAMH Editorial Office [camh@acamh.org](mailto:camh@acamh.org) with an outline proposal. Manuscripts for Review Articles are Measurement Issues should follow the standard format for Original Articles but to a word limit agreed at the point of the proposal being agreed.

### **Innovations in Practice**

*Child and Adolescent Mental Health (CAMH)* promotes evidence-based practice, intervention and service models.

Innovations in practice, intervention and service provision may arise through careful and systematic planning, while others are responsive to need, evolution of existing services, or simply arise because of changing circumstances or technology. In this rapidly evolving field, the Editors of *CAMH* warmly welcome short *Innovations in Practice* papers which aim to allow authors to share with our wide international multidisciplinary readership knowledge and initial impact of new and interesting developments.

Manuscripts submitted as *Innovations in Practice* submissions should follow the standard format for *Original Articles* but be no more than 2500 words, including references and tables. They should briefly set out the aims and detail for the innovation, including relevant mental health, service, social and cultural contextual factors; the evaluation methods used; relevant supporting evidence and data; and conclusions and implications. Submissions may describe formal pilot and feasibility studies or present findings based on other evaluative methods. Contributions outlining important innovations with potential significant impact may be considered even in the absence of evaluative data. Close attention should be paid in all submissions to a critical analysis of the innovation.

### **Manuscript Processing**

*Peer Review Process:* All material submitted to CAMH is only accepted for publication after being subjected to external scholarly peer review, following initial evaluation by one of the Editors. Both original and review-type articles will usually be single-blind reviewed by a minimum of two external referees and only accepted by the decision Editor after satisfactory revision. Any appeal of an editorial decision will first be considered by the initial decision Editor, in consultation with other Editors. Editorials and commissioned editorial opinion articles will usually be subject to internal review only, but this will be clarified in the published Acknowledgement section. Editorial practices and decision making will conform to COPE <http://publicationethics.org/resources/guidelines> and ICMJE <http://icmje.org/> best practice.

*Proofs:* Proofs will be sent to the designated author only. These will be sent via e-mail as a PDF file and therefore a current e-mail address must always be given to the journal office. Only typographical or factual errors may be changed at proof stage, and the publisher reserves the right to charge authors for correction of non-typographical errors.

*Offprints:* The designated author of a published paper will receive a PDF file of their final published article. The designated author should undertake to forward copies of the PDF file to their co-authors.

*Copyright:* If your paper is accepted, the author identified as the corresponding author for the paper will receive an email prompting them to log into Author Services where, via the Wiley Author Licensing Service (WALS), they will be able to complete a license agreement on behalf of all co-authors of the paper.

## Appendix B: Quality Checklist

### Quality Checklist: Quantitative Research

Adapted from Caldwell, Henshaw & Taylor (2005) Quality Assessment Framework

Assessment Area	Description	Score		
		0 No/Not Clear	1 Partially	2 Yes
1. Title	Does it reflect the content?			
2. Abstract	Does it summarise the key components?			
3. Rationale	Is rationale for undertaking the research clearly outlined?			
4. Literature review	Is it comprehensive and up-to-date?			
5. Aim	Is it clearly stated?			
6. Ethical Issues	Are all ethical issues identified and addressed?			
7. Methodology	Is it identified and justified?			
8. Design	Is it clearly identified and the rational evident?			
9. Hypothesis	Is it clearly stated?			
10. Variables	Are the key variables clearly defined?			
11. Population	Is it identified?			
12. Sample	Does it describe and reflect the population?			
13. Data collection	Is the method of data collection valid and reliable?			
14. Analysis	Is the method of data analysis valid and reliable?			
15. Results	Are they presented in a way that is appropriate and clear?			
16. Discussion	Is it clear and comprehensive?			
17. Generalisability	Are the results generalisable?			
18. Conclusion	Is it clear and comprehensive?			

### **Quality Checklist: Qualitative Research**

Assessment Area	Description	Score		
		0 No/Not Clear	1 Partially	2 Yes
1. Title	Does it reflect the content?			
2. Abstract	Does it summarise the key components?			
3. Rationale	Is rationale for undertaking the research clearly outlined?			
4. Literature review	Is it comprehensive and up-to-date?			
5. Aim	Is it clearly stated?			
6. Ethical Issues	Are all ethical issues identified and addressed?			
7. Methodology	Is it identified and justified?			
8. Design	Is the philosophical background and study design identified and the rational evident?			
9. Concept	Are the major concepts identified?			
10. Sample	Is the selection of participants described and method identified?			
11. Data collection	Is the method of data collection auditable?			
12. Analysis	Is the method of data analysis credible and confirmable?			
13. Results	Are they presented in a way that is appropriate and clear?			
14. Discussion	Is it clear and comprehensive?			
15. Generalisability	Are the results transferable?			
16. Conclusion	Is it clear and comprehensive?			

Adapted from Caldwell, Henshaw & Taylor (2005) Quality Assessment Framework

## Appendix C: Table of Quality Assessment Scores

Quantitative/ Mixed Methods	Burns	Byrne	Coles	Cotton	Dogra	Furnham	Hernam	Kelly	Leighton	Mason	Melas	Olsson	Williams	Yamawaki
1. Title	2	1	2	2	2	2	1	1	2	1	2	2	2	1
2. Abstract	1	1	1	2	1	2	2	1	1	2	2	2	2	2
3. Rationale	2	2	1	2	2	2	2	2	2	2	1	2	2	2
4. Literature review	2	2	1	2	1	1	1	1	2	2	2	1	1	1
5. Aims	2	2	2	1	1	2	1	0	1	2	2	1	2	2
6. Ethical Issues	2	1	2	1	1	1	2	1	1	1	0	1	1	1
7. Methodology	2	2	2	1	1	2	2	1	2	2	2	2	1	1
8. Design	1	1	1	1	0	0	1	0	1	0	0	1	1	0
9. Hypothesis	0	0	2	2	0	2	0	0	0	0	0	0	0	0
10. Variables	1	1	1	1	1	1	1	1	2	2	1	1	1	1
11. Population	2	2	1	2	2	2	1	2	2	2	1	2	2	1
12. Sample	1	1	1	2	1	1	1	1	1	1	1	1	1	1
13. Data collection	2	1	2	2	1	1	2	1	1	2	1	1	1	1
14. Analysis	2	2	2	1	1	2	2	1	1	2	1	1	2	2
15. Results	2	2	2	2	1	2	1	2	1	2	2	1	2	2
16. Discussion	2	2	2	2	1	2	1	1	2	2	1	1	2	2
17. Generalisability	1	1	1	2	1	1	1	1	1	1	1	1	1	1
18. Conclusion	0	1	0	2	1	1	1	0	2	1	2	1	1	0
Total (Max = 36)	27	25	26	30	19	27	23	17	25	27	22	20	25	21
% Score	75.0	69.4	72.2	83.3	52.8	75.0	63.9	47.2	69.4	75.0	61.1	55.6	69.4	58.3

Exclude due to quality

Qualitative	MacLean
1. Title	1
2. Abstract	1
3. Rationale	2
4. Literature review	1
5. Aims	2
6. Ethical Issues	2
7. Methodology	1
8. Design	0
9. Concept	1
10. Sample	1
11. Data collection	2
12. Analysis	1
13. Results	1
14. Discussion	1
15. Generalisability	1
16. Conclusion	1
Total (Max = 32)	19
% Score	59.4

## Appendix D: Assessment of Inter-Rater Reliability

Rater 1		
Cotton	Leighton	Melas
2	2	2
2	2	2
2	2	2
2	2	2
1	1	2
0	1	1
0	2	2
1	1	0
2	0	0
1	2	2
2	2	1
2	2	1
2	1	1
1	2	1
2	2	2
2	2	1
2	1	1
2	0	2
28	27	25

Rater 2		
Cotton	Leighton	Melas
2	2	2
2	2	2
2	2	2
2	2	2
2	2	2
2	2	2
0	1	1
0	1	2
0	1	1
2	0	0
2	2	2
2	2	1
2	2	1
0	1	1
2	2	1
2	2	2
2	1	2
2	1	2
2	0	2
28	26	28

Rater1	Rater 2				Row Total
		0	1	2	
	0	5	1	0	6
	1	1	9	6	16
	2	1	2	29	32
Column Total		7	12	35	54

Rater 1	Rater 2			
		0	1	2
	0	0.778		
	1		3.556	
	2			20.74

Expected frequency =  
(Row Total x Column Total)  
/Grand Total

Total Agreements	43	Kappa =
% Agreement	79.63	(Total Agreements - Expected Frequency)
Expected frequency by chance	25.07	/ (Grand Total - Expected Frequency) x 100
Kappa	61.97	

## **Appendix E: Author Guidelines for the Journal of Clinical Sport Psychology**

In preparing manuscripts for publication in the *Journal of Clinical Sport Psychology (JCSP)*, authors are expected to carefully adhere to the guidelines in the Publication Manual of the APA (6th ed., 2010). All articles must be preceded by an abstract, not to exceed 150 words, typed on a separate page. Special attention should be given to the preparation and accuracy of references, and to the absence of sexist and biased language. The manuscript should be double-spaced, including the abstract, references, and any block quotations.

Original manuscripts, not previously published elsewhere or simultaneously submitted to another journal, should be submitted electronically via ScholarOne at [mc.manuscriptcentral.com/hk\\_jcsp](https://mc.manuscriptcentral.com/hk_jcsp). An author account will need to be created by following the directions on the Manuscript Central page. Authors will be asked to submit a "blinded" version of their article and a separate cover sheet document with author names, institutional affiliations, running head, and corresponding author's contact information. No print manuscripts or e-email attachments can be accepted.

The review process is blind, with manuscripts read by at least two reviewers. The review process should take 8-12 weeks. There are no page charges to contributors. Authors of manuscripts accepted for publication must transfer copyright to Human Kinetics, Inc.

Case Conference manuscripts are limited to 7 pages. Empirical, theoretical, and program development articles generally should not exceed 35 pages, including figures, tables, and references. They will be judged according to their contribution to knowledge, presentation of information, appropriateness of the discussion, interpretation of ideas, clarity of writing, and where appropriate methodology/design and data analysis. Authors are expected to have their raw data and descriptive statistics available throughout the editorial review process and are responsible for providing elaboration upon request.

## **Appendix F: Semi-Structured Interview Schedule**

### **Semi-Structured Interview Schedule**

- 1. Can you tell me about your experiences of mental health difficulties?**
  - a. How did they start/develop?
  - b. What did you notice?
  - c. What do you think led to the development of mental health problems?
    - i. What was going on in your life at the time?
  - d. How did your mental health problems affect you?
  - e. How did you view yourself at that time?
  - f. How did you anticipate that other people would respond to you?
    - i. E.g. Family, Friends, Footballers, Coaches, Media, Fans
  - g. How did you experience other people's responses to you?
  - h. What did you do?
  - i. Who did you talk to?
  - j. What was like for you experiencing those difficulties in the professional football environment?
- 2. What was your understanding of mental health before you started to experience difficulties?**
  - a. What things did you associate with mental health?
  - b. What things did you associate with people who experience mental health difficulties?
- 3. What if anything has changed in your understanding of mental health since having these experiences?**
- 4. What was your experience of seeking help and support?**
  - a. *What was your awareness of support?*
  - b. *Did you experience any problems or barriers with accessing support?*
    - i. *What were these?*
  - c. *What was your experience of accessing support?*
- 5. What has been your experience of how mental health problems are viewed by the football community?**
- 6. Thank you for participating in this interview. Based on your experiences is there anything else you would like to tell me?**



## **Appendix G: Ethical Approval Confirmation**



### **Certificate of Ethical Approval**

Student:

Susan Wood

Project Title:

Male Professional Footballers' Experiences of Mental Health and Help Seeking

This is to certify that the above named student has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

23 February 2015

Project Reference Number:

P29281

**REGISTRY RESEARCH UNIT  
ETHICS REVIEW FEEDBACK FORM**

(Review feedback should be completed within 10 working days)

Name of applicant: Susan Wood.....

Faculty/School/Department: [Faculty of Health and Life Sciences] Clinical Psychology

Research project title: Male Professional Footballers' Experiences of Mental Health and Help Seeking

Comments by the reviewer

**1. Evaluation of the ethics of the proposal:**

The proposed study is grounded in a clear rationale and adopts an appropriate methodology. Areas of potential ethical concern have been appropriately addressed. Given the recruitment strategy, it will be important to acknowledge in the write up of the study that the participants had all accessed some form of support for their mental health difficulties (e.g. via the charities through which recruitment will take place).

**2. Evaluation of the participant information sheet and consent form:**

The consent form is generally ethically appropriate. Two amendments are required. Firstly, the date by which participants can withdraw consent needs to be changed to a later date (after anticipated data collection has been completed), for example 31st December 2015 or 31st January 2016. Also, the phrase "In understand" in section 8 of the consent form should be amended to read "I understand". The debrief sheet also contains information regarding date by which participant can withdraw consent and should be amended in line with the consent form.

The participant information sheet is also ethically sound. The applicant is strongly advised to have further discussion with research supervisors about how best to approach the use of prompts in the interview protocol so as to maintain an appropriate balance between the need to prompt for further information and the need to avoid "leading" participants. The final question on the interview protocol is a little unclear. Further consideration of this question and / or rewording (after discussion with the supervision team) is suggested (e.g. are you asking about advice based on the participant's experience? Is this advice for others with mental health problems in the football community or for the football communi

**3. Recommendation:**

(Please indicate as appropriate and advise on any conditions. If there any conditions, the applicant will be required to resubmit his/her application and this will be sent to the same reviewer).

- |                                     |   |
|-------------------------------------|---|
| <input checked="" type="checkbox"/> | Approved - no conditions attached   |
| <input type="checkbox"/>            | Approved with minor conditions (no need to re-submit)   |
| <input type="checkbox"/>            | Conditional upon the following – please use additional sheets if necessary (please re-submit application) |
| <input type="checkbox"/>            | Rejected for the following reason(s) – please use other side if necessary                                 |
| <input type="checkbox"/>            | Not required  |

Name of reviewer: Anonymous.....

Date: 20/02/2015.....

## **Appendix H: Participant Information Sheet**

### ***Participant Information Sheet***

#### ***Male Professional Footballers' Experiences of Mental Health and Help-seeking***

This research study hopes to explore male professional footballers' experiences of mental health and help-seeking. Your participation would involve a one to one interview with the researcher. The duration of the interview can vary but it is not expected to exceed one hour.

The interview will invite you to share your experiences of mental health and factors that you think can affect a footballers' mental health and help-seeking. The interview is not a clinical exploration of your past or directly asking you about your mental health. You have the right to leave the interview at any time. You do not have to provide a reason for withdrawing.

Upon completion of the interview you will be given a debrief information sheet and provided further opportunity to ask any questions you make have. It is hoped that your participation in this research will help to make recommendations of how to support footballers' who do experience mental health difficulties.

Talking about mental health can be difficult and elicit challenging emotions. Should you have any concerns about the information discussed or with emotions you are experiencing you can discuss these with the researcher or your GP. A list of support services and their contact details are also attached.

-

This research study forms part of the researchers' doctoral thesis from the Universities of Coventry and Warwick.

Please read the consent form. This will provide you with information about your rights and explain the process of confidentiality.

Do you have any questions that you would like to ask?

The research teams contact details are provided below should you have any further questions.

#### ***Research Team***

Sue Wood, Lead Researcher

[woods15@uni.coventry.ac.uk](mailto:woods15@uni.coventry.ac.uk)

Jo Kucharska, Research Supervisor

[jo.kucharska@coventry.ac.uk](mailto:jo.kucharska@coventry.ac.uk)

## **Contact Details of Support Services**

The following contacts are available if you need someone to talk to:

**Your GP**

**Your club**

### **Professional Footballers' Association (PFA) 24hr helpline**

Tel (Manchester): 0161 236 0575

Tel (London): 0207 236 5148

Email: [wellbeing@thepfa.co.uk](mailto:wellbeing@thepfa.co.uk)

Web: [www.thepfa.com/wellbeing](http://www.thepfa.com/wellbeing)

### **Sporting Chance Clinic**

Tel: 0870 220 0714

Email: [info@sportingchanceclinic.com](mailto:info@sportingchanceclinic.com)

Web: [www.sportingchanceclinic.com](http://www.sportingchanceclinic.com)

### **Pastoral Care - Score Sports Chaplaincy**

Matt Baker, Pastoral Support Director

**Tel:** 0161 962 6068

**Email:** [matt.baker@scorechaplaincy.org.uk](mailto:matt.baker@scorechaplaincy.org.uk)

**Web:** [www.scorechaplaincy.org.uk](http://www.scorechaplaincy.org.uk)

### ***General Advice and Support - Voluntary sector specialist organisations***

#### **Alcoholics Anonymous**

PO Box 1, Stonebow House, Stonebow, York YO1 7NJ

**Helpline:** 0845 769 7555

**Web:** [www.alcoholicsanonymous.org.uk](http://www.alcoholicsanonymous.org.uk)

#### **Anxiety UK**

**Helpline:** 08444 775 774

**Web:** [www.anxietyuk.org.uk](http://www.anxietyuk.org.uk)

#### **Depression Alliance**

**Tel:** 0845 123 2320

**Web:** [www.depressionalliance.org](http://www.depressionalliance.org)

#### **Help with Stress**

**Web:** [www.helpwithstress.org](http://www.helpwithstress.org)

#### **MIND – the mental health charity.**

**Tel:** 0845 766 0163

**Contact Mind infoline:** 0300 123 3393

**Email:** [info@mind.org.uk](mailto:info@mind.org.uk)

**Web:** [www.mind.org.uk](http://www.mind.org.uk)

#### **National Problem Gambling Clinic**

**Tel:** 0207 534 6699

**Email:** [gambling.cnwl@nhs.net](mailto:gambling.cnwl@nhs.net)

**Web:** [www.cnwl.nhs.uk/gambling.html](http://www.cnwl.nhs.uk/gambling.html)

#### **NHS**

**Tel:** NHS direct on 0845 4647, 24 hours a day, 7 days a week

**Web:** [www.nhs.choice](http://www.nhs.choice)

#### **Samaritans**

**Helpline:** 08457 90 90 90

**Email:** [Jo@samaritans.org](mailto:Jo@samaritans.org)

**Web:** [www.samaritans.org](http://www.samaritans.org)

#### **Time to Change**

**Web:** [www.time-to-change.org.uk](http://www.time-to-change.org.uk)

## Appendix I: Consent Form

### Consent Form

<b>Male Professional Footballers' Experiences of Mental Health and Helping Seeking</b>	<b>Please Tick</b>
I have read and understood the information sheet provided. I have had the opportunity to consider the information and the questions I have asked have been answered to my satisfaction.	
I understand that my participation is completely voluntary. I am aware that I have the right to withdraw my information at any time without needing to give a reason up until the 30 <sup>th</sup> April 2015.	
I understand that I can withdraw from this interview at any point. I do not need to give a reason for my withdrawal.	
I understand that my comments will be kept anonymous and that I cannot be identified from the information I have provided.	
I understand that the interviews will be recorded on a Dictaphone. I am aware that the recordings will be stored securely under an encrypted file and separate from any written information I have provided. I understand that the Dictaphone recording will be wiped once the interview has been transcribed.	
I understand that I can request to read the transcript of my interview and inform the researcher of any sections I would not like to be quoted in the results section.	
I understand that the data collected during the study, may be looked at by the named research team and from regulatory authorities where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.	
I understand that the data collected will be retained for 5 years before being destroyed, in keeping with the universities policies.	
I understand that at any point I may contact the researchers (contact details on the Participant Information Sheet) if I would like more information about the study, if anything is not clear or if I were experiencing distress following my participation and would like advice or support.	
I agree to take part in the above study.	

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Participant)

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Researcher)

## Appendix J: Demographic Information Sheet

### Demographic Information Sheet

*Please answer the following questions about yourself:*

How old are you? _____ years			
How would you describe your ethnicity? (Please tick)			
White-British/Irish	<input type="checkbox"/>	White-Other (please specify)	<input type="checkbox"/>
Asian/Asian British	<input type="checkbox"/>	Black/African/Caribbean/Black British	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	Mixed/Multiple Ethnic Groups	<input type="checkbox"/>
Are you still playing professional football? (Please circle)      Yes                      No			
What is the highest playing level you have achieved? (Please tick)			
Club – Academy	<input type="checkbox"/>	Club – Reserve Team	<input type="checkbox"/>
		International Youth	<input type="checkbox"/>
		Club – First Team	<input type="checkbox"/>
		International Senior	<input type="checkbox"/>
How many clubs have you played at? _____			
What is your current injury status? (Please circle)			
No Injury	Minor Injury	Moderate Injury	Serious Injury
Have you suffered an injury in the past that has prevented you from playing for over 6 weeks? (Please circle)			
Yes	No		
Have you personally experienced difficulties with your mental health? (Please circle)			
Yes	No		
If yes, did you access any support? (Please circle)                      Yes                      No			
If yes, please identify the service and/or the profession you received support from:			
_____			
Do you know someone who has experienced difficulties with their mental health?			
Yes	No		
If 'Yes' please can you indicate your relationship to this person(s)			
Family relative	Friend	Footballer	Prefer not to say

## **Appendix K: Debrief Information Sheet**

### **Debrief Information Sheet**

Thank you for taking time to share your experiences of mental health and help-seeking.

This research hopes to help improve our understanding of the unique experiences faced by professional footballers who have experienced mental health difficulties. The findings from this research will be used to make recommendations about how to support footballers who experience these difficulties.

Talking about mental health can be difficult and elicit challenging emotions. If you are upset or concerned following your participation in this research you can talk to any of the research team. You can also contact the research team if you have any more questions.

If you are feeling unwell or concerned then your GP or the PFA's 24hr helpline are available to help. A list of the other support services available to you is also provided in the Participant Information Sheet.

#### **Professional Footballers' Association (PFA) 24hr helpline**

Tel (Manchester): 0161 236 0575

Tel (London): 0207 236 5148

Email: [wellbeing@thepfa.co.uk](mailto:wellbeing@thepfa.co.uk)

Web: [www.thepfa.com/wellbeing](http://www.thepfa.com/wellbeing)

I would like to remind you that you have the right to withdraw your information from this research at any time without needing to give a reason up until the 30<sup>th</sup> April 2015 by contacting the research team.

Do you have any questions or concerns you would like to raise now?

Thank you for your participation.

#### ***Research Team***

Sue Wood, Lead Researcher  
Supervisor  
[woods15@uni.coventry.ac.uk](mailto:woods15@uni.coventry.ac.uk)

Jo Kucharska, Research  
[jo.kucharska@coventry.ac.uk](mailto:jo.kucharska@coventry.ac.uk)

## Appendix L: Stages of Interpretative Phenomenological Analysis

Adapted from Smith, Flowers and Larkin (2009)

	Stage of Analysis	Description of Process
Ongoing reflection and reflexivity	Stage 1: Reading and re-reading transcripts	Each transcript was read and re-read to facilitate the researchers' immersion within the data. In addition the audio recording of each participant interview was listened to and re-listened to enhance engagement with the data and to allow for reflective notes to be made.
	Stage 2: Initial noting	Line-by-line analysis of each transcript was undertaken. The transcripts were annotated with initial reflections and notes in the right sided margin. Colour coding was used to distinguish between descriptive, linguistic, conceptual and additional (e.g. contradictions or echoes) notes. Checking for the researcher meaning and participant meaning of a word and phrase was undertaken. The process of deconstruction was also undertaken.
	Stage 3: Developing emergent themes	The initial notes were analysed to identify emergent themes based upon the participants' lived-experience and the researchers' interpretation of that experience. Emergent themes were recorded in the left sided margin.
	Stage 4: Searching for connections across emergent themes	For each participant, the researcher explored how the emergent themes fitted together. Emergent themes that did not fit with the aims/scope of the study were disregarded at this stage.
	Stage 5: Moving on to the next case	The process of searching for connections across emergent themes was repeated for each participant. The researcher was attentive to ensure that the previous participant's experience did not infiltrate the analysis of subsequent participants' experiences.
	Stage 6: Searching for patterns across cases	Once each transcript had been analysed the researcher explored connections between the participants. Visual mapping supported this process, and final superordinate and subordinate themes were identified.



## Appendix M: Transcript Excerpt Showing Initial Coding and Emergent Themes

### Example 1: Benjamin

Emergent Themes	29.06.15 Transcript for Participant 2	Initial Noting
Macho culture	34 everyone's... quite erm... a macho culture where you're expected	Macho culture.
Role	35 to be fit and if you're not fit (inhales) it's almost like you're not...	Expected to be fit.
Imagined thought of others	36 fulfilling your role you know and people, you can almost feel	Like not fulfilling your role.
Seeking help SP	37 people talking about you, and god is he injured again (mmm),	Paranoia? Feel people talking about you
Recurring injury	38 what's up with him this time (mm) and sort of questioning your sort	Is he injured again, what's up with him
Powerless	39 of, I don't know, professionalism I suppose. So around that time	Overstating professionalism
Recurring injury	40 the erm... the physio at the time was a new physio, a young guy	
Desperation	41 who'd worked, who'd studied at UNIVERSITY under a guy called	
Self as young	42 NAME of SP (Sports Psychologist) and he suggested you know	Physio suggested speak to sport psychologist
Magic cure	43 why don't we go and speak with NAME SP (uh hm). Ermm.....	Difficult & recurring
Impact of help	44 basically because it was it was difficult and it was recurring and I	couldn't stop it recurring. Powerless?
Link ph + mh	45 I couldn't kind of... kind of stop it recurring.	
Anxiety	46 When you say stop it recurring...	
Hypersensitivity	47 P Injury wise. So they were all like recurring injuries like muscle	Recurring muscle injuries. Ignored
	48 injuries (ok), no kind of big like cruciates or anything major, that	Not major injury. - are these more dismissed if not 'major'?
	49 you'd class as major. All kind of muscle injuries that take like 3, 4,	Repeated muscle injuries
	50 5 weeks then start again (mm) then another muscle injury and	I wouldn't buy anything - Desperate
	51 another muscle injury. So you know I was more, I was at the stage	When young, think magic cure - explaining as being young
	52 you know where I really would try anything to be honest	Find the magic cure. Use of 'you'
	53 (inhales)...that you just...when you're young you think there's just	
	54 some magic cure if you speak to enough people you'll find the	Sport psychologist just what I needed.
	55 magic cure you know (mm) so I went to a few specialists and they	Biggest influence of career
	56 said different things and whatever (mm), try this, try that. So went	SP influence professional + personally as a man
	57 to see this guy NAME SP and it was ermm...from minute one it	
	58 was just the most... just what I needed, it was like the biggest	Work on anxious increasing injury risk
	59 influence on my career to date both professionally as a footballer	Searching body for things
	60 and personally as a as a as a man really. Erm straight away we	Hypersensitivity
	61 got to work on how cause I was more anxious there was increased	Anxiety = body tighter
	62 injury risk because I was constantly looking and searching (um	Playing without freedom
	63 hm) for things that might be wrong and then obviously you're not	
	64 playing with any freedom because you're already tighter and	
	65	
	66	

## Example 2: Craig

Emergent Themes	06.07.15 Transcript for Participant 3	Initial Noting
	229 I I guess when you were with the lads and the banter was great	
	230 how did it feel to be..	
	231	
Buzz (up)	232 P Ah <u>buzzing</u> yeah can't wait to go into work every day (yeah), just	football as work/job
Football as work	233 buzzing to get into the dressing room cause they're they're your	Buzzing
	234 mates as well you know (um hm), just to get in it's vibrant, it's the	Can't wait to go into work every day
Togetherness	235 place..it's rocking. You feel that togetherness and that team ethic	It's vibrant - the place is rocking - metaphor
	236 sort of stuff (mm) and yeah just great environments to be in	Togetherness, team ethic - Belonging
	237 (yeah). Great environments to be in.	Great environment to be in - special environment
	238	
	239 I And then when you come out of that through injury or erm through	
	240 retirement what feelings?	
	241	
Contrast	242 P From from retirement it's gone from <u>that</u> , that you know 20, 30	Contrast:
To Nothing	243 lads everyday... buzzing you know, jokes and just so much going	To Nothing
Change/transition	244 on to when I retired it was like <u>nothing</u> (mm), you know me the	me, the wife + kids
	245 wife and the the kids and that was a massive change (yeah), a	Massive change - emphasis by repetition
	246 massive change but one at the time like as said previously I	Though I was on with it but I wasn't
	247 thought I was all ok with (mm) erm but like I say looking back	Questioning/reflecting whether trying to put on
Thoughts about self	248 obviously... some of the things I was doing you know I I wasn't	that was on
Mash?	249 (mm). I don't know whether I was trying to put on, or whether I did	
	250 put on that I was or I don't know.	
	251	
	252 I What do you think?	
	253	
Transition	254 P Err, probably yeah cause people would ask me ah do you miss it?	say didn't miss it but I did.
Missing env + team	255 (mm) and I'd be like <u>no</u> , no I don't, cause at the time I didn't think I	miss the environments and lads
	256 did erm. I think I did, I used to say I would definitely miss the	said didn't miss football.
	257 environment with being with the lads and stuff but that I didn't miss	
	258 football. Funny and that when I go to games now you know to go	When watch games now - real buzzing /
	259 an watch whoever, CLUB 4 or whoever and that... when the boys	tingles again
	260 come, when the players come out to start the game and get up,	
Buzz + Loss	261 I'm real buzzing, like the tingles again (mm) and that's why I said	Loss of the buzz

### Example 3: Edward

Emergent Themes	27.07.15 Transcript for Participant 5	Initial Noting
Social withdrawal	193	
Hiding self	194 P	Well I kind of wouldn't talk to people, so I wouldn't let them in. Erm
Push others away	195	pushing people away, I think that was part and parcel of it you
Mistrust ppl/world	196	know (mm). Not allowing people to see what was going on in my,
Escapism of T & F	197	to actually reveal that to to somebody in trust. So through that
Unhealthy coping	198	process, it kind of led me more and more into myself (yeah), and
Frustration & Aggression	199	more kind of mistrusting of people out there in the world you know.
Reflection on experience	200	What else er I think the escapism is a big thing (yeah), you know
Thoughts of self	201	just not being with my thoughts and feelings and allowing my
Childlike	202	thoughts and feelings to take control, but also there would be
Critical of self coping	203	aspects of dealing with it in unhealthy ways. So I would like kind
	204	of, I could be quite erm frustrated (um hm). It would come out in
	205	aggression, maybe on the football field or towards family or friends
	206	or partners (um hm) you know, resentment (mm). I would kind of
	207	project all this stuff...and maybe now I look back on it maybe all
	208	this stuff that was going off and that I was projecting out there was
	209	really how I was feeling about myself (mm) you know cause to to
	210	feel like you're not good enough, or you're not dealing with things
	211	or you're not...I think I was angry with me (um hm) with feeling
	212	that way. It was just a really unhealthy kind of way of being and I'd
	213	say in a sense quite childlike. It was very childlike you know, it
	214	wasn't it wasn't mature (mm). It was very reactionary or impulsive
	215	(mm). Very you could say egocentric really you know kind of give
	216	me something, give me something to get away from this internal
	217	stuff (mm), you know change the way that I feel (yeah). So yeah it
	218	was yeah, very very immature or like I say childlike or adolescent
	219	(mm) in the way that I was experiencing the world. It felt very
	220	childlike in an adult environment you know (um hm, um hm).
	221	
	222 I	Thank you for sharing that with me (no its cool yeah). So you
	223	mentioned that it started to affect your relationships (yeah), I just
	224	wondered what relationships you meant by that and how?

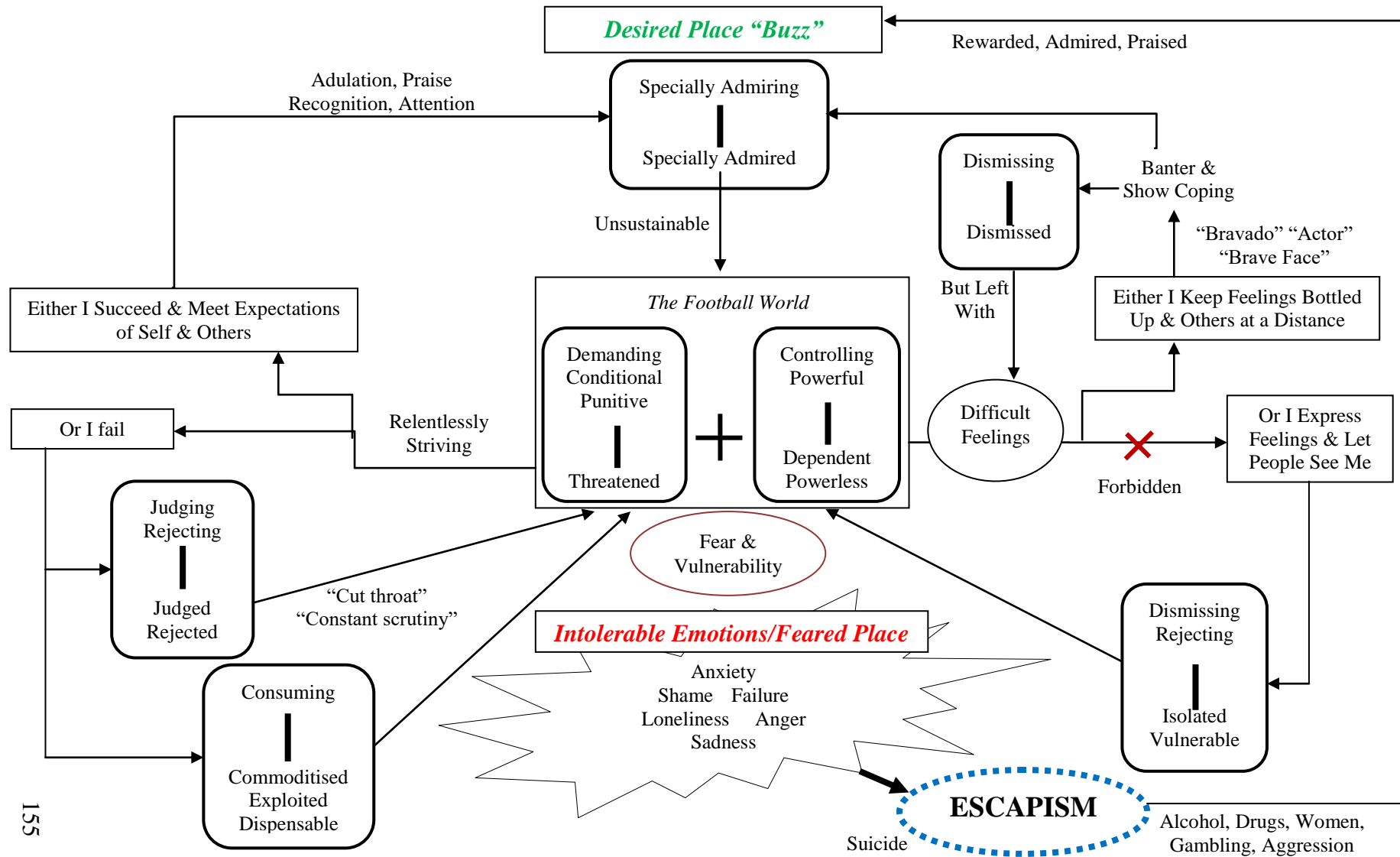
Wouldn't talk to people.  
 Wouldn't let people in - intrusive? to share  
 Push people away  
 Not allow people to see / or to reveal  
 More + more into myself  
 Mistrusting of people / world.  
 Escapism - explaining as big thing for him  
 Not being w/ thoughts + feelings  
 Unhealthy ways of coping  
 Frustrated use of quiet + erm... is heathen  
 Aggression - this or minimising aggression?  
 Different avenues of aggression  
 Resentment - Project.  
 Reflection (neglecting during interview)  
 Feel not good enough / not coping  
 Angry at self.  
 Unhealthy  
 Self as childlike, not mature.  
 Reactional / impulsive.  
 Egocentric  
 Get away from internal stuff  
 Change how I feel  
 Immature, childlike adolescent  
 Emphasis of immature  
 Child in an adult env is he being critical of himself?



## Appendix N: Visual Mapping of Emergent Themes



## Appendix O: Sequential Diagrammatic Reformulation



## **Appendix P: Reformulation Letter to the Collective Footballer**

Dear Professional Footballer,

This letter is my attempt to understand some of your experiences and how they are affecting you now. When we met together it seemed to me that you decided to take part in this research because you wanted to give a voice to your experiences as a professional footballer. I hope that by writing this letter your voice can feel heard.

When you were young you dreamed of becoming a professional footballer; a position of fantasy, special admiration and adulation. You told me that you idolised your favourite players and played football for hours on end in the park with your mates. It was a special time for you when jumpers were goalposts and you pretended to play in the FA cup final. This is where you discovered your love and passion for football. A place where you felt like you really belonged. This was also a place where you could find escapism and be totally absorbed by your love of the game. When you were on the field with your mates and the ball was at your feet there was nothing else in the world.

Signing your first professional contract was an unforgettable experience for you. It was a time of conflicting emotions. You spoke of the elation you felt for your achievement but also the worry and sadness for your mates who were released, some of whom fell out the game. This felt like football's first crime. The conflict between emotions and the loss of young lads whom you had grown up playing football with was tough for you but you felt as though you had to plough on and stay focused because suddenly you were on the road and expected to be a professional footballer. I wondered if this was when you first experienced a sense of fighting for survival in the football world.

You told me of all the hard work, dedication and sacrifice that you put in, to "be best the best that you could be" and to strive towards your aim of becoming a professional footballer. The football world felt powerful, demanding and conditional and so you worked incredibly hard to succeed and meet the expectations set by yourself and others. I was struck by the level of sacrifice that you have made and I felt sad when you told me about the losses you've had in pursuit of your goal.

I noticed that at the times you felt safe enough to be vulnerable with me and to show me how you really felt, I heard the voice, and felt the emotion, of a young lad who felt that he had to bottle up and dismiss normal human feelings in order to continue surviving in this "cut throat" football world. You told me how you feared that if you expressed your feelings you would be seen as weak and that others would be judging and rejecting of you. This left you feeling isolated, vulnerable and dispensable. To you it felt as if admitting to difficulties with your mental health would be a "straight ticket out of football" and this threat made feelings and failure, things to be forbidden. It makes sense that you hid this struggle behind the bravado, the brave face and the banter in order to survive. It sounds like it made it tough for

you to ask for help as you didn't feel others would understand. I felt sad when I thought of you being left stuck, trapped and alone not knowing where to go. I noticed the pull for me to try to rescue you and I wondered whether this was something you hoped for at these difficult times.

You told me that you experienced a lot of early success as a footballer and that you felt as though you were "riding on the crest of a wave". You didn't feel prepared for the highs and lows of becoming a pro. This "emotional rollercoaster" where everything felt like it was "buzzing", special and successful until it flipped to the intolerable emotions brought on by performance, selection, injury and rejection. It sounded as though things became very split for you; either you win or you lose, you're great or you're not wanted, you're in the team or you're out, you're fit or you're "crooked". This sounds really tough. I wondered whether you lost touch with the middle ground where you could hold and accept both the good and the bad. It sounded like one of the ways you tried to cope was to recreate the experience of the "highs" and to escape from the "lows". You shared with me stories of alcohol, drugs, gambling, crime, and women as ways you got that sense of escapism. A way that felt safe to cope. It sounded like some of the hardest moments of all came for you when you "fell out of love with the game" and that escapism you'd felt from football as a child had changed.

You shared with me the journey through injury and pain which were some of the darkest days. I wondered if at times of injury you felt most exposed to the scary feelings of vulnerability and powerlessness. You spoke of the fear as to whether you would play again, the race against time to prove your worth for the next contract, as well as the pain, trauma and torture of the road to recovery. It seemed tough to feel isolated outside of the group and to miss the camaraderie and support of the lads. It sounded like you felt that the coaching staff saw you as "useless", "a dead duck" and "weak". Injuries were a stark reminder of the commoditised and consuming football world which placed you in a position of feeling exploited and dispensable. The message seemed clear to you "Football's a man's world. I've got to be fit and tough to survive".

I was interested in how your relationship with football fluctuated, particularly the process of football 'becoming' a job. This seemed different to the fantasy you had built as a child and the freedom and love you'd felt for football. As you spoke of the pressures of securing contracts, providing for the family, staying fit and maintaining performance I wondered if there was a sense that this special relationship as a footballer couldn't last forever. It sounded like the transition out of football into the real world left you feeling lost. The role that you had played and had strived towards didn't feel compatible and you described the journey of reinventing yourself to once again, try to fit in with the demands and expectations of others. When you spoke of how difficult it was for other people to understand, I wondered how isolated and helpless you might have been feeling as I tried to get a sense of what it meant for you. It left me wondering how hard it might be to ask for help now, having come from a world where asking for help felt so incongruent to survival and success.

During the research interview I wondered how some of your experiences and ways of coping might have arisen with me. I imagine it might have been daunting to meet with me and to not know what to expect or whether you could trust me. I wondered if you were worried that I would be critical or judging of your experiences or career. There were times where the bravado and the actor appeared between us and that's ok, but what really struck me was the bravery you showed to send the actor backstage and invite me closer to your experiences and feelings. It was at these times I felt most connected with you and your experience and I hope that these moments helped you to feel less isolated too.

When you spoke about some of your experiences, I was struck with how powerful and in the present some of these emotions still are for you. There seemed to be times when you were able to be more connected with these and times where you distanced yourself from them, perhaps to try to protect yourself and lock away some of the feelings of pain, sadness and anger that are still raw for you. We all carry with us the feelings that we lock away, and this can be a heavy weight to carry. I hope that as we looked at some of these feelings together you were able to lighten the load.

The interview left me wondering what contributed to your decision to take part and to take a risk with me and step out of the trap of hiding forbidden feelings. It seemed important to you for the next generation of young professional footballers to be nurtured and cared for, perhaps in a way that you felt you were not. I hope that this research, through sharing the experiences that we have tried to make sense of together, will support you and other footballers to feel heard.

Best wishes,

Sue



## **Appendix Q: Reformulation Letter to the Researcher**

Dear Researcher Sue,

This letter is my attempt to understand some of your experiences and how they interacted with the processes of this research. I found it difficult to step back and write a letter that could be a mirror to you and it was helpful to have someone to angle the mirror with me when I got stuck to reveal parts that I couldn't see. Through this letter I hope to help you to gain further insight into the interactions between some of the reciprocal roles that rest within yourself and the worlds of football and clinical psychology in order to enhance the interpretative phenomenological analysis of your research.

You started playing football when you were 5 years old and the enthusiasm you have for football is shared with your family and friends. There have been times of success; winning trophies with your teams and playing for England as well as times of despair, losing crucial games or making mistakes leading to a goal. It sounded like football is one of the things that shaped you as a person and the values you've gained from this have helped with your aim to becoming a clinical psychologist.

When you first shared your research idea I was struck by the passion and enthusiasm you had to give a voice to the difficulties experienced by footballers; a group that you felt was neglected and overlooked. When possible barriers to recruitment and the complications of taking on such a task were discussed I wondered if it felt like your research idea wasn't good enough and that letting go of this idea would feel like you had failed. It was noticeable that this threat of failure seemed to awaken the familiar striving position. After all you were going to fix the FA. You worked even harder to move away from the feared place of failure and on the surface this drove you through the research but it also meant that it was harder to pause, notice the resistance and consider options or adaptations in a more healthy and balanced way.

To you it seemed like undertaking this research was a chance to do something meaningful. You were drawn to a sample that is to an extent idolised and held in a specially admired position. I wondered whether by conducting this research you unconsciously hoped to be held in such a position. When others told you how powerful and worthy they thought the research was you noticed that it made you feel special. Unfortunately this position is unsustainable and there were times, such as when you were analysing the data, where you felt pulled into the feared place of worthlessness. In response to this you tried to move away by striving even more or by disconnecting from the research. This process within the research seemed to parallel some of the feelings you experienced through clinical training, as well as the dichotomy of the 'highs' and 'lows' of the football world, whereby you could move quickly between the buzz and excitement of the research, to feelings of exhaustion and despair.

In contrast to the specially admired position you noticed that at times you felt as if other people were dismissing the importance of the research and the difficulties

faced by footballers. This left you feeling angry, dismissed and rejected. I wondered whether you had become caught in an enactment of the reciprocal roles that seemed active in the football world. Whereby footballer's emotional difficulties can be considered as forbidden, unjustified or self inflicted leading them to feel judged, dismissed or rejected.

When conducting the interviews you noticed some of the powerful pulls in the room. You shared that when a footballer described their sense of belief that 'they knew they could make it', you noticed a passing thought of criticism of their career. Your knowledge of your own reciprocal roles helped you to recognise that this was not normally you and this reflection allowed you to be aware of how particularly self-critical this participant was. This invitation was a pull to a position of judging or criticising their achievements but you were able to step away from this without enacting this role in the interview. As this position feels uncomfortable for you, I wondered whether you might have sought to move away from this experience perhaps before the footballer had fully shared what he had intended. However when I reviewed the audio I noticed that you allowed the participant space to continue to direct the interview.

After an interview where you tried to contain the raw grief and murderous rage of one participant recounting his experience you felt the need to debrief and seek support from your research team. Although you could have met with the team immediately after the interview you described feeling as if it wasn't warranted and an expectation that you should be able to cope with the feelings that had arisen. I wondered whether you got caught up in a procedure where you felt that either you express your feelings and fear a judgement that you can't cope or you don't express your feelings but they are left unprocessed and unheard, leaving you feeling overwhelmed and alone. It is understandable that you got pulled into this problem procedure given the parallels between some of the processes in the football world expressed by the participant and the self-expectations in the world of a trainee clinical psychologist. This portrayal of coping did not make room for a shared closeness with the pain and perhaps paralleled the 'bravado' or the 'actor' in the football world. Afterwards you noticed the need to step out of this pattern and having experienced the research team as supportive and containing you felt safe to approach them and work through the experience together, perhaps an opportunity that is not always available to footballers.

During the interviews you were able to identify how the footballers' positions of feeling powerless and vulnerable activated your own reciprocal roles and the temptation to rescue them. This is a familiar position for you and one that you have become aware of during clinical training. I think that this awareness enabled you to retain your stance as a researcher and sit with their vulnerabilities rather than try to alleviate these. I wonder whether the way the footballers expressed their experiences also elicited the urge to re-enact this role. Perhaps at times when they felt powerless and vulnerable they also longed for a rescuer.

In the midst of the research, as you sat in the crowd watching a football match you couldn't ignore some of the reciprocal roles in action between the footballer and the fans. In that moment, when you were so in touch with their vulnerability, your view

of football had changed. You felt out of love with football. It was no longer special and you had been pulled into just seeing the 'dark side' of the game. I wondered if this paralleled the dichotomy and splitting processes communicated by the participants' experiences of the football world. As you later stepped back it seemed to make you aware of just how powerful these positions were. It also sounds like you were able to reconnect and hold football as a whole.

I was struck by the impact the interviews had on you and how visceral the feelings were when you shared how it felt to listening to a raw and unprocessed emotional journey. At times you felt sick as you connected with their experiences, whilst at others times intrusive thoughts and images about getting injured invaded you. I wonder if your reaction reflected the empathetic identification you had with their experiences as well touched upon your own embodied memories that overlapped with the themes expressed. It was evident that your commitment and openness to sit with this experience enabled the footballer to step out of their unhelpful patterns and to experiencing 'surviving' this pain. It left me wondering whether this experience was another step for you too and added to the shift occurring within as you continue to become more accepting and open with yourself through clinical training. This seems so different to my picture of you when you first started this journey. Perhaps this change is epitomised by your invitation to move to a vulnerable position through this reflective letter.

I wondered how some of the reciprocal roles may have arisen during the process of analysing the interviews. You noticed how the drive to feel special and admired through the research and to fight against the fear of feeling rejected or dismissed tempted you to use language in a way that was powerful and might not have reflected the participants' experiences. An awareness of these processes enabled you to reflect upon the language used to describe the themes and to be attentive to staying true to their experience. You also observed how some of the emotional experiences left you feeling overwhelmed at times and that an avoidance of these feelings can be an unhelpful pattern you get pulled into. It sounded like this awareness helped you to identify when you were at-risk of minimising an experience in order to describe it in a way that matched the intensity expressed by the footballer.

I hope that through this letter you have been able to reflect upon the dynamic processes arising throughout the research in order to give a truer voice to the footballers' experiences.

Warm regards,

Sue in the integrated roles of the Self, Clinician and Researcher