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Tackle Your Feelings: Experience of Help-Seeking for Mental Wellbeing Concerns in
Professional Rugby Union Players

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26

Abstract

27 Limited research into professional rugby union players' experiences of seeking
28 formal support for their mental health exists, despite comparable rates of mental health
29 issues amongst elite rugby players with the general population. This qualitative study
30 explored professional players' actual experiences of accessing Rugby Players
31 Ireland's mental wellbeing service, via separate focus group discussions with
32 professional players (n = 5) and player development managers (PDMs, n = 4) who
33 refer players into the service. An inductive reflexive thematic analysis identified three
34 themes detailing players' (1) *journey to disclosure* of their mental health difficulties, (2)
35 their *expectations and engagement with the wellbeing service*, and (3) participants'
36 *reflections on mental health experiences in a high-performance environment*.
37 Embedding mental health as a key component of player development in high-
38 performance environments, improving mental health literacy, normalising mental
39 health experiences and encouraging help-seeking would help promote player
40 wellbeing and support holistic development alongside sporting performance.

41

Introduction

42 Elite athletes are as likely as the general population to experience mental health
43 difficulties (Gorczyński et al., 2017; Woods et al., 2022) but are less likely to seek help
44 (Gulliver et al., 2012; Ojio et al., 2021). Peak competitive years in elite sport tend to
45 coincide with the peak age for risk of onset for a range of mental health difficulties
46 (Hughes & Leavey, 2012). Elite athletes may be exposed to additional unique
47 pressures on their mental health and psychological wellbeing which are not
48 encountered in the general population, such as potential career termination due to
49 injury (Kuettel & Larson, 2020). Whilst promoting athlete mental health may be
50 important for sporting performance, mental health is a valuable resource for athletes

51 outside of competition and across the lifespan. Improving mental health allows for the
52 development of holistic and balanced athletic identities (Marsters & Tiatia-Seath,
53 2019) and can aid the successful management of difficult career transitions including
54 retirement (Henriksen et al., 2019).

55 A particular challenge associated with understanding the experience of mental
56 health issues amongst elite athletes is that good mental health is not necessarily a
57 prerequisite for elite performance, although improved mental health may promote
58 longer term performance (Moesch et al., 2018). Accordingly, the performative nature
59 of mental health in elite sport may mean athletes only recognise potential issues, and
60 consider seeking help, when there is a notable impact on their performance (Coyle et
61 al., 2017). Whilst research aiming to understand the mental health of elite athletes is
62 receiving increased attention (Larsen et al., 2021), there is a limited understanding of
63 the experiences of seeking help for mental health-related difficulties amongst
64 professional rugby union players, particularly in Ireland, the focus of the present study.

65 There may be several reasons why help-seeking amongst elite athletes is low.
66 Common barriers to mental health-related help-seeking identified amongst elite
67 athletes across sports include perceptions of negative consequences associated with
68 seeking help, lack of time, negative past experiences, unsupportive organisational
69 environments, psychological stress, fear, pride, and poor mental health literacy (e.g.,
70 Coyle et al., 2017; Kola-Palmer et al., 2020). Other barriers associated with mental
71 health help-seeking in elite athletes include being male (Watson, 2005), perceived
72 stigma (Bird et al., 2018), and perceived attitudes of other athletes towards help-
73 seeking and cultural norms relating to masculinity and self-reliance (King et al., 2022).

74 Enabling factors that influence elite athletes to seek support for mental health-
75 related concerns are much less researched. Many factors are involved in formal help-

76 seeking, including recognition there is a problem, and identifying the problem requires
77 professional support, openness to seeking support, access to services, choice of
78 services and cultural norms (Rickwood, 2020). Encouragement from others, previous
79 positive experiences, a supportive environment, and positive attitudes of their coach
80 were facilitators in the intention to seek support in young elite Olympic Australian
81 athletes (Gulliver et al., 2012). A recent study of professional male ice-hockey players
82 found if help-seeking was viewed to benefit the team performance, whilst serving an
83 individual's needs, help-seeking was facilitated (Crawford et al., 2022). Informal
84 sources of support such as family and partners may be valuable to elite rugby players
85 (Marsters & Tiatia-Seath, 2019); however, actual help-seeking amongst elite rugby
86 union player in relation to formal sources of support requires further research.

87 Several studies have investigated the mental health experiences of
88 professional elite rugby union players, ranging from experiences of depression and
89 anxiety to suicidal ideation (e.g., Ojio et al., 2021). There is evidence to indicate that
90 levels of depressive and anxiety symptoms can be elevated amongst current
91 professional rugby league players, with some higher rates compared to the general
92 population (Nicholls et al., 2020). Amongst a large sample of current professional
93 rugby players (across all codes), common mental health difficulties reported over a
94 12-month prospective study including psychological distress and eating disorders
95 (11%), sleep disturbances (12%), problematic alcohol use (22%), and symptoms of
96 anxiety/depression (28%) (Gouttebarga et al., 2018).

97 Mental health literacy is defined as the “knowledge and beliefs about mental
98 disorders which aid their recognition, management or prevention” (Jorm et al., 1997,
99 p. 182). Previous work with professional rugby league players reported increased
100 mental health literacy and higher perceived stress were associated with higher odd

101 ratios for seeking help from a UK athlete mental health charity (Kola-Palmer et al.,
102 2020). Higher stress and lower mental health literacy were associated with poorer
103 current mental health (Kola-Palmer et al., 2019). A content analysis of qualitative
104 responses from Kola-Palmer et al.'s 2020 study identified perceived stigma (including
105 embarrassment, pride, shame) and low mental health literacy (e.g., not knowing where
106 to seek help) were the most frequently mentioned barriers to help-seeking. Rugby
107 players may require additional approaches other than a knowledge-based educational
108 approach to encourage them to seek help. A recent study of 233 Japan Rugby top
109 league male rugby union players found while greater mental health knowledge was
110 associated with less stigma to others with mental health difficulties, players tended not
111 to seek help for themselves (Ojio et al., 2021). The nature of rugby as a team sport
112 could positively and negatively influence their help-seeking behaviours, given the
113 opportunities for social support and team bonding, alongside perceived pressures to
114 perform, cultural norms, and competition for starting places (Kola-Palmer et al., 2020).

115 Given the relative lack of qualitative research with professional rugby union
116 players, particularly the actual experiences of seeking formal help for mental health-
117 related experiences, this study explored a sample of professional Irish rugby union
118 players' experiences of accessing mental health support. A novelty of this study is its
119 focus on understanding the experiences of professional rugby players who accessed
120 formal help for mental wellbeing issues, which will help to improve pathways to care
121 for other players (Seidler et al., 2017).

122 Method

123 Context

124 The development and implementation of a mental wellbeing service for rugby
125 players in Ireland is an initiative of Rugby Players Ireland (RPI), the collective body

126 representing elite rugby union players. Mental wellbeing is a pillar of RPI's Player
127 Development Programme which aims to promote greater life balance and prepare for
128 a positive transition post-retirement. Current and former professional players can
129 access support through a local Player Development Manager (PDM), or by emailing
130 or phoning a dedicated confidential line. Access through PDMs is currently the most
131 chosen route. Players are then referred for a screening (triage) with a clinical
132 psychologist who determines the optimal support strategy and referral pathway. There
133 is no clinical threshold for referral or support and players can access the service for a
134 range of issues including, but not limited to, depression, anxiety, addiction,
135 bereavement, exposure to trauma, relationship issues and stress (see Rice et al.,
136 (2020) for a similar service structure). The mental wellbeing service was developed to
137 cater for a predicted increase in players seeking support due to a mental health
138 awareness raising and anti-stigma campaign, i.e., Tackle your Feelings (TYF;
139 <https://www.tackleyourfeelings.com>). TYF is a public-facing campaign which
140 encourages and supports individuals to look after their mental health. The campaign
141 features professional rugby players sharing stories of their mental health challenges.

142 **Design**

143 Focus groups were chosen to explore the experiences of professional rugby
144 players who accessed support for their mental wellbeing. PDMs were also sampled in
145 the study given their key roles as promoters of help-seeking and gatekeepers for the
146 wellbeing service. Focus groups comprising of individuals with similar experiences can
147 lead to richer data due to group interaction which can stimulate spontaneous ideas
148 and personal disclosures that may go unnoticed in in-depth individual interviews
149 (Roller & Lavrakas, 2015). Focus groups can also enhance discussion of personal
150 issues by providing supportive environments which is integral when discussing

151 sensitive topics (Roller & Lavrakas, 2015), and this approach has been adopted when
152 exploring mental health issues in males (Rochlen & Hoyer, 2005) and exploring help-
153 seeking in young elite athletes (Gulliver et al., 2012). The first author moderated the
154 focus group discussions. She is a PDM employed by RPI and works within one of the
155 high-performance rugby union squads. Ethical approval was granted by a Third-Level
156 Ethics Institutional Review Board.

157 **Participants**

158 All 44 professional players who had engaged with the RPI's mental wellbeing
159 services were invited to participate in the current study. The inclusion criteria were
160 players needed to be senior professional rugby union players, who were over the age
161 of 18 years, and had engaged in RPI's mental wellbeing service in the preceding two
162 years (January 2019 – December 2020). For PDMs, they needed to be employed by
163 RPI during the same period. A sample of five players ($n = 5$ male; $M_{age} = 26.2$ years,
164 $SD = 2.4$; time spent in a professional rugby environment (including at Academy level)
165 $M_{year} = 8$, $SD = 2.6$; post academy professional contract $M_{years} = 5.6$, $SD = 2.4$
166 years) and four PDMs ($n = 2$ male; $n = 2$ female; $M_{age} = 37$ years, $SD = 7.5$) consented
167 to taking part in the study, representing over 10% of players who had accessed the
168 service and all the PDMs working at RPI. Ethnicity and other personally identifiable
169 characteristics are not reported to maintain confidentiality due to the high-profile nature
170 of the participants.

171 **Materials**

172 A semi-structured schedule was employed to guide the focus group discussions
173 and to allow participants flexibility and direction over the discussions. Interview guides
174 developed by the research team, were informed by existing research, and focused on
175 self-reliance, confidentiality, stigma, enablers to help-seeking, the help-seeking

176 process, perceptions of professional help and mental health-related experiences,
177 (e.g., Rickwood, 2020). The role of professional sporting environments and barriers to
178 help-seeking were also discussed (Kuettel & Larson, 2020). Players were asked about
179 previous experiences of help-seeking and PDMs were asked about conversations they
180 have with players about accessing support.

181 **Procedure**

182 Participants in both focus groups were contacted by the mental wellbeing
183 service manager at RPI via email with an invitation to participate. Potential volunteer
184 participants were sent an electronic link with all the study information. Once
185 consented, a date and time for the online focus group was set, convenient for all
186 participants. Both focus groups were conducted on-line and were audio and visual
187 recorded, using Zoom Video Communications (www.zoom.us). Participants were
188 aware of this prior to giving consent and at the beginning of the video call. The focus
189 groups were held two weeks apart, with the PDM focus group occurring first. The
190 discussions lasted 64 minutes (PDMs) and 65 minutes (players). All participants were
191 verbally debriefed at the end of the focus group.

192 **Analytical Strategy**

193 This study employed reflexive thematic analysis (Braun & Clarke, 2019) guided
194 by critical realism. This critical realist approach meant that a shared reality in terms of
195 how the players accessed support from the service was assumed, whilst considering
196 that this reality is mediated by the individual players' subjective experiences, their
197 personal sense-making, and the social context of professional rugby (i.e., a
198 combination of ontological realism and epistemological relativism; Maxwell, 2012).
199 The focus groups discussions were transcribed verbatim with pseudonyms assigned
200 to each participant. Data from both focus groups was analysed separately; initially,

201 transcripts were read repeatedly to immerse the researcher in the data. Data was then
202 analysed inductively, and the content examined, generating numerous initial codes.
203 Themes were developed from the initial coding of the players' focus group data and
204 combined to create broader themes using thematic mapping. The PDM focus group
205 codes were thematically mapped onto the themes generated from the players' focus
206 group, with additional themes identified that did not fit with players' themes. Final
207 theme definitions were composed to capture the essence of each theme and written
208 up into the present report.

209 To improve trustworthiness of the analysis, several approaches were used to
210 maintain a focus on the data from the discussions. Firstly, players' experiences of help-
211 seeking were triangulated with views of PDMs, who act as gatekeepers to the mental
212 wellbeing service. Secondly, participants were sent a copy of the broad themes for
213 member reflections. One player responded to include greater detail on his views of
214 why he delayed seeking support. Thirdly, the first author kept a diary of their reflections
215 on the data collection and analysis process due to their current role within the RPI (see
216 reflexivity for more detail). Finally, initial analyst triangulation was achieved through
217 regular meetings between the first and second authors to discuss the findings, allowing
218 for researcher interpretations to develop and for common themes to be established.
219 During the write up, the third author acted as an independent analyst who provided a
220 sense check of themes and narrative of the analysis (see Supplementary File 1 for the
221 COREQ checklist for the present study).

222 **Reflexivity**

223 The first author is a PDM with over 20 years' experience working in high-
224 performance sport, including working for Rugby Players Ireland. In their role they have

225 awareness and understanding of the mental wellbeing service and the infrastructure
226 of RPI and therefore is familiar to all participants which allowed for a more
227 conversational flow to the focus groups. The second author acted as a supervisor on
228 the project and is an experienced practitioner and researcher in sport psychology. The
229 third author is an experienced researcher in mental health and health psychology.

230 **Results**

231 Three main themes were identified during the reflexive thematic analysis.
232 These themes describe the experience of formal help-seeking for mental health-
233 related concerns in professional rugby union players who had accessed Rugby
234 Players Ireland's wellbeing service. Players, and the Player Development Managers
235 (PDMs), discussed their *journey to disclosure, expectations and engagement with the*
236 *wellbeing service, and their later reflections on mental health experiences in a high-*
237 *performance environment.*

238 **Journey to Disclosure**

239 This theme focuses on players' journeys of recognising and disclosing having
240 difficulty with their mental health, something which was discussed in detail by all the
241 participants. The initial recognition of one's mental health difficulties was the first step
242 to players considering seeking help, particularly when they were not performing well
243 which seemed to trigger an initial reflection on their mental health.

244 *I feel like it was all kind of mixed up and that I wasn't performing well ... I wasn't*
245 *sure if it was because I wasn't playing well that then I was ... unhappy or was I*
246 *unhappy and then I wasn't playing well. (Conor)*

247 Players had difficulty disentangling their mental health and emotional wellbeing
248 from their performance in terms of understanding a potential cause-and-effect

249 relationship. This seemed to lead to some players attempting to work on their mental
250 health in a similar way to how they would approach the physical or technical aspects
251 of their rugby performance. This approach hindered many from accepting that there
252 may be an issue with their mental health, as Dan discusses:

253 *It definitely clouded what was best for me, I'd always bought into that persona*
254 *that I'm a rugby player...that I had massive effort on the pitch...I felt that*
255 *whatever mental troubles I was in that if I just kept plugging through them I*
256 *would be fine ... the reality is I actually ended up going to the psychologist far*
257 *later than I should have... the reason I didn't go when I really, really needed it*
258 *was ... I just didn't want to give up on that persona.*

259 Dan discussed how his self-perception or social identity as a “rugby player”
260 meant that he coped with his mental health issues by continuing his high physical effort
261 on the pitch, in the hope these difficulties would resolve themselves or dissipate. This
262 approach prevented Dan from recognising the extent of his mental health difficulties
263 and delayed any help-seeking action. Many players discussed their own personal
264 difficulty in recognising problems with their mental health. Myles described:

265 *Knowing yourself when you are actually in it, is the hard part... I think for me*
266 *realizing oh OK, now I'm in that bracket, that's what took me probably years to*
267 *understand ...and it probably got to the very extreme of it before I realized, oh*
268 *sh*t yeah ... I need help.*

269 The inability to recognise the extent of a problem sooner caused Myles to
270 experience escalated psychological distress before the realisation occurred. Players
271 outlined how an escalation of symptoms and increased psychological stress, facilitated
272 their disclosure. Henry revealed:

273 [The physiotherapist said] *definitely don't be scared to go get help. I went off*
274 *for a week, did my own thing ...I tried to go to training and I just was sitting in*
275 *the car and I couldn't go, it was at that point then that I knew ... I called [the*
276 *PDM] in the [club] car park ...I was in a bad enough state. So yeah, someone*
277 *planted the seed and then it just got bad enough that I had to sort it out.*

278 For many players, there appeared to be a 'point of no return' where their mental
279 health difficulties had to worsen to a point where they had to seek help. Although, there
280 still seemed to be a sense of self-reliance and that they could work through their own
281 difficulties, unless prompted by external party that they needed to seek more formal
282 help (e.g., Henry's extract above). A preference for self-reliance, in addition to some
283 poor mental health literacy and poor recognition of mental health difficulties, appeared
284 to be common barriers to help-seeking amongst these elite rugby players. Players also
285 spoke about disclosing mental health concerns to different club members including
286 team doctors, physiotherapists and PDMs. The availability of staff at clubs where
287 players could discuss mental health concerns was highlighted by Dan:

288 *I had a couple of issues ... I probably wasn't behaving appropriately ... losing*
289 *my temper a bit too much ... I had a couple of chats with [the PDM], and [she]*
290 *said that there's an option for me to meet with people outside the [club] ...I*
291 *kinda decided to do so on the back of that, because I knew there was something*
292 *not right with me really, mentally.*

293 In Dan's situation, the presence of a trusted staff member and a referral
294 pathway was key in his decision making to seek support from a person outside of the
295 club. This was echoed by one of the PDMs, "Jack", who outlined "*for me, it's the*
296 *relationship ...a player is not going to open up straight away ... but over time when*

307 *they understand you as an individual, they understand you can empathize with them*".
308 This extract highlights the importance of having support on the ground and building
309 these relationships over time which is key for players disclosing these issues. Players
300 and PDMs both discussed that trusted relationships to aid help-seeking also came
301 from more informal sources outside of the support staff. Mary, a PDM, noted "*I think*
302 *other players have been huge... and I found with my team that it's been probably the*
303 *biggest [facilitator]... it's kind of had a domino effect*".

304 Whilst outside of the club structure, players outlined family members and close
305 friends were sources of support, as Conor revealed; "*they were definitely the people*
306 *who helped me the most*". Dan mentioned sharing it with his sister, while Henry "*told*
307 *everyone, I told my family, my girlfriend, my closest friends*". When players did reveal
308 their help-seeking to family members, reactions were positive and supportive.

309 Players spoke about greater awareness of mental health in professional club
310 environments, and how the "Tackle your Feelings" campaign using current rugby
311 players as ambassadors aided this. Henry remarked "*it just personalises it a little bit*
312 *and you know other people have been there and done something similar*". This
313 emphasizes the importance of role modelling in normalising mental health experiences
314 amongst fellow players. All players agreed that ambassadors who took part in the
315 campaign and who played at their clubs seemed approachable and someone they felt
316 they could speak to. Owen observed "*other people being there, going through the*
317 *same things you're going through ... they can be a point of contact*".

318 **Expectations and Engagement with the Wellbeing Service**

319 This theme focuses specifically on players' expectations of formal sources of
320 support, past experiences seeking formal mental health support, and their

321 expectations and experiences of engaging with the service. All the sampled players
322 discussed how experiences of accessing other formal sources of support were a key
323 reason many players delayed their future engagement in wellbeing services.

324 *I had one experience... when I was in the Academy, and I didn't enjoy it at all I*
325 *felt he was like trying to bring up stuff that I didn't want to chat about and then*
326 *after that I was kind of quite adverse to ever going and seeking it, which is*
327 *probably why I was very slow to [go again]. (Dan)*

328 The first experience working with a psychologist or therapist was key to setting
329 future expectations. Like many players, discussing topics that Dan was not ready to
330 disclose, or wanted to discuss, negatively impacted his overall view of formal sources
331 of support. Myles revealed his first experience “*probably made me worse*” and when
332 he did return to see a different psychologist, he “*didn't utilise it fully...I wasn't*
333 *completely honest with the guy...I was hesitant, but once I got comfortable with it, it*
334 *was definitely helpful*”. Henry described his first reaction to the service as “*a lot of*
335 *hocus pocus*”, thinking it was not going to be helpful:

336 *Initially I didn't think it was gonna work... I think the more I stuck with it, the*
337 *more I began to buy into it myself, I got a huge benefit from it and now a year*
338 *down the road it's something I wish I'd paid more attention earlier. I remember*
339 *the first day ... ringing my mum saying, 'Jaysus I don't know'. I think the fact I*
340 *got booked in for six sessions ... in my head I was like, I'll do the six with [the*
341 *same practitioner] and about halfway through I was like this is brilliant.*

342 Henry's experience highlights the importance of a set block of sessions as part
343 of his support package, this appeared to aid the development of a relationship with the

344 counsellor, increased engagement with the support, and led to a positive outcome.

345 The players also spoke about service efficiency, as Dan illustrates:

346 *It took me long enough to get courage up to go talk to [the PDM], but then when*
347 *it happened it was 100%, it was quick, and it was easy. I thought it could have*
348 *been ...like a bullsh*t story that you had to go through after meeting [the PDM],*
349 *you might have to meet another few people... but it was actually, it's very*
350 *simple.*

351 It was important that there was an effective pathway to care for the players so
352 that when they do disclose, it is met with an efficient and simple process. This also
353 outlines the players preconceived notions of the steps taken for referral and how that
354 could contribute to the hesitancy to engage.

355 **Reflections on Mental Health Experiences in a High-Performance Environment**

356 This theme details the players' reflections on their experiences and changed
357 expectations of help-seeking before, during, and after they used the RPI wellbeing
358 service. Both the players and PDMs reflected on the need to embed mental health as
359 part of their elite rugby profession. Players discussed their changing views of seeking
360 support for their mental health:

361 *I'd like to think that you'd feel comfortable hopefully talking to someone in the*
362 *changing room, but you...you might not. If I was back last year, I don't know if*
363 *I would have felt comfortable talking to anyone. (Henry)*

364 When he was going through stressful periods, Henry also remarked about how
365 easy it was to “walk into a changing room and put on a brave face. No one would
366 really...be any the wiser for it. ...nobody might pick up on it”, but now feels:

367 *I'm very different today...as I was this time a year ago...if someone came up to*
368 *me and said Henry I'm struggling. Sure, I hadn't, I hadn't struggled with myself*
369 *before that, so I wouldn't... have had a breeze as to what to have said to him,*
370 *whereas now, I'd be very different.*

371 The final part of the extract outlines Henry's initial feelings of uncertainty and
372 lack of clarity on how to approach discussing mental health in an elite rugby
373 environment, and the views shared by other players. Specifically, perceptions of the
374 "changing room" and how most players tend to put on a "brave face" when they are
375 going through periods of heightened psychological distress. This highlights the need
376 to improve players' mental health literacy and confidence to speak out and support
377 their teammates who may be experiencing similar difficulties. This perceived shame
378 or embarrassment associated with seeking mental health-related support, which partly
379 seemed to be related to the changing room culture, meant that many of the players
380 chose to keep their use of the RPI service hidden from their teammates.

381 *I was kind of going [to see the psychologist] on like a Wednesday, which is the*
382 *day off...you know you'd be in the same coffee shops all the time...so like why*
383 *would I be going into town? ...I had to lie about what I was doing, ... I definitely*
384 *wasn't comfortable just being like, oh yeah, I was just in seeing someone so,*
385 *that was a bit of a challenge for me. (Conor)*

386 The effort and discomfort players felt when trying to create excuses to disguise
387 the act of seeing a psychologist highlight how accessing mental health support still
388 has stigma attached to it, and players are reluctant disclosing it to teammates. One
389 reason for this, could be, as Myles described:

390 *I'd fear this fella is going to ask me why I was going, when I didn't even really*
391 *know myself, so I wasn't gonna be able to explain it to him... that's probably*
392 *why you wouldn't want to speak to someone... because of the possible*
393 *discussion about it, more so than the stigma... I'd have had no problem saying*
394 *it to someone if they weren't gonna ask me what I was going for.*

395 For Myles, he had no problem disclosing he was seeing a psychologist but
396 revealing why he sought help was a source of potential discomfort. This emphasises
397 the importance of equipping players with the tools to both discuss mental health issues
398 and communicate compassionately with other players who are experiencing
399 difficulties. Following their own experiences of accessing RPI's wellbeing service, the
400 players discussed having a greater admiration for and appreciation of those players
401 who disclose a mental health difficulty, as Myles describes:

402 *I think some fellas ... might see people... as a weakness in them that they go*
403 *to get help, whereas I suppose having been through it, I'd say I have a certain*
404 *appreciation for playing against people and how tough they are...you lads*
405 *[other participants in the focus group] are pretty f**king tough... I think now*
406 *knowing the fact that ... you have gone to get help ... I would probably think*
407 *more of you, as opposed to less of you.*

408 This was echoed by Dan, who also revealed that taking part in the focus group
409 was a "pleasant" experience as he got to interact with "another four lads" who had
410 experienced something similar. This underscores the importance of peer networks in
411 an elite rugby player-focused mental health support service.

412 The players later discussed how having come through the RPI support service,
413 they now believe that mental health is something should be focused on at an earlier

414 age and stage of their career. Myles describes how if he “*had actually understood this*
415 *smaller side of it [mental health], when I was... in my early twenties, I probably would*
416 *have had a more enjoyable twenties*”. While Henry remarked:

417 *I wish I had a better understanding of how all this worked. I do think it should*
418 *be something that's incorporated into our lives, a lot earlier... 'cause I was really*
419 *under prepared for what I went through... in terms the Academy ... maybe there*
420 *can be a little bit more education around [mental health].*

421 An earlier focus on players’ mental health may help to not only normalise mental
422 health issues for players but prepare them for future stressors. Dan added that
423 introducing younger players to “*a session or two*” with a psychologist would be hugely
424 beneficial as the lessons learnt are not only needed for rugby, but “*forever really*”. This
425 was echoed by Patrick, a PDM, who remarked:

426 *Educate our younger guys, the Academy, to have this with them right through*
427 *their careers. You have less of a battle as a PDM down the road...it just*
428 *becomes part of it, like their nutrition...they can take it with them beyond rugby*
429 *into their next career as well.*

430 All players outlined two key approaches for normalising mental health in the
431 team environment. Conor proposed:

432 *If accessing support was more of a thing, I think people would just be like ‘oh*
433 *sure, I'd be interested in doing that’. There could be a bit more from the playing*
434 *group ... that it is not that big a deal to go see a counsellor.*

435 All participants discussed embedding mental health as a key component of a
436 high-performance environment, with formal sources of support as something for all

437 players to use at any time, not just when in difficulty. Supporting this, Myles felt that
438 mental health screening should occur at the same intensity of physical screening:

439 *It's not in your questionnaire to fill out every morning... Like who really cares*
440 *if you are off your food as opposed to actually struggling with something, like*
441 *if there's a second questionnaire you would fill out every morning, shouldn't*
442 *your emotional headspace be as important your physical headspace?*

443 Providing players with more regular mental and emotional wellbeing checks
444 would help them better understand their mental state, and detect changes in mood,
445 fatigue, stress, or other recognised triggers of mental health difficulties. The PDMs
446 also discussed that encouraging players' help-seeking for mental health-related may
447 promote help-seeking and skill acquisition in other areas (e.g., education). As Patrick,
448 a PDM revealed:

449 *When we build up that trust ... and they've gone and got help...one of the tools*
450 *to deal with their... mental wellbeing is about being occupied outside of the*
451 *game... to maybe engage in off-field development which has a knock-on effect*
452 *on their wellbeing... in my own experience I would have had that.*

453 This aligns with the promotion of holistic player development environments that
454 view mental health as central to a culture of excellence and has long term benefits for
455 life beyond sport. The players did, however, debate who should oversee this process.
456 Some felt that mental health should be *"incorporated, in terms of the content of a week*
457 *for Academy players"*, however Henry believed it should be *"outsourced to*
458 *psychologists"*, while Myles argued that *"if you outsource it...how would it have an*
459 *impact on your day then...how could an [outsourced psychologist] say to a head*
460 *coach, come here...[Owen] can't train today cause he is not feeling great"*.

461 The PDMs offered insights into why there were disagreements amongst players
462 regarding who oversees and takes responsibility for player mental health. For
463 example, Jack (a PDM), described how mental health can be pushed down the list of
464 priorities for players as *“they have a game weekly, there’s weekly highs and lows, and
465 ... [mental health] can get side-lined...it’s down the list when it comes to importance”*.
466 Patrick agreed, stating *“the problem for me is, that staff change, or circumstances
467 change, or the pressure comes on in the game...and this stuff can be pushed right to
468 the back”*. Mary also agreed but noted that mental health is *“something you can’t
469 ignore now, so environments have become safer for people that might be struggling”*.
470 In summary, both players and PDMs talked about the importance of embedding and
471 making mental health a key focus of players’ sporting and personal development.

472 Discussion

473 Elite rugby players may experience similar levels of mental health related
474 distress and difficulties as found in the wider general population, however there is a
475 limited understanding of players’ experiences of accessing formal support for their
476 mental health in the context of a high-performance sporting environment. This study
477 explored the help-seeking experiences of professional rugby players who had
478 accessed Rugby Players Ireland’s wellbeing service, and PDMs who refer players to
479 the service. Three key themes were developed during the reflexive thematic analysis
480 of focus group discussions held with players and PDMs, which detailed (1) players’
481 *journey to disclosure* of their mental health difficulties, (2) the players’ *expectations
482 and engagement with the wellbeing service*, and (3) all participants’ *reflections on
483 mental health experiences in a high-performance environment*. There was clear
484 hesitancy amongst elite players to acknowledge their own mental health difficulties
485 because of various concerns (e.g., reactions from other players and coaches, stigma,

486 competitive pressures), but also evidence of poor mental health literacy and
487 tendencies towards self-reliance and a focus on physical over mental health.

488 In terms of players' *journeys to disclosure*, the professional players in our study
489 tended to only acknowledge their mental health difficulties when their rugby
490 performance was affected. There was often a difficulty in terms of players'
491 understanding of whether their mental health issues arose prior to, or during, periods
492 of poor sporting performance. Players tended to focus on their physical training to work
493 through their mental health difficulties and only sought more formal support when their
494 mental health became unmanageable and/or when others openly encouraged them to
495 seek support (e.g., club support staff, physiotherapists). These findings are similar to
496 those reported in previous studies with elite athletes, particularly athletes' preference
497 for self-reliance, difficulty in recognising initial mental health difficulties, and the (late)
498 recognition of issues when broader performance is impacted (e.g., Coyle et al., 2017;
499 Kola-Palmer et al., 2020).

500 The second theme, *expectations and engagement with the wellbeing service*,
501 describes how players' past, mostly negative, experiences of formal mental health
502 help-seeking deterred them from accessing other forms of support and delayed future
503 help-seeking attempts. A key discussion in this theme was when players do disclose
504 difficulties with their mental health, and eventually contact or access support services,
505 support needs to be readily available and care pathways tailored and efficient in terms
506 of delivery. Addressing misconceptions of what accessing support services involve
507 may aid help-seeking in professional rugby players.

508 The final theme, *reflections on mental health experiences in a high-*
509 *performance environment*, saw both PDMs and players discuss the importance of

510 embedding mental health support as a key part of a high-performance professional
511 sporting environment. Players discussed how seeking specific mental health support
512 was associated with embarrassment and a potential fear of teammates' social
513 disapproval, to the extent that players would disguise or lie about occasions where
514 they accessed formal support. Acknowledging that they were seeking mental health
515 support was a potential source of discomfort, but the act of consulting a psychologist
516 more generally was not discussed in a comparable manner (e.g., when speaking to a
517 sports psychologist to improve performance more broadly). Whilst there appeared to
518 be a consensus about the need to make players' mental health a focus within
519 professional rugby environments, in a similar manner to physical performance, there
520 was disagreement about who would have responsibility for overseeing mental health
521 services (e.g., the player themselves, the team, coaches or medical staff, PDMs, or
522 more external sources like a referral network of psychologists).

523 **Clinical Implications**

524 The results of the present study offer unique perspectives into experiences of
525 professional rugby union players seeking formal support for their mental health. Thus,
526 the findings may help guide mental health practitioners working with professional
527 rugby union players or in professional team sport environments. It was evident across
528 the themes and discussions with players and PDMs that there is a need to improve
529 players' mental health literacy, not just to improve knowledge of the spectrum of
530 mental health experiences but to promote awareness of available support resources
531 for players, and to staff supporting players. Embedding mental health literacy training
532 as part of early intervention efforts for elite athletes may promote knowledge of key
533 mental health experiences, reduce mental health-related stigma, and promote help-
534 seeking confidence and referrals (Sebbens et al., 2016). Mental health literacy

535 programmes for athletes tend to cover: (i) general and player-specific risk factors for
536 poor mental health; (ii) key signs or symptoms of poor mental health; (iii) how and from
537 whom to seek help; and (iv) basic techniques to promote mental health (Purcell et al.,
538 2019). Our findings suggest such programmes should also include: (i) the
539 normalisation of mental health-related conversations in high-performance sport
540 environments (how to talk to others about what you might be experiencing, and how
541 to actively listen and support others who disclose to you); and (ii) what to expect from
542 psychological support. Improving mental health literacy is important in elite
543 performance settings, not just amongst players but other club personnel (Breslin et al.,
544 2018; Gulliver et al., 2012; Purcell et al., 2019), as is having trusted and established
545 relationships for facilitating disclosure, providing clear referral pathways, and
546 signposting to appropriate services (Rickwood, 2020).

547 An unexplored approach to facilitating help-seeking in elite sport may be to
548 focus on the role of teammates as informal sources of support. Involving players in
549 such interventions may help to normalise the experience of mental ill-health in sport,
550 promote help-seeking referrals, and challenge perceived team cultural/social norms
551 that may restrict help-seeking behaviours and disclosures whilst also worsening
552 outcomes (Crawford et al., 2022). Players' genuine concern for teammates could be
553 used to co-produce campaigns and interventions to improve overall mental health
554 support in professional rugby environments. Using player ambassadors has a positive
555 effect on improving health related behaviours for males (Mind, 2014), and as males
556 generally seek support less than females (Watson, 2005), this could have many
557 positive benefits by improving offers of support, promoting early detection, and
558 reducing stigma. Players acting as ambassadors for such campaigns should also be
559 equipped with the skills to support and effectively signpost their peers.

560 Additional clinical implications arising from our findings include the need to
561 focus mental health support earlier in players' professional careers, particularly at
562 Academy level. Purcell et al. (2019) propose an early intervention framework, whose
563 preventative foundational components includes individual athlete-focused
564 development. RPI's Player Development Programme is an example of such a
565 programme where PDMs are central to players accessing RPI's wellbeing service as
566 part of their role as promoters and gatekeepers to the service. Mental health should
567 be considered as part of players' holistic development, equipping them with skills for
568 life beyond and after rugby, and in encouraging development in other life domains
569 (e.g., education; Schinke et al., 2018). This aligns with recommendations by Henriksen
570 et al. (2019) and Larsen et al. (2021) who propose the employment and embedding of
571 mental health practitioners within the performance environment. A recent evidence-
572 informed framework promoting mental wellbeing in elite sporting environments has
573 suggested such mental health practitioners would help promote a mentally healthy
574 environment, not just for players, but all stakeholders from coaches to support staff
575 and administrators (Purcell et al., 2022). Thus, mental health, wellbeing, and holistic
576 development, are embedded in the performance system as opposed to being
577 independent and accessed only when there is a problem.

578 Finally, whilst there is no "one size fits all" approach to organising sport-focused
579 mental health support services across countries (Larsen et al., 2021), it was evident
580 in the current study that players have differing opinions on how such services should
581 be organised and who should take responsibility for player wellbeing. Whilst mental
582 health support is often viewed as a natural extension of sport psychology, in many
583 countries sports psychology training does not include clinical training (Roberts et al.,
584 2016). Providing a service that allows players their confidentiality and autonomy but

585 at the same time meets the need of the sport, requires strong mental health leadership
586 that transcends athletic performance (Larsen et al., 2021).

587 **Strengths and Limitations**

588 There are several strengths and limitations to the current study. While the use
589 of focus groups provided a useful method to explore shared experiences, it may have
590 limited how much the participants were willing to disclose (Sparkes & Smith, 2014).
591 The present study sampled current rugby union professional players, an under-
592 represented group in the research literature, however, the experiences of players in
593 other rugby codes (e.g., league, sevens), other cultures and races (e.g., Pacific Island
594 nations, Asian players) or in the women's game may be qualitatively different.
595 Additionally, the players in the current study were selected based on their referral
596 through RPI's mental wellbeing service. Players who seek help from other sources
597 (informal and formal, e.g., family and community-based services) may experience
598 different pressures and barriers to seeking mental health-related help. A major
599 strength of this study was the recruitment of professional rugby players whose
600 perceptions of help-seeking were grounded in *actual* experiences. All players had
601 sought support within 18 months of taking part in the research and were representative
602 of all four professional clubs in Ireland. This research also heard the views of PDMs,
603 who play an early intervention and gatekeeping role.

604 **Conclusion**

605 Whilst rugby players are as likely to experience a range of mental health-related
606 issues as the rest of the population, there is a tendency for elite male rugby players to
607 delay or not seek formal help with their mental health. The current qualitative study
608 explored the experiences of mental health-related help-seeking amongst a sample of

609 male professional rugby union players in Ireland who had accessed Rugby Players
610 Ireland's wellbeing support service, and the PDMs who refer players into the service.
611 Professional rugby players face several challenges when seeking formal mental health
612 support, including difficulties in acknowledging and recognising mental health
613 difficulties, perceptions that teammates and club officials would have negative
614 reactions to their disclosure of difficulties, and previous negative experiences of
615 seeking support. Our findings indicate a clear need to improve mental health literacy
616 in professional rugby, normalise the experience of mental health issues, destigmatise
617 mental health help-seeking amongst rugby players, and embed mental health as a key
618 component of player development in elite performance environments and life beyond
619 rugby. Campaigns such as Rugby Players Ireland's Tackle Your Feelings have the
620 potential to normalise mental health experiences in professional rugby, but there is a
621 need to better equip players with the skills and knowledge to identify when they
622 themselves and their teammates are experiencing difficulties with their mental health.

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751 **Supplementary File 1.** Consolidated criteria for reporting qualitative studies (COREQ) checklist

752

| No | Item | Guide questions/description | Details |
|--|--|--|---|
| Domain 1: Research team and reflexivity | | | |
| <i>Personal Characteristics</i> | | | |
| 1. | Interviewer/facilitator | Which author/s conducted the interview or focus group? | The first author. |
| 2. | Credentials | What were the researcher's credentials? <i>E.g. PhD, MD</i> | PhD. |
| 3. | Occupation | What was their occupation at the time of the study? | Player Development Manager. |
| 4. | Gender | Was the researcher male or female? | Female. |
| 5. | Experience and training | What experience or training did the researcher have? | Over 20 years' experience working in high-performance sport |
| <i>Relationship with participants</i> | | | |
| 6. | Relationship established | Was a relationship established prior to study commencement? | Yes, the first author is employed by RPI and was known to the participants. |
| 7. | Participant knowledge of the interviewer | What did the participants know about the researcher? <i>e.g. personal goals, reasons for doing the research</i> | Participants knew researcher was a PDM and the research was being conducted by Rugby Players Ireland. |
| 8. | Interviewer characteristics | What characteristics were reported about the interviewer/facilitator? <i>e.g. Bias, assumptions, reasons and interests in the research topic</i> | Professional background of interviewer, reason for the research topic and background of the facilitator was made known to all participants. |
| Domain 2: study design | | | |
| <i>Theoretical framework</i> | | | |

| No | Item | Guide questions/description | Details |
|------------------------------|---------------------------------------|---|---|
| 9. | Methodological orientation and Theory | What methodological orientation was stated to underpin the study? <i>e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis</i> | A reflexive thematic analysis (Braun and Clarke, 2019) guided by a critical realist approach. |
| <i>Participant selection</i> | | | |
| 10. | Sampling | How were participants selected? <i>e.g. purposive, convenience, consecutive, snowball</i> | Purposive, all players who had accessed the RPI mental wellbeing service were approached to take part in the study. All Player Development Managers (PDM) working for RPI took part in the staff focus group. |
| 11. | Method of approach | How were participants approached? <i>e.g. face-to-face, telephone, mail, email</i> | Via email. |
| 12. | Sample size | How many participants were in the study? | 9 (five players; four PDMs) |
| 13. | Non-participation | How many people refused to participate or dropped out? Reasons? | 44 players were invited, five consented to participate in the study (39 did not respond to the invite). No participants withdrew. |
| <i>Setting</i> | | | |
| 14. | Setting of data collection | Where was the data collected? <i>e.g. home, clinic, workplace</i> | Online. |
| 15. | Presence of non-participants | Was anyone else present besides the participants and researchers? | No. |
| 16. | Description of sample | What are the important characteristics of the sample? <i>e.g. demographic data, date</i> | Summary details of the sample demographics are provided in the Methods |

| No | Item | Guide questions/description | Details |
|------------------------|------------------------|---|--|
| | | | section. Note that due to the high profile nature of the sample, further details cannot be provided without compromising data confidentiality. |
| <i>Data collection</i> | | | |
| 17. | Interview guide | Were questions, prompts, guides provided by the authors? Was it pilot tested? | The schedule was not pilot tested. |
| 18. | Repeat interviews | Were repeat interviews carried out? If yes, how many? | None. Both focus groups were conducted on-line using Zoom Video Communications, with audio and visual recording. |
| 19. | Audio/visual recording | Did the research use audio or visual recording to collect the data? | Transcriptions of the audio were transcribed verbatim. |
| 20. | Field notes | Were field notes made during and/or after the interview or focus group? | Between 45 – 64 mins. |
| 21. | Duration | What was the duration of the interviews or focus group? | Data saturation is not required for reflexive thematic analysis as per Braun and Clarke's (2019) approach. |
| 22. | Data saturation | Was data saturation discussed? | Yes, participants reflected and provided feedback on the initial themes (see Methods section) |
| 23. | Transcripts returned | Were transcripts returned to participants for comment and/or correction? | |

| No | Item | Guide questions/description | Details |
|--|--------------------------------|--|---|
| Domain 3: analysis and findings | | | |
| <i>Data analysis</i> | | | |
| 24. | Number of data coders | How many data coders coded the data? | The lead author. |
| 25. | Description of the coding tree | Did authors provide a description of the coding tree? | Not relevant for the reflexive thematic analysis approach. An inductive analysis was conducted – therefore themes were driven by the data as much as possible. |
| 26. | Derivation of themes | Were themes identified in advance or derived from the data? | N/A |
| 27. | Software | What software, if applicable, was used to manage the data? | Yes, general feedback on the initial themes was solicited from participants. |
| 28. | Participant checking | Did participants provide feedback on the findings? | |
| <i>Reporting</i> | | | |
| 29. | Quotations presented | Were participant quotations presented to illustrate the themes / findings? Was each quotation identified? e.g. <i>participant number</i> | Yes, see the Results section for quotations. |
| 30. | Data and findings consistent | Was there consistency between the data presented and the findings? | Yes. |
| 31. | Clarity of major themes | Were major themes clearly presented in the findings? | Yes. See the Results section. Where appropriate, there is a discussion of unique/individual cases (see the Results section). |
| 32. | Clarity of minor themes | Is there a description of diverse cases or discussion of minor themes? | |

Author Accepted Version