

1 **A Qualitative Examination of Factors Inhibiting and Facilitating Professional Mental Health**
2 **Help-Seeking Following Injury in Sub-Elite Club Gaelic Footballers**

3

4 **Abstract**

5 Mental health issues are common in Gaelic footballers, with injury significantly increasing
6 the risk of experiencing symptoms of a common mental disorder. However, professional help-seeking
7 is not common in athletes, with a preference for informal help sources who may be untrained and
8 inexperienced to provide help and support. Participation at the sub-elite, or club, level represents the
9 broadest playing population in Gaelic football and therefore, the current study aimed to examine the
10 barriers and facilitators to professional mental health help-seeking among sub-elite adult Gaelic
11 footballers. Male (n=14) and female (n=13) sub-elite Gaelic footballers with a history of injury
12 participated in a focus group. Focus groups were audio-taped, transcribed verbatim and thematically
13 analysed. Education, the attitudes, actions and opinions of others and accessibility were perceived as
14 key barriers and facilitators to help-seeking among sub-elite Gaelic footballers. Negative self-attitudes
15 to help-seeking and characteristics of the professional help-provider were identified as additional
16 barriers. Interventions aimed at reducing identified barriers must be introduced and professional
17 mental health help-seeking facilitated to ensure Gaelic footballers are managing their mental health
18 post-injury.

19 **Key words:** Injury psychology; GAA; Recreational players; Barriers; Education

20 Gaelic football is a popular Irish field-based team sport (Sport Ireland, 2019). Over 370,000
21 male (Sport Ireland, 2014) and 200,000 female players (O'Connor et al., 2020) with an average age of
22 24 to 26 years (Corrigan et al., 2023; Mangan et al., 2020) are registered with over 2,600 and 1,000
23 clubs, respectively (Gaelic Athletic Association, 2016; Ladies Gaelic Football Association, 2011).
24 Participation occurs at elite and sub-elite levels; elite Gaelic footballers compete at national level with
25 their representative inter-county team, while sub-elite players compete recreationally at club level
26 (Mangan et al., 2017). Players withstand intense physical demands due to the high-intensity, high-
27 velocity nature of the game (McIntyre, 2005). Gaelic games players also face intense mental demands
28 and may encounter more than 600 distinct stressors, related to diet and hydration, finances, career
29 transition, team selection or communications with teammates, coaches, or support staff (Arnold &
30 Fletcher, 2012), that can elicit symptoms of a mental health issue (Gouttebauge et al., 2016).

31 Mental health issues are prevalent, with 48% of elite Gaelic players reporting symptoms of
32 anxiety or depression (Gouttebauge et al., 2016) and 37% of collegiate players reporting mild
33 depression (Sheehan et al., 2018). Injury is a stressor that can increase players risk of experiencing a
34 mental health issue (Gouttebauge et al., 2016) and injuries are common in Gaelic football (8.3 to 17.9
35 injuries occurring per 1000 participation hours) (O'Connor et al., 2020; O'Connor et al., 2017;
36 Crowley et al., 2011; Wilson et al., 2007). Moderate (8-21 days' time loss) and severe injuries (>21
37 days' time loss) are common within the sport (O'Connor et al., 2017), with greater severity time loss
38 injuries recognised as a risk factor for experiencing mental health issues (Gouttebauge et al., 2016).

39 Mental health help-seeking is an adaptive coping process where an individual endeavours to
40 obtain external assistance to deal with a mental health concern (Rickwood and Thomas, 2012). Help-
41 seeking can be conceptualised by the Health Belief Model (HBM; Rosenstock et al., 1988;
42 Rosenstock, 1966), which has been adapted to specifically conceptualise mental health help-seeking
43 (Henshaw & Freedman-Doan, 2009). HBM assumes mental health care utilisation is related to threat
44 (perceived susceptibility and severity), expectations (perceived benefits, barriers, and self-efficacy),
45 and cues to action (Henshaw & Freedman-Doan, 2009). The model also perceives sociodemographic
46 and psychosocial factors to influence help-seeking (Henshaw & Freedman-Doan, 2009; Rosenstock,
47 1966). Additionally, help-seeking can be conceptualised by the help-seeking model (HSM; Rickwood

48 et al., 2005), which considers four stages; awareness of symptoms and an appraisal help may be
49 required, expression of symptoms and a need for support, awareness and availability of sources of
50 help, and willingness to seek out and disclose to sources (Rickwood et al., 2005).

51 Despite the prevalence of mental health issues, athletes demonstrate a reluctance to seek
52 professional help (Gorczyński et al., 2019), which may be conceptualised through HBM and HSM.
53 Education, the attitudes, actions and perception of others and accessibility are recognised as barriers
54 and facilitators to professional mental health help-seeking post-injury in elite Gaelic footballers
55 (O’Keeffe et al., 2022). In addition, negative attitudes towards help-seeking (Watson, 2005), stigma
56 (Gulliver et al., 2012a) and the perceptions of teammates (Lopez and Levy, 2013) and a lack of
57 awareness of help resources or the symptoms of a mental health issue (Gulliver et al., 2012a) have
58 been acknowledged to limit athletes’ proactive help-seeking behaviours.

59 Help-seeking may also be influenced by the broader culture of sport, which assumes mental
60 toughness (Pike, 2018) and athletes’ abilities to deal with pressures and expectations (Bauman, 2016).
61 Mental toughness can be a positive indicator of mental health (Gucciardi et al., 2017) and is
62 associated with sport-related wellbeing (Bird et al., 2021). Athletes with greater levels of mental
63 toughness may report less mental health help-seeking stigma (Bird et al., 2021). However,
64 contradictory, mental toughness is also viewed negatively (Bauman, 2016), where help-seeking may
65 be perceived to undermine athletic identity and mental toughness (Pike, 2018). The highly physical
66 nature of Gaelic football may add to players’ perceptions that they must adhere to this mental
67 toughness ideology and that seeking help is the antithesis of the strength that athletes should portray
68 (Pike, 2018). Mental toughness may be heightened through a gendered lens (Pike, 2018) and the
69 perception of masculinity (Moreland et al., 2018). This masculinity or greater levels of gender role
70 conflict among athletes, which can be influenced by coaches and the sport setting (Steinfeldt et al.,
71 2011), can result in greater stigma towards professional mental health help-seeking (Steinfeldt et al.,
72 2009). Differences are also evident in coping responses between genders following injury (Kontos et
73 al., 2013), with female athletes significantly more likely to seek help (Barnard, 2016). Therefore,
74 understanding and examining the factors affecting help-seeking in male and female Gaelic footballers
75 is important.

76 Informal supports, particularly from family and friends, are preferred among Irish student-
77 athletes when seeking help for mental health issues (Drew & Matthews, 2019) and family and friends
78 can provide emotional and practical support for injured athletes (Yang et al., 2010; Johnston &
79 Carroll, 1998). This preference may be due to the personal and non-professional relationship evident
80 (Rickwood & Thomas, 2012), the lack of awareness of professional services (Gulliver et al., 2012a)
81 and/or the absence of associated access barriers (e.g., cost, time, transport; Lopez & Levy, 2013;
82 Gulliver et al., 2012a) that may be evident when accessing formal services. However, informal
83 supports may be untrained, inexperienced, and liable to make a mistake (Hughes et al., 2018) and may
84 lack the appropriate awareness to provide help for difficult issues (Rickwood et al., 2005). Thus,
85 utilising professional help-seeking supports, who can provide evidence-based treatments (Deane et al.,
86 2001), is essential for the appropriate management of mental health issues following injury.

87 Qualitative research supports the inclusion of the athlete voice and their direct perspectives
88 and insight, and can provide new understandings (Bekker et al., 2020), beyond the scope of
89 quantitative research. Despite current qualitative research identifying barriers and facilitators to
90 mental health help-seeking in elite Gaelic footballers (O’Keeffe et al., 2022), there is no current
91 research in sub-elite Gaelic footballers. Gaelic football is unique compared to other international
92 sports as all participants play at the sub-elite club level, but the best players are also chosen to play
93 with their county team at the elite level (Mangan et al., 2020). However, it is estimated only 0.3% of
94 sub-elite players are chosen to also play at the elite level (Mangan et al., 2020), so the majority of the
95 population of Gaelic footballers are solely involved at the sub-elite level. Sub-elite players can face
96 similar physical and mental demands, while also balancing their personal and professional lives, but
97 are often exposed to lower levels of preparation (Wilson et al., 2007), so findings evident in elite
98 players cannot be applied to the sub-elite population. Therefore, as the sub-elite level represents the
99 broadest playing population in Gaelic football (McGuigan et al., 2018), it is essential to understand
100 the factors affecting help-seeking specifically in sub-elite Gaelic footballers. Thus, the aim of the
101 current study was to qualitatively examine the barriers and facilitators to professional mental health
102 help-seeking following injury among male and female sub-elite Gaelic footballers with a history of
103 moderate or severe injury.

104

105 **Materials and Methods**

106 *Design*

107 The study was underpinned by an interpretative research paradigm, recognising the subjective
108 nature of knowledge but also that knowledge is influenced by social and cultural environments
109 (Creswell, 2009). The paradigm was supported with a relativist ontology (multiple realities exist, but
110 that reality is subjective and dependent upon human interpretation and knowledge [Braun & Clarke,
111 2013]) and subjectivist epistemology (knowledge exists within that is created based on individuals
112 own reality and experiences [Bleiker et al., 2019]).

113 Data was collected via focus groups, which allow a rich, descriptive interpretation (Crust,
114 2008). Focus groups allow participants to compare their opinions (Bloodworth & McNamee, 2010)
115 and challenge social norms and individual perceptions (Browne, 2016). The group dynamic was also
116 important to replicate the social environment participants are accustomed to within the team sport of
117 Gaelic football and allow connections of experiences. Ethical approval was granted by the
118 Institutional Research Ethics Committee (#20180201) and informed consent was provided.

119 *Participants*

120 Male (n=14; 23.3±4.4 years of age; 16.1±4.0 years Gaelic football experience) and female
121 (n=13; 22.5±5.0 years of age; 13.3±4.6 years Gaelic football experience) sub-elite Gaelic footballers
122 with a history of moderate or severe injury were purposively recruited via social media/word of
123 mouth. Injury severity was defined as the number of days missed from Gaelic football participation;
124 moderate (7-21 days) or severe (>21 days; O'Connor et al., 2016). Injuries were limited to the
125 previous three years to include participants with experience of injuries of greater severity that resulted
126 in a significant amount of time loss and potentially prolonged psychological consequences, while also
127 limiting the effects of recall issues. The data collection period was guided by the concept of
128 information power (Braun & Clarke, 2021a; Malterud et al., 2016), where data collection ceased when
129 participants had provided extensive relevant information (see Supplementary File 1).

130 *Procedures*

131 Participants were assigned to a focus group based on their convenient time and location. A
132 minimum of four participants (range: 4-5 participants) were assigned to each focus group to support
133 discussion and create an intimate environment appropriate for discussing a sensitive or complex topic
134 (Moser & Korstjens, 2018). Injury severity was not considered when assigning participants. Focus
135 groups were moderated by the primary author, lasted 46.0 ± 7.6 minutes and were audiotaped and
136 video recorded, with the video utilised to support transcription. Focus groups began with the
137 collection of demographic information (age, gender, years playing Gaelic football and history of
138 injury). Name tags were issued to facilitate group discussion and participants were instructed on
139 appropriate focus group behaviour (see Supplementary File 2). To allow for a common understanding
140 of mental health issues, definitions of key terms and a case vignette of a Gaelic footballer's
141 experience of mental health issues following injury were presented (see Supplementary File 3).

142 Focus group procedures were designed to replicate methods previously described by Gulliver
143 et al. (2012a). An initial written task was completed where participants noted three things that might
144 stop them from seeking help when experiencing a negative psychological reaction to injury. Group
145 discussion ensued, with each participant given the opportunity to introduce personal perceived
146 barriers with little input from the moderator. Additional barrier topics derived from the literature were
147 then presented one by one to the group for discussion by the moderator and participants were given an
148 opportunity to present any additional barriers. Following discussion, the barriers' ranking task was
149 completed (see Supplementary File 4). Similar procedures (i.e., written task, group discussion and
150 ranking task) were repeated in the examination of help-seeking facilitators. At the end of the group
151 discussion, participants were reminded help is available when experiencing mental health issues and
152 were directed to contact their GP if necessary.

153 *Data Analysis*

154 Focus groups were transcribed verbatim, with participants randomly allocated a unique
155 genderised identification number (e.g., M1= male participant one; F10= female participant ten).
156 Transcribed focus groups were coded by the primary author in NVivo12 (QSR International,
157 Melbourne, Australia) via a six-phase reflexive thematic analysis process (Braun & Clarke, 2021b),
158 aligning with the relativist ontological position and subjectivist epistemology of this study. Detailed

159 analytical processes are outlined in Supplementary Material 5. Core categories were those evident in
160 the majority of groups and were further classified into themes and sub-themes. Written tasks were
161 thematically classified and visually represented according to the prevalence of each theme. The
162 barrier and facilitator ranking tasks were reverse scored and summed, with a higher score indicating a
163 higher ranked barrier or facilitator. The Standards for Reporting Qualitative Research (SRQR) were
164 adhered to (O'Brien et al., 2014; see Supplementary File 6).

165 *Trustworthiness*

166 Investigator triangulation was conducted via a coding consistency check (Woods et al., 2015)
167 by the primary author with two of the authors [SOC and NNC]. Disagreements during analysis were
168 discussed between authors to acknowledge and challenge alternative interpretations of the data, which
169 encouraged reflexivity (Cowan & Taylor, 2016), reducing the potential for individual researcher bias
170 (Johnson et al., 2020). Method triangulation (Korstjens & Moser, 2018) was also completed in the
171 collection of data through both group discussion and written barrier and facilitator tasks. Furthermore,
172 multiple examples from the transcripts are provided in the results, outlining the shared viewpoints but
173 diverse contribution of participants. This use of multiple investigators, sources of data, and theoretical
174 viewpoints is suggested as a method of triangulation to reduce the chance of individual bias (Biddle et
175 al., 2001).

176

177 **Results**

178 Six focus groups were conducted, 3 groups with male and 3 groups with female sub-elite
179 Gaelic footballers. A history of severe injuries was more common (male=10, female=9) than
180 moderate injuries (male=4, female=4). The familiarity of participants within the groups varied. Figure
181 1 depicts a schematic representation of the evident barriers and facilitators identified in the focus
182 groups. Participant quotes are presented below, including the unique genderised participant
183 identification number.

184 [Insert Figure 1]

185 *Barriers*

186 Stigma and poor awareness of services (not knowing how, where or when to seek help) were
 187 recognised as key barriers to help-seeking in the initial written task (Figure 2) and the ranking task
 188 (Table 1). Lack of education, stigma, negative self-attitudes to seeking help, accessibility issues and
 189 characteristics of the professional help-provider were identified as core barrier categories in the group
 190 discussions (Table 2).

191 [Insert Figure 2]

192 [Insert Table 1]

193 [Insert Table 2]

194 **A. Lack of Education**

195 **Poor awareness of services**

196 Male and female sub-elite Gaelic footballers acknowledged that within the club environment,
 197 the opportunities and supports for mental health help-seeking are extremely limited and there is “*a*
 198 *real lack of psychological help*” (F3). Players acknowledged Gaelic football participation can be a
 199 really enjoyable experience and players are reaping the benefits of participation for their physical and
 200 mental health, but that environment can suddenly change, and players can struggle to cope when they
 201 experience an injury: “*everything is going fine, next thing you’re hit with an injury ... but you don’t*
 202 *know how to deal with it*” (M9). There was a shared perception that the knowledge of where or how to
 203 seek help was particularly lacking. Without that necessary knowledge, help-seeking cannot be
 204 supported as players don’t know “*where to even start*” (F6) when experiencing psychological distress
 205 and looking for help – M1: “*I would have no idea about who I contact in my area. Do I go through*
 206 *the club? Do I go through it privately? Are there specific people relative to sport or do I go to a*
 207 *general one?*”. In addition, male Gaelic footballers discussed “*fear of the unknown*” (M10) of what to
 208 expect in a consultation with a professional and not knowing the benefits or importance of seeking
 209 help:

210 M3: *I think even if you see what some clubs have these days ... there’s access to strength and*
 211 *conditioning, there’s access to a couple of coaches, there’s video analysis. I know some clubs*
 212 *around the country have GPS and technology like that, so I think in some places anyway,*

213 *there is provisions there but it's just not something that's considered important enough I*
 214 *imagine.*

215 **Not knowing about mental disorders and their symptoms**

216 A concerning lack of awareness of mental disorders was evident, where *"it's never explained*
 217 *to players what a psychological reaction to injury is, so they don't know what they are experiencing"*
 218 (M13). There was a shared understanding that negative reactions to injury can be a normal part of
 219 being injured but players can struggle with identifying when those symptoms are deemed excessive,
 220 where they don't know *"how bad is bad enough ... to need to go get help"* (F11). Although openly
 221 recognising these two factors (don't know what a psychological reaction is and not knowing what is
 222 excessive enough to need to get help), there was a shared hidden factor within this sub-theme that
 223 players did not openly acknowledge as a barrier, but rather what was evident within the dynamic of
 224 the group discussion. This related to players perceptions that they are not actually experiencing mental
 225 health issues, but instead this is just *"the way it is when you are trying to recover"* (M3) and a normal
 226 part of being injured – *"the reason I'm feeling bad is because I'm not playing so when I go back*
 227 *playing, everything will sort itself out but ... it doesn't just get better overnight. It takes time to get*
 228 *better"* (M9).

229 **B. Stigma**

230 Help-seeking was comprehensively viewed as not 'the done thing' when experiencing mental
 231 health issues, as the stigma and fear of the perception of others outweighed the benefits that players
 232 may get when demonstrating this vulnerability. The community element played a huge part with that
 233 stigma and the taboo associated with mental health help-seeking. Gaelic football can be considered a
 234 pivotal social outlet for young and old within the community, so for sub-elite players within that club
 235 community, there was an astounding *"fear of what others are saying"* (F11) or *"what other people*
 236 *would think"* (F11) if they were to seek help for mental health difficulties. By seeking help, they were
 237 disrupting the community's perception of them as resilient role models, where community members
 238 now *"view them differently"* (F5) or *"think they are delicate"* (F1) and *"it can come across that they*
 239 *seem weak"* (M4). It was notably perceived by male Gaelic footballers that there is *"more of a stigma*
 240 *for men to open up about their feelings"* (M10).

241 That community element of Gaelic football also relates to the internal team dynamic, where
 242 players are dependent upon the support of their teammates. Gaelic football, as a team sport, requires a
 243 supportive and cohesive unit to achieve optimal performances and success on the field and there was a
 244 reluctance among players to upset this team dynamic – “*everyone wants to keep a team positive so*
 245 *you would feel you are bringing down the team if you were saying I’m really just not well at the*
 246 *moment*” (F12). The stereotypical societal viewpoint of “*men have to be strong and sort themselves*”
 247 (M8) was a strong observation among male players, passed from older to youth club players and
 248 persisting across the team. This archaic viewpoint was perceived as most notably present in the club
 249 setting, due to that intense common community, instilling this perception that men “*just don’t get*
 250 *help*” (M8). Similarly, female players feared the “*bitchy*” (F9) environment that can predominate the
 251 women’s game and team setting “*so you would be worried what other players think*” (F9).

252 The imbedded community setting that commonly underpinned stigma across the group
 253 discussions varied for the coach. The coach may be brought in from outside of that club, diminishing
 254 this ‘pride of community’, but instead introducing ‘the unknown’, leading to players’ reluctance to
 255 show their struggles with mental health issues – “*I don’t know (the coach) very well so I am not going*
 256 *to open myself up*” (F1). For female Gaelic football teams, many coaches are male, so “*you’re not*
 257 *going to sit down and talk to them*” (F4), enhancing the stigma. The fear that “*you appear weak or*
 258 *soft*” (M11) was reiterated when discussing stigma from coaches, with fear of the repercussions of
 259 seeking help – “*if they think I’m weak willed or weak mentally, are they going to trust me later on in*
 260 *the season?*” (M3).

261 **C. Negative self-attitudes to seeking help**

262 **Feeling professional help is not necessary**

263 The lack of importance and prioritisation of seeking professional help was a common
 264 viewpoint and was encapsulated with the perception that players are not important enough to require
 265 or seek help and that “*their problem just isn’t a big enough problem to be sorted out*” (M1).
 266 Participants believed they are simply Gaelic footballers who are struggling with their experience of
 267 injury, while there are others experiencing broader and more life-impacting experiences, like grief,
 268 illness, and death. Instead, players reported they may feel low simply as a consequence of injury and

269 that “*it’s just the way it has to be for that time while you’re trying to recover and then once you get*
 270 *back, that kind of cancels it, you’re back playing football*” (M3). Denying that need for help came full
 271 circle, acknowledging that players don’t feel important enough or their problem is not worthy enough
 272 and that if they wait it out, they “*think it’s going to be fine, you don’t need help*” (M13).

273 **Feeling it is better to manage on your own**

274 Although a team sport, male players felt they must self-manage their mental health issues
 275 without burdening the team and “*deal with whatever is going around in their head themselves*” (M7).
 276 Gaelic football is an entirely amateur sport, which may have incited this belief that when you
 277 experience mental health issues, you “*deal with it yourself*” (M7). That non-professionalism of the
 278 organisation as a whole led to this assumed widespread belief that the individual is disregarded and
 279 that the “*GAA [Gaelic Athletic Association] expects you to deal with stuff like that yourself ... they*
 280 *don’t see the importance of it*” (M6).

281 **Feeling embarrassed**

282 Embarrassment was unique to female Gaelic footballers, acknowledging players “*would be*
 283 *ashamed of going*” (F11) to seek help when experiencing mental health issues post-injury. Female
 284 players noted this connection to the emotional reaction to injury and how their pride may be affected
 285 by displaying such emotions, not just related to the perception of others, but for their own opinion of
 286 self, where they “*feel like I am letting myself down*” (F2).

287 **D. Accessibility issues**

288 Club Gaelic footballers, involved for enjoyment of the game and love of the sport, self-fund
 289 all associated costs of participation and thus acknowledge key accessibility issues when covering the
 290 costs of mental health help-seeking. Injury and the associated costs of physical rehabilitation can be
 291 burdensome in itself, without adding or prioritising professional mental health supports. Players
 292 framed physical recovery as centrally important, with other factors gone by the wayside – “*I suppose*
 293 *sometimes you might think that money is better spent on helping you physically and getting you back*
 294 *to play rather than talking to someone*” (F11). Seeking mental health supports is just “*another*
 295 *expense on top of it all*” (F13). At a club level, the amateur nature of the sport means clubs “*don’t*
 296 *have the funds to be having extra people like that around the whole time to talk to*” (M2).

297 **E. Characteristics of professional help provider**

298 A lack of experience of the professional help provider was a deterrent to seeking help. There
299 was a highlighted need for acceptance from the professional providing support for players to feel
300 comfortable opening up and discussing their personal experiences of mental health issues. There was
301 a minimum need for the professional to have a clear understanding of sport or “*any sort of sporting*
302 *background*” (F6) to allow players voice their vulnerabilities. However, players noted a preference for
303 the professional to specifically “*know Gaelic football and what is expected of you*” (F4) to ensure they
304 understood the pressures involved when playing at the sub-elite level. Without that experience,
305 players acknowledged they would be averse to seeking help, “*reluctant to open up*” (M13) and less
306 willing to “*listen to their opinions*” (M3).

307

308 ***Facilitators***

309 Awareness of services and social support were recognised as key help-seeking facilitators in
310 the initial written task (Figure 3). Social support and a positive attitude to seeking help from the coach
311 and teammates was also deemed important in the ranking task (Table 1). In addition, awareness and
312 the ability to express your feelings and seeing a mental health professional as part of sports
313 participation and training were also highly ranked (Table 1). The attitudes, actions and opinions of
314 others, education and accessibility were key facilitator categories acknowledged during group
315 discussions (Table 2).

316

[Insert Figure 3]

317 **A. Attitudes, actions and opinions of others**

318 **Social support**

319 Participants valued social support and having people in your corner as integral to feeling
320 supported when seeking help for mental health difficulties, most notably internally within the sporting
321 environment from teammates, coaches, and management and externally from family and friends. In
322 terms of that support from the coach or management, players consistently discussed the need for a
323 positive attitude from these social networks – “*knowing that if you go to them, they say go get help*
324 *and that’s great that you have this problem, and we want you to get help for it*” (F6). Along with a

325 positive attitude, encouragement from team management was essential, and may be viewed as a cue to
326 action, as those authoritative figures are responsible for making team decisions so having them trust
327 you as a player and encouraging you to become the best version of yourself physically and mentally
328 was important.

329 The support of teammates was essential for female Gaelic footballers to facilitate help-
330 seeking. Players acknowledged that these are the people you are around the most, and at club level,
331 you often play with these same players for many years from underage all the way through to adult
332 level so they know you best and can “*see you are not yourself*” (F11) and therefore, players trust
333 them and value their support most. This was unique to female players, perhaps due to the greater
334 acceptance of vulnerabilities evident among female players, that may not be seen to the same extent in
335 male team settings. However, male players may instead be more willing to demonstrate those
336 vulnerabilities to their immediate circle and uniquely noted the importance of family and friends in
337 the provision of social support, where they are “*saying it’s OK to go get treatment, that they are*
338 *behind you and supportive in what you are doing*” (M5).

339 **Normalising help-seeking**

340 A common perception of Gaelic football participants was the need for acceptance of mental health
341 help-seeking, in line with the acceptance currently evident when looking to improve performance,
342 become a better player or seek help for any struggle or physical issue an individual is experiencing.
343 Speaking about mental health and hearing stories of others who have sought help would drive the
344 behaviour and instil the belief that this is just what happens when a player struggles with their mental
345 health. In order to create that normalised environment, players discussed the need to “*keep things as*
346 *normal as possible*” (M1) and for “*the people around you, that they don’t make a big deal of it*” (M1).
347 The societal influence was also noted, acknowledging the need for players demonstrating a
348 vulnerability to be accepted, that they are not just indestructible athletes but instead they can struggle
349 with their mental health while also being this outstanding role model within the community. Players
350 called for that acceptance of mental health help-seeking in line with injury rehabilitation, imbedding it
351 within the process of recovery– “*if you are on the physio table, you have no problem walking in,*

352 *talking about (injury) and all that but mental health, we just don't talk about it enough. If we could*
353 *change that, it would be easier to get help, and everyone would do it"* (F12).

354 **B. Education**

355 **Awareness of services**

356 Gaelic footballers perceive a need for education on the services available to support mental
357 health and facilitate help-seeking. Players discussed the importance of "*increasing awareness around*
358 *mental health or how to deal with injuries*" (M10), stating that "*if there was more awareness out*
359 *there ... then people would definitely go see someone*" (M2). Players acknowledged that due to being
360 an amateur sport, financial constraints may limit the provision of services directly in the sub-elite
361 playing environment but simply by raising awareness of what services are available external to the
362 club would support help-seeking. This awareness may be a cue to action as players know "*where you*
363 *could go when you needed that help*" (M12). It was suggested that knowledge could be shared at the
364 start of the season during accustomed pre-season team meetings that happen nationally within each
365 club and that awareness could be shared in simple formats, such as a handout of the available services
366 or a list of resources.

367 Along with awareness of what services are available, there was a shared understanding that
368 help-seeking could be facilitated if players also understood what the help-seeking process would look
369 like. As highlighted above, players recognised the source of help would likely be external to the club
370 setting, and therefore would not be a familiar voice to whom they may be comfortable sharing their
371 vulnerabilities with but having "*an idea what to expect*" (F12) in an appointment or consultation with
372 a professional would make it easier for them to open up and seek that help. Players noted the
373 awareness of what to expect with physical rehabilitation is there but that needs to be replicated for
374 psychological rehabilitation post-injury – "*you wouldn't go into a surgery or physio clinic without*
375 *having them explain to you, I'm going to do this to you, it's the exact same thing. The more knowledge*
376 *you have before you go, the more comfortable you will be ... the more likely you are going to talk*"
377 (M3).

378 **Understanding mental disorders and their symptoms**

379 An awareness of the signs and symptoms of mental health issues and the ability to recognise
380 them was deemed essential to supporting mental health help-seeking. This knowledge went beyond
381 just knowing what they are experiencing, but instead players discussed a clear need to understand
382 what are the common mental health issues that may be experienced, the signs and symptoms of those
383 mental health issues and the indicators of what might aggravate or exacerbate those factors. It was
384 noted by players that recognition and knowledge was directly linked to proactive behaviours and
385 could be perceived as a distinct cue to action: *“if you recognise the symptoms ... you would have more*
386 *confidence to go and speak to somebody”* (F2). Players related their current understanding back to the
387 physical consequences of injury but acknowledged that in many cases the symptoms of injury are not
388 just physical but that many players can struggle mentally also but that recognition may be lacking –
389 *“when you hurt your knee, straight away you know there is pain but how do you know what you’re*
390 *feeling in your head? Just knowing that would definitely make it easier to actually go and get help”*
391 (F10). Interesting to note, players did not just want greater awareness of services for themselves as
392 players, but also recognised the need for coach education. Managers and coaches play a multifaceted
393 role in overseeing the dynamics of the team and they may be able to support help-seeking by simply
394 recognising the need for help. However, players did acknowledge that the club Gaelic football
395 environment does not always allow for that demonstration of vulnerabilities but in more open team
396 settings, where players are valued beyond their performances on the field, help-seeking can be
397 facilitated by a supportive coach or manager that is appropriately educated.

398 **Awareness of others who have experienced mental health issues**

399 Linked with the normalisation of seeking help, players discussed the importance of knowing
400 others who had experienced mental health issues following injury who play in similar environments
401 and share their first hand stories– *“it definitely would help if you heard or read about other people*
402 *who have gone through the same thing”* (F12). That normalisation and recognition of others’
403 experience of mental health issues and help-seeking behaviours facilitated acceptance, willingness,
404 and comfort with help-seeking. Knowing others have been through those experiences was important
405 so they are aware they *“are not the only one feeling like that”* (F11), and these players are still able to
406 play successfully and live productive lives away from sport. The importance of role models, and

407 notably “*high profile examples*” (M7), facilitated that awareness but players acknowledged the need
 408 for role models specific to Gaelic footballers - “*It’s probably going to take a couple of players to*
 409 *stand up and say I did it and I felt great after it. You know being able to tell others to try it ... because*
 410 *if you thought other people were going to go to them you would feel sure why wouldn’t I try that*”
 411 (F12).

412 **C. Accessibility**

413 **Financial support**

414 Access to financial supports was important to sub-elite Gaelic footballers to support mental
 415 health help-seeking. However, players acknowledged that providing financial support is not a quick
 416 fix, particularly for sub-elite clubs who may already be struggling to financially support the associated
 417 day-to-day costs of running a club within the realms of amateur sport. Grants, funding from the
 418 county board or claiming the costs from player insurance were suggestions for how costs of mental
 419 health help-seeking could be covered. Players acknowledged that physical injury rehabilitation does
 420 receive support and that mental recovery should be viewed equally – “*it should be in the same bracket*
 421 *as physio or going to a doctor so it should be covered by clubs*” (M9).

422 **Convenience of access**

423 Mental health help-seeking could be facilitated by minimising the need for excessive travel to
 424 seek support by providing services local to the club setting or within the college environment for
 425 collegiate players – “*easily available, easy to get to ... you know it’s there and you can get to it easy*
 426 *instead of having to travel far*” (F13). Best case scenario was the availability of services within the
 427 club – “*some sort of person in the club or locally that they are the go-to person when you feel like that*
 428 *after injury*” (M12). However, players acknowledged that convenient access can be more difficult
 429 within the club environment, particularly for rural clubs as there “*wouldn’t be many (resources) in*
 430 *rural clubs and out in the countryside*” (M6) but there was a recognition that services should be
 431 available within a reasonable distance so players are not required to travel to a major city to access
 432 services, which may be several hours away. Players also discussed convenient access to help-seeking
 433 resources may be facilitated by linking psychological and physical rehabilitation – “*if someone is*
 434 *injured, when they are having their rehab session, make sure there is a session for a psychologist*

435 *before or after, have them both the same*" (F7). Linked within this was the need for athletic therapists
436 or physiotherapists to have education and training in injury psychology, but also practical experience,
437 so they can provide comprehensive support for both physical and mental health.

438 **Access to online resources**

439 Players recognised that online resources would be most beneficial as they are not associated with
440 geographical limitations, financial access barriers or long waiting lists and provide a confidential
441 initial help-seeking service. Players acknowledged that online or text-based services can be beneficial
442 *"where instead of you having to go meet somebody that you don't want to, you just send a text and it's*
443 *just an anonymous text"* (M3). Use of online resources was deemed less daunting, where players are
444 protected by a lack of that face-to-face contact, and they can say what they want without judgement or
445 can rewrite and edit text or emails. Providing education on mental health online was also plauded by
446 players because young people, those with whom they play Gaelic football with in the club setting, are
447 often online and this form of mental health education could be viewed in a more positive light.

448

449 **Discussion**

450 Sub-elite club players represent the broadest playing population in Gaelic football (McGuigan
451 et al., 2018). Therefore, the current study aimed to qualitatively examine the barriers and facilitators
452 to mental health help-seeking following injury as perceived by sub-elite Gaelic footballers. Mental
453 health help-seeking behaviours can be influenced by perceived barriers (Henshaw & Freedman-Doan,
454 2009; Rosenstock, 1966) and in the current study, lack of education, stigma, accessibility issues,
455 negative self-attitudes to help-seeking and characteristics of the professional help provider were
456 identified as barriers. Contrary to being inhibitors, education, the attitudes, actions and opinions of
457 others, and accessibility were facilitators to help seeking. Intricacies within the perceived barriers and
458 facilitators were evident, with differences reported by male and female players. Not knowing the
459 benefits or what to expect when seeking professional help, and the preference to self-manage were
460 noted barriers in male players, while social support from family and friends was a unique facilitator.
461 In contrast, social support from teammates was a facilitator in female players but not knowing how to
462 seek help and feeling embarrassed were barriers.

463 Education

464 Players perceive education to be a substantive factor influencing mental health help-seeking
465 following injury. There was a documented need for greater awareness of the symptoms of mental
466 disorders and the services available to support players, with these factors also recognised previously
467 in elite Gaelic footballers (O’Keeffe et al., 2022) and elite (Wood et al., 2017; Gulliver et al., 2012a)
468 and collegiate athletes (Moore, 2017). Players perceived the Gaelic football club environment does
469 not often foster and prioritise education and awareness of services, which may be related to clubs’
470 own access barriers (e.g., lack of club funding to provide education, lack of psychological support
471 structures locally or within the amateur club setting to create educational programmes or resources,
472 lack of prioritisation of the need for psychological supports with a focus on physical supports).

473 HBM acknowledges proactive mental health help-seeking behaviours relate to the severity of
474 symptoms (Henshaw & Freedman-Doan, 2009; Rosenstock et al., 1988; Rosenstock, 1966) and by
475 having the knowledge to recognise symptoms of a mental health issue, players may be prompted to
476 act, thus supporting and facilitating help-seeking behaviours. HSM similarly recognises a need for the
477 awareness of both symptoms and sources of help for an expression of those symptoms and a need for
478 help (Rickwood et al., 2005) and therefore, education must be prioritised. Strategies that increase
479 mental health knowledge and players’ awareness of resources may be beneficial to support help-
480 seeking (Bird et al., 2020), with mental health literacy (MHL) interventions shown to improve mental
481 health knowledge in athletes (Liddle et al., 2019; Breslin et al., 2018). Mental health educational
482 programs that describe where, when and who to signpost a person to if they need help (Breslin et al.,
483 2019) and highlight a clear pathway of available support services (Moesch et al., 2018) are essential.
484 Educational programmes, to be successful, must be sports-specific and considerate of specific
485 contextual and operational factors, underpinned by appropriate theories and models, and be delivered
486 by those with appropriate training and expertise (Breslin et al., 2019). The development of a sports-
487 specific MHL intervention for Gaelic footballers needs to be prioritised to facilitate professional
488 mental health help-seeking.

489 The attitudes, actions and opinions of others

490 The provision of MHL education may also be essential in reducing the stigma associated with
491 professional mental health help-seeking, a key barrier identified in the current study and previously in
492 elite Gaelic footballers (O’Keeffe et al., 2022) and athletes (Moreland et al., 2018; Arvinen-Barrow et
493 al., 2014; Lopez & Levy, 2013; Gulliver et al., 2012a). The stigma associated with mental health help-
494 seeking may be emphasised due to the positive team dynamic fostered to create a winning
495 environment within Gaelic football. Fear of others’ perceptions was also deemed to be heightened in
496 the team setting, with a reluctance to seek mental health support to avoid being seen as weak by their
497 teammates/coaches and losing trust or their place on the team. Female Gaelic footballers fear the
498 stigma from coaches as, notably evident in sub-elite Gaelic football and other female sports (Walker
499 & Bopp, 2011), coaches are predominantly male. This creates a reluctance to seek help and when
500 combined with the assumed Irish societal stigma associated with help-seeking (Dunne et al., 2018),
501 mental health cannot be supported following injury.

502 MHL interventions can improve athlete knowledge of mental disorders but may also initiate
503 positive attitudes towards those experiencing mental distress and increase confidence to help those in
504 need (Bapat et al., 2009). A MHL and destigmatising intervention, including information regarding
505 the prevalence and symptoms of mental disorders, help-seeking resources and evidence-based
506 treatments and their effectiveness, has previously been utilised to decrease stigma in elite athletes
507 (Gulliver et al., 2012b).

508 Improving the perception of others may also be supported by normalising help-seeking and
509 increasing players’ awareness of others who have experienced mental health issues, key help-seeking
510 facilitators noted in the current study. Athletes recognise that normalising mental health problems and
511 help-seeking is important (Gulliver et al., 2012a) and by increasing awareness of others who have
512 sought help, athletes may have greater confidence in mental health services and more positive
513 attitudes and intentions to seeking help (Vogel et al., 2007). Consultation with a mental health
514 professional as standard practice when a player sustains an injury may be beneficial in normalising
515 and destigmatising help-seeking. However, due to the recreational nature of sub-elite Gaelic football,
516 the feasibility of this approach is questionable, while the increased burden on struggling mental health
517 services may also be inappropriate. Alternatively, education may be beneficial, where a greater

518 understanding of mental health may be enabled and the conversation around mental health may be
519 initiated, leading to greater outcomes in normalising help-seeking. Additionally, creating a cultural
520 shift where help-seeking is seen as normal practice in supporting individuals' own mental health
521 would be beneficial. Cultural changes are not easily implemented and may only be successful with
522 widespread advocacy for mental health supports. However, sport settings are beneficial
523 environments to initiate change (Purcell et al., 2022) so a shift within the culture of Gaelic football
524 may be more achievable.

525 Social support was an additional facilitator, as also identified in elite Gaelic footballers
526 (O'Keeffe et al., 2022) and athletes (Gulliver et al., 2012a). Collegiate athletes with greater social
527 support have improved attitudes towards seeking professional psychological help (Nam et al., 2013),
528 while those lacking adequate social support structures may be more reluctant to seek help compared
529 with those with moderate or high levels of social support (Nagai, 2015). With sub-elite Gaelic
530 football, players begin at the youth level and progress through the age-ranked teams to adult level,
531 often playing with the same or similar cohort of players as they progress. This development through
532 the ages fosters friendships and trusting relationships both on and off the field and can be an important
533 factor to uniquely support mental health help-seeking in sub-elite Gaelic footballers. To normalise
534 help-seeking, these relationships should be curated to create that supportive stigma-free environment.

535 *Accessibility*

536 Access to resources is essential, with financial support, or lack of, an important barrier and
537 facilitator among sub-elite Gaelic footballers, similar to previous research (O'Keeffe et al., 2022;
538 Jewett et al., 2019; Schinke et al., 2018; Lopez & Levy, 2013). Financial support is available for
539 Gaelic footballers through injury schemes established within governing associations (Gaelic Athletic
540 Association, 2019; Ladies Gaelic Football Association, 2018). However, there is a lack of consensus
541 whether mental health or psychological rehabilitation services will be reimbursed under these
542 schemes, adding to access issues. GAA policy states medical expenses can be reimbursed but the first
543 €100 of each claim is not covered (Gaelic Athletic Association, 2019), whereas within the LGFA,
544 private treatments outside of athletic therapy, physiotherapy or GP visits must be pre-approved
545 (Ladies Gaelic Football Association, 2018). The requirement for pre-approval may be seen as an

546 additional deterrent, where a player is forced to disclose their mental health issues with others prior to
547 getting help. In contrast, elite Gaelic footballers have greater access to supports, with free counselling
548 services provided by the Gaelic Players Association (Gaelic Players Association, 2021) and some elite
549 teams employing a sports psychologist as part of the medical team (Kelly et al., 2018).

550 The amateur nature of Gaelic football repeats access barriers, where clubs cannot financially
551 support players' mental health and players do not get paid so may not have the personal finances to
552 seek professional help. Attitudinal barriers may also present in the club setting, where mental health
553 help-seeking is not prioritised due to a primary focus on physical recovery. However, clubs do not
554 have the capabilities to generate income overnight to fund these essential services and therefore
555 additional supports must be considered and prioritised at an organisational level. The current findings
556 reiterate not only the need for additional funding but facilitation of local access. There is estimated to
557 be over 3,600 clubs in urban and rural communities spread across the island of Ireland (Gaelic
558 Athletic Association, 2016; Ladies Gaelic Football Association, 2011) and therefore, access cannot
559 uniquely be provided in large urban areas, the mental health of the rural club player must also be
560 considered.

561 Access to online resources was a key facilitator among sub-elite Gaelic footballers, as evident
562 previously in elite Gaelic footballers (O'Keeffe et al., 2022) and athletes (Gulliver et al., 2012a).
563 Acting as a novel and alternative self-help strategy, the internet allows those experiencing mental
564 health issues to utilise online tools to seek assistance (Rickwood & Thomas, 2012). Use of the internet
565 is common, with 66% of Irish collegiate students searching the internet for health information
566 (Horgan & Sweeney, 2012), with 31% accessing online mental health information previously and
567 68% indicating future use of online services if required (Horgan & Sweeney, 2010). Online services
568 can be beneficial due to the convenience and anonymity associated with their use (Kauer et al., 2014;
569 Gulliver et al., 2012b). Thus, the use of reputable and appropriate online services should be promoted
570 among sub-elite Gaelic footballers.

571 *Perceptions of help-seeking process*

572 Male and female sub-elite Gaelic footballers deemed the characteristics of the help provider
573 and their lack of experience of sport or Gaelic football as an important barrier to help-seeking.

574 Athletes may worry the help-provider may not understand their problem (Gulliver et al., 2012a) and
575 prefer to seek help from those with knowledge and experience of sports participation (Lopez & Levy,
576 2013). Therefore, establishing a good rapport (Gulliver et al., 2012a) and providing players with
577 knowledge of professional mental health help resources that understand the demands of Gaelic
578 football are essential to facilitate help-seeking.

579 Self-efficacy (Rosenstock et al., 1988; Rosenstock, 1966) and a willingness to seek support
580 (Rickwood et al., 2005) can aid proactive health behaviours. Negative self-attitudes, in particular,
581 feeling professional help is not necessary and denial of a need for help, were acknowledged as
582 additional barriers among sub-elite Gaelic footballers, similar to previous research (O’Keeffe et al.,
583 2022; Lopez & Levy, 2013; Gulliver et al., 2012a). Young athletes may be conditioned not to inform
584 others when they are struggling and to battle through difficulties, a perception assumed to echo mental
585 toughness (Potter, 2014). Gaelic footballers may face additional pressures due to the unique social
586 context of the GAA in Ireland (Ipsos MRBI, 2016) and players recognition as perceived leaders and
587 community ambassadors (Kelly et al., 2018). Players may perceive help-seeking to be inconsistent
588 with this mental toughness and athletic identity assumed of Gaelic footballers, leading to the adoption
589 of negative self-attitudes towards seeking help. However, the opposite may be helpful, encouraging
590 players to view mental toughness as the ability to talk about how they are feeling and ask for help
591 (Potter, 2014), which may be facilitated through appropriate educational and destigmatising
592 interventions.

593 *Gender Differences*

594 Demographic and psychosocial factors can influence proactive health behaviours
595 (Rosenstock, 1966) and thus consideration of the influence of gender on help-seeking is essential.
596 Differences in attitudes to help-seeking were noted, with male sub-elite Gaelic footballers discussing
597 the perception that it is better to manage on your own, as also identified previously in elite Gaelic
598 footballers (O’Keeffe et al., 2022). This negative attitude to help-seeking may be linked to a lack of
599 education, as male players also report a lack of knowledge of the benefits and perceived value of
600 seeking psychological help and uncertainty of what to expect in an appointment or consultation with a
601 professional, as acknowledged in previous research (Bird et al., 2020; Gulliver et al., 2012a).

602 Therefore, in agreement with previous findings, MHL must be improved to support mental health
603 help-seeking.

604 Feelings of embarrassment were acknowledged as a barrier to help-seeking among female
605 sub-elite players, similar to previous research (O’Keeffe et al., 2022; Kola-Palmer et al., 2020;
606 Clement et al., 2015; Gulliver et al., 2012a). Embarrassment can be viewed as internalised stigma
607 (Clement et al., 2015), where an athlete is too embarrassed to show what they perceive as a personal
608 vulnerability or weakness of their character (Barney et al., 2006). A lack of emotional competence
609 may also be a factor with embarrassment (Rickwood et al., 2005), where players do not understand
610 the symptoms they are experiencing, finding it difficult to seek help. MHL interventions may be
611 beneficial in highlighting the symptoms of mental health issues and creating acceptance for seeking
612 help and the implementation of suitable interventions for sub-elite Gaelic footballers must be
613 considered.

614 ***Limitations***

615 Mental health is a sensitive topic (Breslin et al., 2019) and Gaelic footballers may have been
616 reluctant to discuss their own personal experiences. However, prior to the beginning of the focus
617 group, participants were reminded they were not required to disclose personal information from their
618 own mental health experiences following injury and were free to opt of the discussion where desired.
619 Participants were also reminded of the confidential nature of the focus groups. In addition,
620 participants were not currently injured, which may have limited responses. However, participants
621 were required to have a recent history of a moderate or severe injury and were assumed to be able to
622 report the barriers and facilitators they perceived to affect professional mental health help-seeking
623 from their own experience of injury.

624 **Conclusions**

625 Education is a key barrier and facilitator to professional mental health help-seeking. Mental
626 health literacy interventions that address the awareness of help-seeking services and increase players’
627 knowledge of mental health issues, while reducing stigma and improving attitudes to help-seeking,
628 may be beneficial in normalising the use and increasing the awareness of professional mental health
629 support services. By increasing education and knowledge, perceived barriers are reduced, and

630 proactive help-seeking behaviours underpinned by HBM and HSM are supported. Interventions that
631 facilitate a greater awareness of help-seeking may aid the mental health of Gaelic footballers through
632 rehabilitation and allow for successful return to play, which is essential for overall team success.

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635 **Declaration of Interest Statement**

636 No potential conflicts of interest are reported by the authors.

637 **Data Availability Statement**

638 The data that support the findings of this study are available from the corresponding author upon
639 reasonable request.

640

641 **References**

642 Arnold, R. & Fletcher, D. (2012). A research synthesis and taxonomic classification of the
643 organizational stressors encountered by sport performers. *Journal of Sport & Exercise*
644 *Psychology, 34*(3), 397-429.

645 Arvinen-Barrow, M., Massey, W.V. & Hemmings, B. (2014). Role of sport medicine professionals in
646 addressing psychosocial aspects of sport-injury rehabilitation: Professional athletes' views.
647 *Journal of Athletic Training, 49*(6), 764–772.

648 Bapat, S., Jorm, A. & Lawrence, K. (2009). Evaluation of a mental health literacy training program for
649 junior sporting clubs. *Australasian Psychiatry, 17*(6), 475-479.

650 Barnard, J. D. (2016). Student-Athletes' perceptions of mental illness and attitudes toward help-seeking.
651 *Journal of College Student Psychotherapy, 30*(3), 161–175.

652 Barney, L.J., Griffiths, K.M., Jorm, A.F. & Christensen, H. (2006). Stigma about depression and its
653 impact on help-seeking intentions. *Australian & New Zealand Journal of Psychiatry, 40*(1), 51-
654 54.

655 Bauman, N.J. (2016). The stigma of mental health in athletes: are mental toughness and mental health
656 seen as contradictory in elite sport? *British Journal of Sports Medicine, 50*(3), 135-136.

- 657 Bekker, S., Bolling, C., Ahmed, O.H., Badenhorst, M., Carmichael, J., Fagher, K., Hägglund, M.,
658 Jacobsson, J., John, J.M., Litzy, K. & Mann, R.H. (2020). Athlete health protection: why
659 qualitative research matters. *Journal of Science and Medicine in Sport*, 23(10), 898-901.
- 660 Biddle, S.J., Markland, D., Gilbourne, D., Chatzisarantis, N.L. & Sparkes, A.C. (2001). Research
661 methods in sport and exercise psychology: Quantitative and qualitative issues. *Journal of Sports
662 Sciences*, 19(10), 777-809.
- 663 Bird, M.D., Chow, G.M. & Cooper, B.T. (2020). Student-athletes' mental health help-seeking
664 experiences: A mixed methodological approach. *Journal of College Student Psychotherapy*,
665 34(1), 59-77.
- 666 Bird, M.D., Simons, E.E. & Jackman, P.C. (2021). Mental Toughness, Sport-Related Well-Being, and
667 Mental Health Stigma Among National Collegiate Athletic Association Division I Student-
668 Athletes. *Journal of Clinical Sport Psychology*, 15(4), 306-322.
- 669 Bleiker, J., Morgan-Trimmer, S., Knapp, K. & Hopkins, S. (2019). Navigating the maze: Qualitative
670 research methodologies and their philosophical foundations. *Radiography*, 25(Supp.1), S4-S8.
- 671 Bloodworth, A. & McNamee, M. (2010). Clean Olympians? Doping and anti-doping: The views of
672 talented young British athletes. *International Journal of Drug Policy*, 21(4), 276-282.
- 673 Braun, V. & Clarke, V. (2021a). To saturate or not to saturate? Questioning data saturation as a useful
674 concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise
675 and Health*, 13(2), 201-216.
- 676 Braun, V. & Clarke, V. (2021b). One size fits all? What counts as quality practice in (reflexive) thematic
677 analysis?. *Qualitative Research in Psychology*, 18(3), pp.328-352.
- 678 Braun, V. & Clarke, V. (2013). *Successful Qualitative Research: a Practical Guide for Beginners*. SAGE
679 Publications.
- 680 Breslin, G., Haughey, T., O'Brien, W., Caulfield, L., Robertson, A. & Lawlor, M. (2018). Increasing
681 athlete knowledge of mental health and intentions to seek help: The State of Mind Ireland (SOMI)
682 Pilot Program. *Journal of Clinical Sport Psychology*, 12(1), 39-56.
- 683 Breslin, G., Smith, A., Donohue, B., Donnelly, P., Shannon, S., Haughey, T.J., Vella, S.A., Swann, C.,
684 Cotterill, S., Macintyre, T. & Rogers, T. (2019). International consensus statement on the

- 685 psychosocial and policy-related approaches to mental health awareness programmes in sport.
686 *BMJ Open Sport & Exercise Medicine*, 5(e000585), 1-7.
- 687 Browne, A.L. (2016). Can people talk together about their practices? Focus groups, humour and the
688 sensitive dynamics of everyday life. *Area*, 48(2), 198-205.
- 689 Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N., Morgan, C.,
690 Rüschi, N., Brown, J.S. & Thornicroft, G. (2015). What is the impact of mental health-related
691 stigma on help-seeking? A systematic review of quantitative and qualitative studies.
692 *Psychological Medicine*, 45(1), 11-27.
- 693 Corrigan, J., O'Keeffe, S. & O'Connor, S. (2023). Barriers and facilitators to injury prevention in ladies
694 Gaelic football: A qualitative study. *Physical Therapy in Sport*, 59, 151-161.
- 695 Cowan, D. & Taylor, I.M. (2016). 'I'm proud of what I achieved; I'm also ashamed of what I done': a
696 soccer coach's tale of sport, status, and criminal behaviour. *Qualitative Research in Sport,*
697 *Exercise and Health*, 8(5), 505-518.
- 698 Creswell, J. (2009). Research design: Qualitative, quantitative, and mixed methods approaches. SAGE
699 Publications.
- 700 Crowley, J., Jordan, J. & Falvey, E. (2011). A comparison of Gaelic football injuries in males and
701 females in primary care. *Irish Medical Journal*, 104(9), 268-270.
- 702 Crust, L. (2008). A review and conceptual re-examination of mental toughness: Implications for future
703 researchers. *Personality and Individual Differences*, 45(7), 576-583.
- 704 Deane, F.P., Ciarrochi, J., Wilson, C.J., Rickwood, D. & Anderson, S. (2001). Do high school students'
705 intentions predict actual help seeking from school counsellors. In *Eighth annual conference of*
706 *Suicide Prevention Australia*, Sydney, Australia.
- 707 Drew, B. & Matthews, J. (2019). The prevalence of depressive and anxiety symptoms in student-
708 athletes and the relationship with resilience and help-seeking behavior. *Journal of Clinical Sport*
709 *Psychology*, 13(3), 421-439.
- 710 Dunne, S., MacGabhann, L., Amering, M. & McGowan, P. (2018). "Making people aware and taking
711 the stigma away": Alleviating stigma and discrimination through dialogue. *Irish Journal of*
712 *Applied Social Studies*, 18(1), 15-28.

- 713 Gaelic Athletic Association. (2019). *GAA Injury Benefit Fund. Summary Document*. Available at:
714 <https://www.gaa.ie/api/pdfs/image/upload/gebojvigimhpptq7hjm4.pdf>
- 715 Gaelic Athletic Association. (2016). *About the GAA*. Available at: [https://www.gaa.ie/the-gaa/about-](https://www.gaa.ie/the-gaa/about-the-gaa/)
716 [the-gaa/](https://www.gaa.ie/the-gaa/about-the-gaa/)
- 717 Gaelic Players Association. (2021). *Player Welfare – Player Injury Support*. Available at:
718 <https://www.gaelicplayers.com/player-welfare/#player-injury-support>
- 719 Gorczynski, P., Gibson, K., Thelwell, R., Papathomas, A., Harwood, C., & Kinnafick, F. (2019). The
720 BASES expert statement on mental health literacy in elite sport. *The Sport and Exercise Scientist*,
721 *59*, 6–7.
- 722 Gouttebauge, V., Tol, J.L. & Kerkhoffs, G.M. (2016). Epidemiology of symptoms of common mental
723 disorders among elite Gaelic athletes: a prospective cohort study. *The Physician &*
724 *Sportsmedicine*, *44*(3), 283-289.
- 725 Gucciardi, D.F., Hanton, S. & Fleming, S. (2017). Are mental toughness and mental health
726 contradictory concepts in elite sport? A narrative review of theory and evidence. *Journal of*
727 *Science and Medicine in Sport*, *20*(3), 307-311.
- 728 Gulliver, A., Griffiths, K.M. & Christensen, H. (2012a). Barriers and facilitators to mental health help-
729 seeking for young elite athletes: a qualitative study. *BMC Psychiatry*, *12*(157), 1-14.
- 730 Gulliver, A., Griffiths, K.M., Christensen, H., Mackinnon, A., Calear, A.L., Parsons, A., Bennett, K.,
731 Batterham, P.J. & Stanimirovic, R. (2012b). Internet-based interventions to promote mental
732 health help-seeking in elite athletes: an exploratory randomized controlled trial. *Journal of*
733 *Medical Internet Research*, *14*(3), e69.
- 734 Henshaw, E.J. & Freedman-Doan, C.R. (2009). Conceptualizing mental health care utilization using
735 the health belief model. *Clinical Psychology: Science and Practice*, *16*(4), 420-439.
- 736 Horgan, A. & Sweeney, J. (2012). University students' online habits and their use of the Internet for
737 health information. *CIN: Computers, Informatics, Nursing*, *30*(8), 402-408.
- 738 Horgan, A. & Sweeney, J. (2010). Young students' use of the Internet for mental health information and
739 support. *Journal of Psychiatric & Mental Health Nursing*, *17*(2), 117-123.

- 740 Hughes, G., Panjawni, M., Tulcidas, P. & Byrom, N. (2018). *Student Mental Health: The role and*
741 *experiences of academics*. Student Minds.
- 742 Ipsos MRBI. (2016). *Healthy Ireland Survey 2016: Summary of Findings*. The Stationary Office.
743 Available at: <https://assets.gov.ie/16000/9e29f3fde1f048468485985093754bfd.pdf>
- 744 Jewett, R., Kerr, G., & Tamminen, K. (2019). University sport retirement and athlete mental health: A
745 narrative analysis. *Qualitative Research in Sport, Exercise and Health*, 11(3), 416-433.
- 746 Johnson, J.L., Adkins, D. and Chauvin, S. (2020). A review of the quality indicators of rigor in
747 qualitative research. *American Journal of Pharmaceutical Education*, 84(1), 138-146.
- 748 Johnston, L.H. & Carroll, D. (1998). The provision of social support to injured athletes: a qualitative
749 analysis. *Journal of Sport Rehabilitation*, 7(4), 267-284.
- 750 Kauer, S.D., Mangan, C. & Sancu, L. (2014). Do online mental health services improve help-seeking
751 for young people? A systematic review. *Journal of Medical Internet Research*, 16(3), e66.
- 752 Kelly, E., Banks, J., McGuinness, S. & Watson, D. (2018). *Playing Senior Inter-County Gaelic Games*
753 *Experiences, Realities and Consequences*. The Economic and Social Research Institute (ESRI).
754 Available at: <https://www.econstor.eu/bitstream/10419/197501/1/RS76.pdf>.
- 755 Kola-Palmer, S., Lewis, K., Rodriguez, A., & Kola-Palmer, D. (2020). Help-seeking for mental health
756 issues in professional rugby league players. *Frontiers in Psychology*, 11(570690), 1–9.
- 757 Kontos, A.P., Elbin, R.J., Newcomer Appaneal, R., Covassin, T., & Collins, M.W. (2013). A
758 comparison of coping responses among high school and college athletes with concussion,
759 orthopedic injuries, and healthy controls. *Research in Sports Medicine*, 21(4), 367–379.
- 760 Korstjens, I. & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4:
761 Trustworthiness and publishing. *European Journal of General Practice*, 24(1), 120-124.
- 762 Ladies Gaelic Football Association. (2018). *Injury Fund*. Available at:
763 <https://ladiesgaelic.ie/resources/injury-fund/>
- 764 Ladies Gaelic Football Association. (2011). *About us*. Available at: [https://ladiesgaelic.ie/the-](https://ladiesgaelic.ie/the-lgfa/about-us/)
765 [lgfa/about-us/](https://ladiesgaelic.ie/the-lgfa/about-us/)

- 766 Liddle, S.K., Deane, F.P., Batterham, M. & Vella, S.A. (2019). A Brief Sports-Based Mental Health
767 Literacy Program for Male Adolescents: A Cluster-Randomized Controlled Trial. *Journal of*
768 *Applied Sport Psychology*, 33(1), 20-44.
- 769 Lopez, R.L. & Levy, J.J. (2013). Student athletes' perceived barriers to and preferences for seeking
770 counseling. *Journal of College Counseling*, 16(1), 19-31.
- 771 Malterud, K., Siersma, V.D. & Guassora, A.D. (2016). Sample Size in Qualitative Interview Studies:
772 Guided by Information Power. *Qualitative Health Research*, 26(13), 1753-1760.
- 773 Mangan, S., Collins, K., Burns, C. & O'Neill, C. (2020). The positional technical and running
774 performance of sub-elite Gaelic football. *Science & Medicine in Football*, 4(3), 182-191.
- 775 Mangan, S., Ryan, M., Devenney, S., Shovlin, A., McGahan, J., Malone, S., O'Neill, C., Burns, C. and
776 Collins, K. (2017). The relationship between technical performance indicators and running
777 performance in elite Gaelic football. *International Journal of Performance Analysis in Sport*,
778 17(5), 706-720.
- 779 McGuigan, K., Hughes, M. & Martin, D. (2018). Performance indicators in club level Gaelic football.
780 *International Journal of Performance Analysis in Sport*, 18(5), 780-795.
- 781 McIntyre, M.C. (2005). A comparison of the physiological profiles of elite Gaelic footballers, hurlers,
782 and soccer players. *British Journal of Sports Medicine*, 39(7), 437-439.
- 783 Moesch, K., Kenttä, G., Kleinert, J., Quignon-Fleuret, C., Cecil, S. & Bertollo, M. (2018). FEPSAC
784 position statement: mental health disorders in elite athletes and models of service provision.
785 *Psychology of Sport & Exercise*, 38, 61-71.
- 786 Moore, M. (2017). Stepping outside of their comfort zone: Perceptions of seeking behavioral health
787 services amongst college athletes. *Journal of Issues in Intercollegiate Athletics*. Special Issue,
788 130-144.
- 789 Moreland, J.J., Coxe, K.A. & Yang, J. (2018). Collegiate athletes' mental health services utilization: A
790 systematic review of conceptualizations, operationalizations, facilitators, and barriers. *Journal of*
791 *Sport & Health Science*, 7(1), 58-69.
- 792 Moser, A. & Korstjens, I. (2018). Series: Practical guidance to qualitative research. Part 3: Sampling,
793 data collection and analysis. *European Journal of General Practice*, 24(1), 9-18.

- 794 Nagai, S. (2015). Predictors of help-seeking behavior: Distinction between help-seeking intentions and
795 help-seeking behavior. *Japanese Psychological Research*, 57(4), 313-322.
- 796 Nam, S.K., Choi, S.I., Lee, J.H., Lee, M.K., Kim, A.R. & Lee, S.M. (2013). Psychological factors in
797 college students' attitudes toward seeking professional psychological help: A meta-analysis.
798 *Professional Psychology: Research & Practice*, 44(1), 37-45.
- 799 O'Brien, B.C., Harris, I.B., Beckman, T.J., Reed, D.A. & Cook, D.A. (2014). Standards for reporting
800 qualitative research: a synthesis of recommendations. *Academic Medicine*, 89(9), 1245-1251.
- 801 O'Connor, S., Bruce, C., Teahan, C., McDermott, E. & Whyte, E. (2020). Injuries in Collegiate Ladies
802 Gaelic Footballers: A 2-Season Prospective Cohort Study. *Journal of Sport Rehabilitation*, 30(2),
803 261-266.
- 804 O'Connor, S., McCaffrey, N., Whyte, E.F. & Moran, K.A. (2017). Epidemiology of injury in male
805 collegiate Gaelic footballers in one season. *Scandinavian Journal of Medicine & Science in*
806 *Sports*, 27(10), 1136-1142.
- 807 O'Connor, S., McCaffrey, N., Whyte, E.F. & Moran, K.A. (2016). Epidemiology of injury in male
808 adolescent Gaelic games. *Journal of Science & Medicine in Sport*, 19(5), 384-388.
- 809 O'Keefe, S., Ní Chéilleachair, N., Campbell, M. & O'Connor, S. (2022). Barriers and Facilitators to
810 Mental Health Help-Seeking in Elite Gaelic Footballers Post-Injury: A Qualitative Study.
811 *Research Quarterly for Exercise and Sport*, 93(3), 488-503.
- 812 Pike, E.C. (2018). Mental illness stigma. In Atkinson, M. (Ed.). *Sport, Mental Illness, and Sociology*
813 (pp.9-22). Emerald Publishing Limited.
- 814 Potter, M. (2014). One Coach's X and O: Pay Attention, Give Permission. In Brown, G.T. (Ed.). *Mind,*
815 *Body and Sport. Understanding and Supporting Student-Athlete Mental Wellness* (pp.10-11).
816 National Collegiate Athletic Association.
- 817 Purcell, R., Pilkington, V., Carberry, S., Reid, D., Gwyther, K., Hall, K., Deacon, A., Manon, R.,
818 Walton, C.C. & Rice, S. (2022). An evidence-informed framework to promote mental wellbeing
819 in elite sport. *Frontiers in Psychology*, 13, 780359.
- 820 Rickwood, D. & Thomas, K. (2012). Conceptual measurement framework for help-seeking for mental
821 health problems. *Psychology Research & Behavior Management*. 5, 173-183.

- 822 Rickwood, D., Deane, F.P., Wilson, C.J. & Ciarrochi, J. (2005). Young people's help-seeking for
823 mental health problems. *Australian e-journal for the Advancement of Mental health*, 4(3), 218-
824 251.
- 825 Rosenstock, I.M. (1966). Why people use health services. *The Milbank Memorial Fund Quarterly*, 44(3,
826 part 2), 94-124.
- 827 Rosenstock, I.M., Strecher, V.J. & Becker, M.H. (1988). Social learning theory and the health belief
828 model. *Health Education and Behavior*. 15(2), 175-183.
- 829 Schinke, R. J., Stambulova, N. B., Si, G., & Moore, Z. (2018). International society of sport psychology
830 position stand: Athletes' mental health, performance, and development. *International Journal of*
831 *Sport & Exercise Psychology*, 16(6), 622–639.
- 832 Sheehan, R.B., Herring, M.P. & Campbell, M.J. (2018). Longitudinal relations of mental health and
833 motivation among elite student-athletes across a condensed season: Plausible influence of
834 academic and athletic schedule. *Psychology of Sport & Exercise*, 37, 146-152.
- 835 Sparkes, A.C. and Smith, B. (2014). *Qualitative research methods in sport, exercise and health: From*
836 *process to product*. Routledge.
- 837 Sport Ireland. (2014). *Irish Sports Council Looks Forward to Another Exciting Year Ahead*. Available
838 at: [https://www.sportireland.ie/news/irish-sports-council-looks-forward-to-another-exciting-](https://www.sportireland.ie/news/irish-sports-council-looks-forward-to-another-exciting-year-ahead)
839 [year-ahead](https://www.sportireland.ie/news/irish-sports-council-looks-forward-to-another-exciting-year-ahead)
- 840 Sport Ireland. (2019). *Irish Sports Monitor Mid-Year Report*. Ipsos MRBI. Available at:
841 <https://www.sportireland.ie/sites/default/files/2019-11/ism-2019-mid-year-report-final.pdf>
- 842 Steinfeldt, J. A., Foltz, B., Mungro, J., Speight, Q., Wong, Y. J. & Blumberg, J. (2011). Masculinity
843 socialization in sports: Influence of college football coaches. *Psychology of Men & Masculinity*,
844 12, 247-259.
- 845 Steinfeldt, J. A., Steinfeldt, M. C., England, B. & Speight, Q. (2009). Gender role conflict and stigma
846 toward help-seeking among college football players. *Psychology of Men & Masculinity*, 10, 260-
847 270.

- 848 Vogel, D.L., Wade, N.G., Wester, S.R., Larson, L. & Hackler, A.H. (2007). Seeking help from a mental
849 health professional: The influence of one's social network. *Journal of Clinical Psychology*, 63(3),
850 233-245.
- 851 Walker, N.A. & Bopp, T. (2011). The underrepresentation of women in the male-dominated sport
852 workplace: Perspectives of female coaches. *Journal of Workplace Rights*, 15(1), 47-64.
- 853 Watson, J.C. (2005). College student-athletes' attitudes toward help-seeking behavior and expectations
854 of counseling services. *Journal of College Student Development*. 46(4), 442-449.
- 855 Wilson, F., Caffrey, S., King, E., Casey, K. & Gissane, C. (2007). A 6-month prospective study of
856 injury in Gaelic football. *British Journal of Sports Medicine*, 41(5), 317-321.
- 857 Wood, S., Harrison, L.K. & Kucharska, J. (2017). Male professional footballers' experiences of mental
858 health difficulties and help-seeking. *The Physician & Sportsmedicine*, 45(2), 120-128.
- 859 Woods, D., Meade, M.M., Mahoney, C. & Breslin, G. (2015). Elite athlete receptivity to sport
860 psychology consulting in Ireland. *The Irish Journal of Psychology*, 36(1-4), 66-82.
- 861 Yang, J., Peek-Asa, C., Lowe, J.B., Heiden, E. & Foster, D.T. (2010). Social support patterns of
862 collegiate athletes before and after injury. *Journal of Athletic Training*, 45(4), 372-379.

Table 1 **Top ranked help-seeking barriers and facilitators among sub-elite Gaelic footballers**

	Male	Female
	N=14	N=13
	Score*	
Barriers		
Not knowing how or where to seek help	20	19
Worried about what others will think	24	14
Not knowing when to seek help	-	19
Facilitators		
Being aware of your feelings and finding it easy to express them	11	22
Coach has a positive attitude to seeking help	13	12
Teammates have a positive attitude to seeking help	-	16
All athletes are required to see a counsellor or psychologist as part of their preparation and training	17	-

Note: *Score calculated by reverse scoring ranked activity (i.e., 3=1, 2=2, 3=1) and summed across participants. Higher score indicates higher ranked barrier or facilitator.

Table 2 Core categories, themes and sub-themes identified during focus groups

Core categories	Themes	Sub-themes
	Barriers	
Lack of education	Poor awareness of services	Not knowing where to seek help Not knowing the benefits or importance of seeking help ¹ Not knowing what to expect in a professional consultation ¹ Not knowing how to seek help ²
	Not knowing about mental disorders and their symptoms	
Stigma	From teammates From coach and management	
Negative attitudes to seeking help	Feeling professional help is not necessary Feeling it is better to manage on your own ¹ Feeling embarrassed ²	
Accessibility issues	Cost of services	
Characteristics of professional help provider	Professional help-provider's lack of experience of sport or Gaelic football	
	Facilitators	
Attitudes, actions and opinions of others	Social support	From coach and management From teammates ² From family and friends ¹
	Normalizing help-seeking	
Education	Awareness of services	Knowing where to seek help Knowing what to expect in a professional consultation
	Understanding mental disorders and their symptoms	
	Awareness of others who have experienced mental health issues	
Accessibility	Financial support Convenience of access Access to online resources	

Note: ¹only discussed by male participants; ²only discussed by female participants

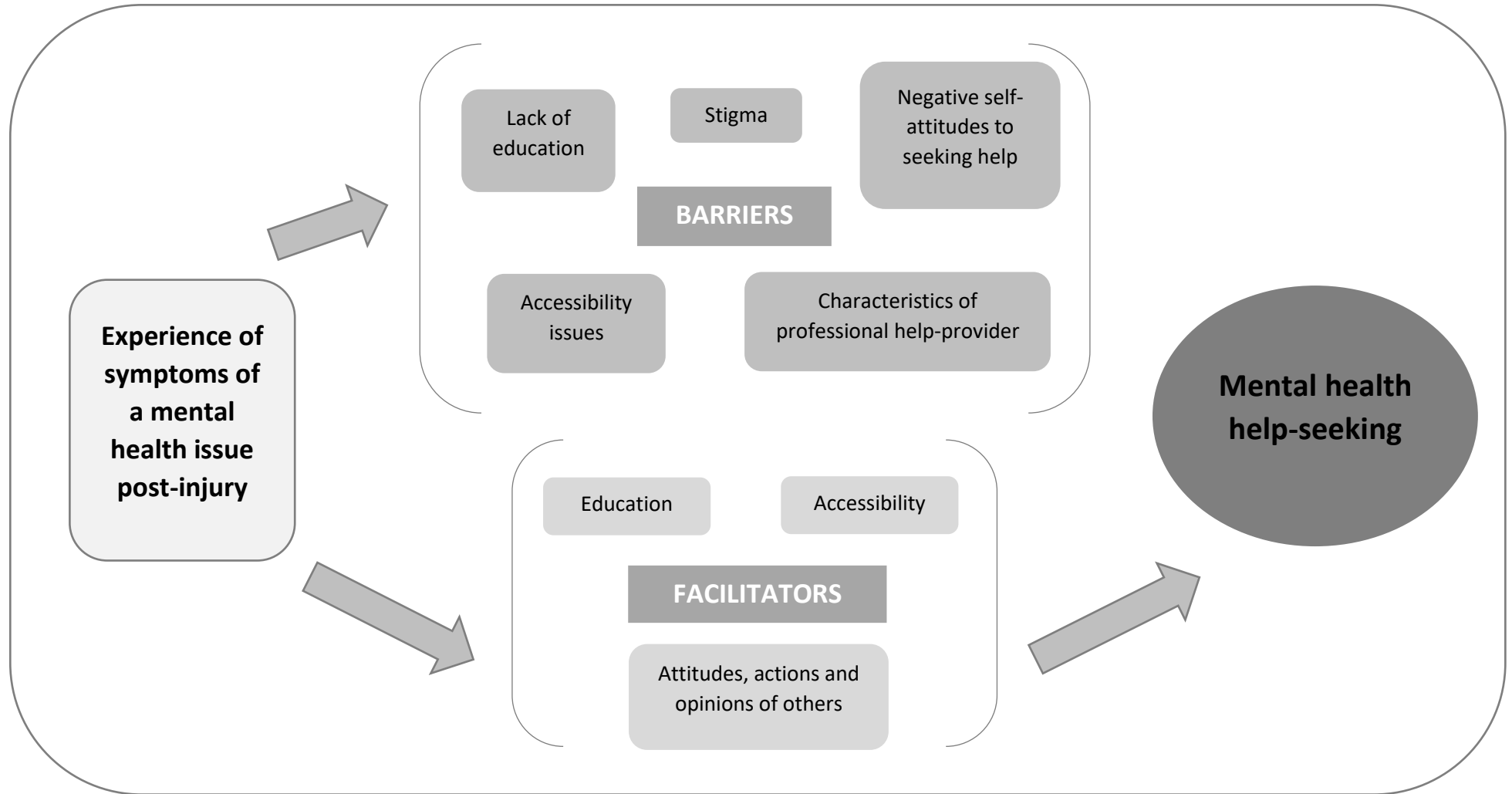


Figure 1 A schematic representation of factors inhibiting and facilitating mental health help-seeking post-injury as identified in focus groups

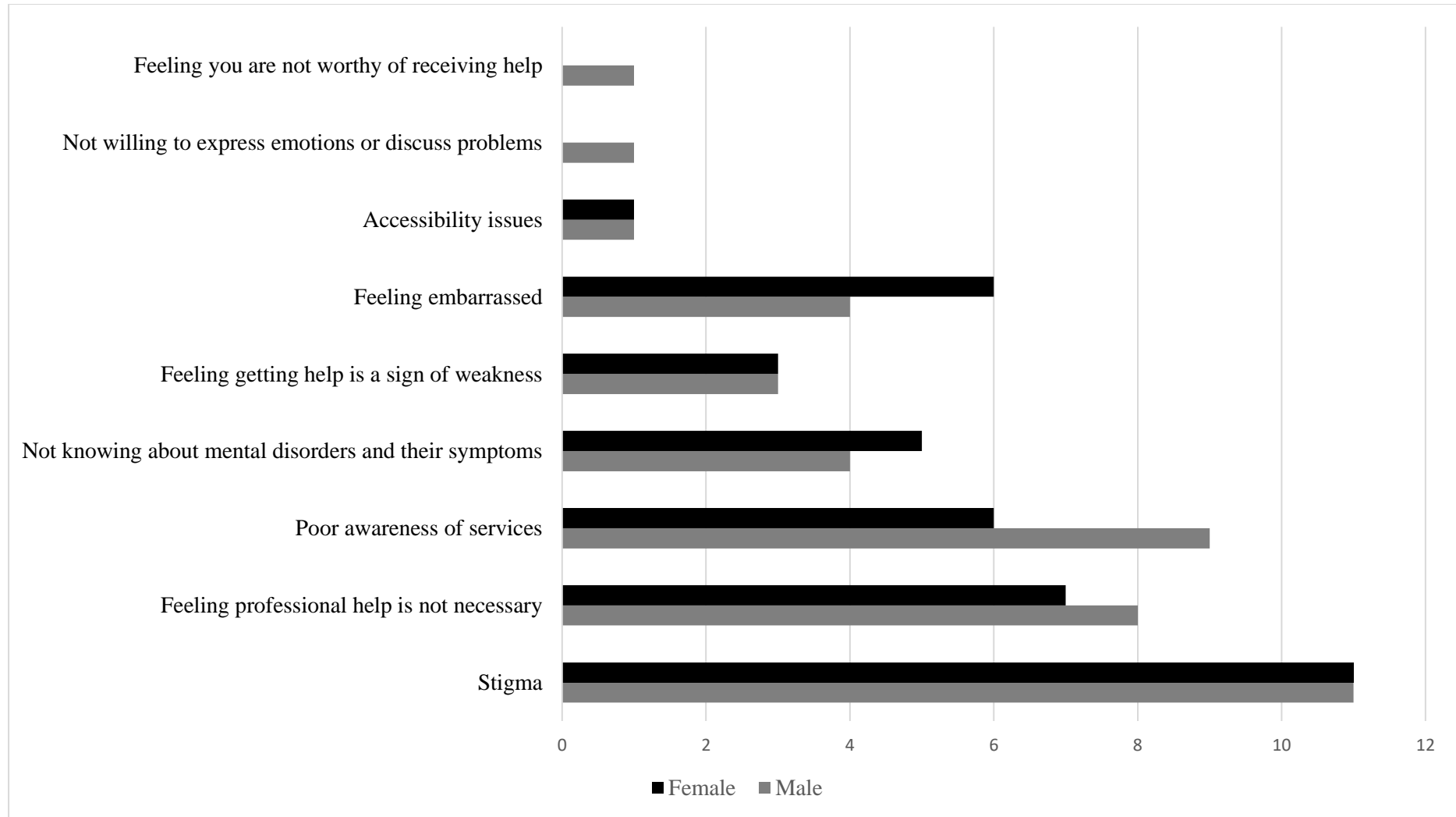


Figure 2 Barriers to help-seeking among sub-elite Gaelic footballers identified in the written task

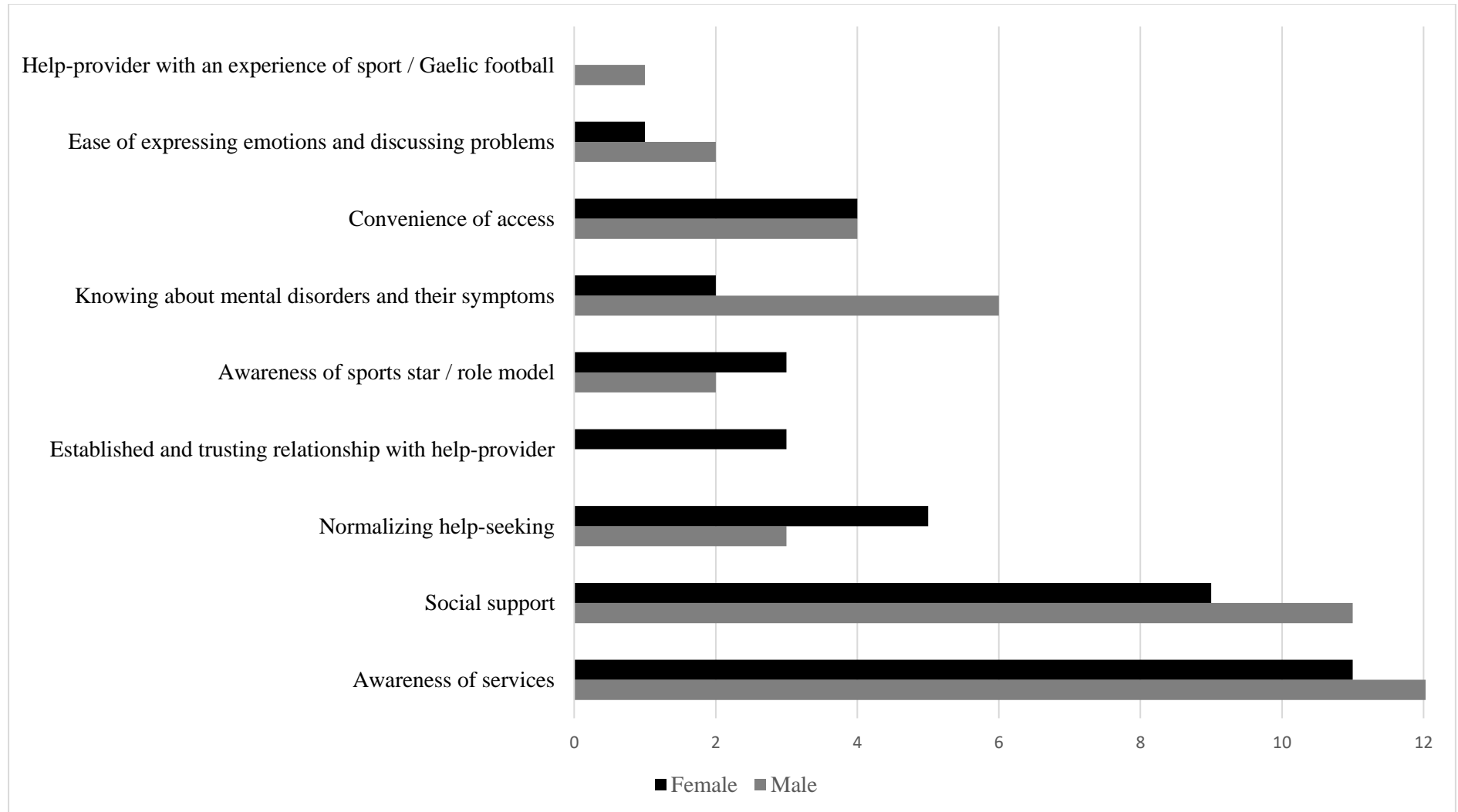


Figure 3 Facilitators to help-seeking among sub-elite Gaelic footballers identified in the written task

Supplementary Material

Supplementary File 1 Determination of Information Power

Qualitative research can utilise the concept of information power to ensure a sample size is adequate. Information power relates to the belief that the more relevant information that is represented with the data, the fewer participants that are required (Malterud et al., 2016).

The decision on information power in the current study was guided by five inter-related factors, proposed by Malterud et al. (2016), as outlined in the table below. Appraisal of information power ensued throughout the study, where sample size was considered after preliminary analysis of initial focus groups and continued until data collection was concluded.

Factors	Consideration	Decision and justification in the current study
Aim	Narrow or Broad	Narrow – the study aim was deemed to be narrow as it sought to identify the barriers and facilitators to <i>mental health</i> help-seeking, specifically in <i>sub-elite Gaelic footballers</i> that had a history of <i>moderate or severe injury</i> .
Specificity	Dense or Sparse	Sparse – although there was a specified target group (i.e., sub-elite Gaelic footballers), there was deemed to be variation of participant experiences (history of injury that varied from moderate to severe, which may have resulted in varying experiences of mental health issues and thus, varying perceptions of mental health help-seeking).
Theory	Applied or None	Applied – the study was underpinned by the Health Belief Model (HBM) and Help-Seeking Model (HSM).
Dialogue	Strong or Weak	Strong – the focus group moderator had significant experience of Gaelic football and background knowledge of barriers and facilitators to mental health help-seeking. She had also completed qualitative data collection previously and a pilot study specific to this study. This allowed for facilitation of the group discussion and interactive dialogue between participants. Examination of information power throughout the study, and particularly after preliminary analysis of focus groups, identified the depth of <i>meaningful</i> conversations which was evident in the comprehensive participant quotes that related specifically to the study aim.
Analysis	Case or Cross-Case	Cross-case – focus groups created transcripts of shared participant responses and perceptions. Analysis required consideration of the shared viewpoints and also, the independent perceptions of each participant.

Supplementary File 2 Instructions on appropriate focus group behaviour

Thank you for agreeing to participate in this focus group discussion. We are interested in the views and opinions of all participants and not of particular individuals. I am going to ask you some questions about your perception of barriers and facilitators to help-seeking when experiencing psychological distress post-injury. I hope these questions will simulate discussion amongst you. I will not be contributing to the discussion but I am here to moderate the session by keeping track of time and making sure all of the issues of interest are discussed. You can ask me to repeat a question if you need to, but apart from that, I will contribute as little as possible. I am also going to record the discussion, so please speak clearly. Try to voice your opinion as often as possible but not at the expense of interrupting each other.

(Breen, 2006)

Confidentiality

All participants are reminded that the focus group discussion will be recorded in audio and in video. Recordings will solely be used in the analysis of responses. Access to the recordings will be limited to the research staff and will be stored on an encrypted hard drive. Public presentation of any piece of the recordings will not take place.

Obviously an inherent issue with discussion as part of a group is that anything shared with the researcher is shared with the other people in the discussion also. However, participants will not be questioned individually on their personal experiences of psychological distress post-injury and will purely be asked to discuss their perceptions and opinions.

(Morgan, 1997)

Voluntary nature of the discussion

Participation in the focus group discussion is entirely voluntary and you may stop participating at any time. If you feel uncomfortable discussing any aspect of the discussion, feel free to opt out of discussing that topic.

Supplementary File 3 Focus Group Case Vignette and Definitions

Case Vignette

Toby is a starting senior Gaelic football player and top scorer of a Division 1 team. After jumping up to catch a ball during a challenge match, Toby landed awkwardly and suffered a serious ankle sprain on his dominant foot. After his initial evaluation, the doctors, as well as the head athletic therapist, informed Toby that he would likely be side-lined for at least 5-6 weeks but would not require surgical repair to his ankle. Since playing underage football, you have known Toby to be an outgoing, cheerful, and upbeat person. However, since hearing his prognosis, Toby appears discouraged, because he trained hard through winter to become season ready. For the first few weeks following his injury diagnosis, you notice that Toby is often 5-10 minutes late to rehab appointments, rarely engages in small talk and generally seems sad. He still completes all his exercises and stretches as instructed by the athletic therapist but is visibly frustrated with his rehabilitation timeline and lack of progress early on. You've also noticed that, even though he attends team trainings, he normally stands on the side-line and doesn't say much.

Adapted from Cormier and Zizzi (2015)

Definitions

Seeking help	Looking for help from a professional source, e.g. a doctor, counsellor or a psychologist	<i>Gulliver et al. (2012a)</i>
Psychological distress	A state of emotional suffering characterised by symptoms of depression (e.g. lost interest, sadness, hopelessness) and anxiety (restlessness, feeling tense)	<i>Mirowsky and Ross (2002)</i>
Barriers	Factors that can make it harder or stop you from getting help	<i>Gulliver et al. (2012a)</i>
Facilitators	Factors that can make it easier for you to seek help	<i>Gulliver et al. (2012a)</i>

Supplementary File 4 Barrier and Facilitator Written Tasks

Barrier Ranking Written Task

Please rank the top 3 barriers below by numbering them (1, 2, 3) in order of those you see as the most important in *stopping* an athlete from seeking help when experiencing psychological distress post-injury.

Barrier	
Not knowing about mental disorders or what the symptoms are	
Not knowing when to seek help	
Not knowing how or where to seek help	
Not knowing what to expect in a doctor's appointment or counselling session	
Gender	
Culture	
Religion	
Age group	
Not having enough time	
Cost of Services	
Location of Services	
Transportation	
How you feel about yourself seeking help	
Worried about what your coach will think	
Worried about what your teammates will think	
Worried about what your friends will think	
Worried about what your family will think	
Trusting your psychologist	
Worried about what others will think	
Other (please explain)	

Note: Barrier and facilitator ranking tasks were adapted from Gulliver et al. (2012)

Facilitator Ranking Written Task

Please rank the top 3 facilitators below by numbering them (1, 2, 3) in order of those you see as the most important that could make it *easier* to get help when experiencing psychological distress post-injury.

Facilitator	
Being aware of your feelings and finding it easy to express them	
Already knowing a health professional quite well (e.g., counsellor, doctor)	
Coach has a positive attitude to seeking help	
Teammates have a positive attitude to seeking help	
Friends have a positive attitude to seeking help	
Family have a positive attitude to seeking help	
Other people have a positive attitude to seeking help	
Other people's encouragement to seek help	
The staff (e.g., receptionist, doctor, counsellor) are friendly and approachable	
All athletes are required to see a counsellor or psychologist as part of their preparation and training	
Anonymous access to information and help (e.g., the internet)	
Information	
Other (please explain)	

Note: Barrier and facilitator ranking tasks were reverse scored, where 1= 3 points, 2= 2 points, and 3= 1 point, and summed, in line with procedures used by Gulliver et al. (2012).

Supplementary File 5 Thematic Analysis Process

Phase One: Familiarisation with the transcripts

Facilitating the focus groups and completing verbatim transcription of the recordings allowed initial familiarisation with the transcripts. This familiarisation process ensued across the period of data collection, where preliminary coding was completed to support appraisal of information power. At the point when data collection ceased, each transcript was independently reviewed again, and read and re-read to allow familiarisation collectively across all transcripts.

Phase Two: Systematic coding of the dataset

Coding of the transcripts adopted both a deductive and inductive approach. Help-seeking can be conceptualised according to the Health Belief Model (HBM) and in the current study, HBM and pre-determined barriers and facilitators to help-seeking were utilised in the deductive coding of the transcripts (theory-driven and evidence-driven deductive coding). Inductive coding was also completed, where perceptions of participants unique to the cohort (sub-elite players) and the sport under investigation (Gaelic football) were coded (data-driven inductive coding).

Phase Three: Identification of initial themes

A process of review followed where all codes (i.e., individual units of data that were coded as one perception or viewpoint) were interpreted for commonalities and aggregated meanings. This ensued across each transcript, where initial themes were considered by merging codes with shared meanings and making redundant multiple iterations of common viewpoints. Data that aligned within these initial themes were collated, and further reviewed and refined to align with or become separate themes.

Phase Four: Development, and review of provisional themes

At this stage, it became evident there were some clear factors that were perceived as both barriers and facilitators (i.e., lack of education was viewed as a barrier but participants acknowledged improving education would be a facilitator to mental health help-seeking). Therefore, initial themes identified became core categories and were considered the central barriers and facilitators perceived by participants. The intricacies of each core category were subsequently represented with the themes and sub-themes.

Therefore, to ensure these intricacies and the detail beyond the core categories was captured, analysis reverted to step three, where identification of initial themes was repeated, supplementing the processes initially completed at step three. This was to ensure the nuance of participant perceptions was not lost within the core category, but now was represented efficiently within the themes and sub-themes. The development and review of these provisional themes was a timely process, where the coded data was reviewed for their relevance to the themes and sub-themes, and the themes and sub-themes were reviewed in relation to the coded data.

Phase Five: Finalisation of core categories, themes and sub-themes

Defining the core categories, themes and sub-themes involved detailed interpretation of ‘the story’, as told by participants, in relation to the core aim of the research, to examine sub-elite Gaelic footballers perceived barriers and facilitators to mental health help-seeking. The fit of the sub-themes within each theme and each theme within its core category was determined and solidified. The final process of this stage was refining and finalising the name of each core category, theme and sub-theme. These were

ensured to be clearly representative of participants' viewpoints, as evident in the detail of the transcripts. Phase five adopted a collaborative approach, where the research team weighed in and provided their opinions and perceptions of the core categories, themes and sub-themes, and how the coded data aligned within each of these components.

Phase Six: Reporting of the final thematic analysis results

The final report of barriers and facilitators was prepared. This was an evolving process, where an initial draft was collated, but revisions from the primary author and additionally from the research team led to the final version evident in the current form of the manuscript.

**Supplementary Material 6 Standards for the Reporting Qualitative Research
(SRQR) Checklist (O'Brien et al., 2014)**

Topic	Page No(s).
Title and Abstract	
Title - Concise description of the nature and topic of the study Identifying the study as qualitative or indicating the approach (e.g., ethnography, grounded theory) or data collection methods (e.g., interview, focus group) is recommended	1
Abstract - Summary of key elements of the study using the abstract format of the intended publication; typically includes background, purpose, methods, results, and conclusions	1
Introduction	
Problem formulation - Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement	2-4
Purpose or research question - Purpose of the study and specific objectives or questions	4
Methods	
Qualitative approach and research paradigm - Qualitative approach (e.g., ethnography, grounded theory, case study, phenomenology, narrative research) and guiding theory if appropriate; identifying the research paradigm (e.g., postpositivist, constructivist/ interpretivist) is also recommended; rationale**	5
Researcher characteristics and reflexivity - Researchers' characteristics that may influence the research, including personal attributes, qualifications/experience, relationship with participants, assumptions, and/or presuppositions; potential or actual interaction between researchers' characteristics and the research questions, approach, methods, results, and/or transferability	5-6
Context - Setting/site and salient contextual factors; rationale**	5-6
Sampling strategy – How and why research participants, documents, or events were selected; criteria for deciding when no further sampling was necessary (e.g., sampling saturation); rationale**	5 Supplementary File 1
Ethical issues pertaining to human subjects - Documentation of approval by an appropriate ethics review board and participant consent, or explanation for lack thereof; other confidentiality and data security issues	5
Data collection methods - Types of data collected; details of data collection procedures including (as appropriate) start and stop dates of data collection and analysis, iterative process, triangulation of sources/methods, and modification of procedures in response to evolving study findings; rationale**	5-6
Data collection instruments and technologies - Description of instruments (e.g., interview guides, questionnaires) and devices (e.g., audio recorders) used for data collection; if/how the instrument(s) changed over the course of the study	6 Supplementary File 2, File 3 and File 4
Units of study - Number and relevant characteristics of participants, documents, or events included in the study; level of participation (could be reported in results)	5-6
Data processing - Methods for processing data prior to and during analysis, including transcription, data entry, data management and security, verification of data integrity, data coding, and anonymization/de-identification of excerpts	5-7 Supplementary File 5

Data analysis - Process by which inferences, themes, etc., were identified and developed, including the researchers involved in data analysis; usually references a specific paradigm or approach; rationale**	6-7 Supplementary File 5
Techniques to enhance trustworthiness - Techniques to enhance trustworthiness and credibility of data analysis (e.g., member checking, audit trail, triangulation); rationale**	7
Results/Findings	
Synthesis and interpretation – Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory	7-17 Table 1 Table 2 Figure 1 Figure 2 Figure 3
Links to empirical data – Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings	7-17
Discussion	
Integration with prior work, implications, transferability, and contribution(s) to the field - Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/generalizability; identification of unique contribution(s) to scholarship in a discipline or field	17-23
Limitations – Trustworthiness and limitations of findings	23
Other	
Conflicts of interest – Potential sources of influence or perceived influence on study conduct and conclusions; how these were managed	23-24
Funding – Sources of funding and other support; role of funders in data collection, interpretation, and reporting	Reported in manuscript with author details

*The authors created the SRQR by searching the literature to identify guidelines, reporting standards, and critical appraisal criteria for qualitative research; reviewing the reference lists of retrieved sources; and contacting experts to gain feedback. The SRQR aims to improve the transparency of all aspects of qualitative research by providing clear standards for reporting qualitative research.

**The rationale should briefly discuss the justification for choosing that theory, approach, method, or technique rather than other options available, the assumptions and limitations implicit in those choices, and how those choices influence study conclusions and transferability. As appropriate, the rationale for several items might be discussed together.