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**Supporting Young Elite Athletes with Mental Health Issues: Coaches' Experience and
their Perceived Role**

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Running head: Coaches' supporting young athletes with MHIs

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Abstract

This study explored talent development coaches’ experiences of athletes having faced mental health issues. A second objective was to allow participants to share their opinion on how sport environments could improve the support offered to coaches and athletes encountering mental health issues. A thematic analysis was performed on eleven verbatim transcribed interviews realised with UK-based talent development coaches. While monitoring and supporting their athletes’ performance and wellbeing was viewed as day-to-day practice, dealing with mental health issues was, however, not considered as part of their role for a variety of reasons. Findings also suggest that coaches need more a suitable and context-specific knowledge and tools to appropriately respond and support their athletes. Generating a better understanding of coaches’ perceived role, knowledge, and needs to adequately support their athletes suffering from mental health issues is crucial for the design of sport-specific interventions and for the athletes themselves.

Keywords: thematic analysis, talent development, sport, mental health, coaching.

43 **Supporting Young Elite Athletes with Mental Health Issues: Coaches' Experience and**
44 **their Perceived Role**

45 A growing body of evidence illustrates that athletes, as with the general population,
46 are subject to mental health issues (MHIs; Gouttebarga et al., 2018a; Rice et al., 2016;
47 Roberts, Faull, & Tod, 2016; Schaal et al., 2011). MHIs should not be conceived as merely
48 the presence of psychopathology in the same way that mental health should not be defined as
49 simply the absence of psychopathology (Henriksen et al., 2019; Keyes, 2005); this
50 understanding is important as subclinical levels of mental disorders can negatively impact
51 one's functioning and performance (Gouttebarga et al., 2018b; Gulliver, Griffiths, &
52 Christensen, 2012; Schinke, Stambulova, Si, & Moore, 2017). Reflecting this, in the present
53 paper, the term "MHIs" refers to a mental disorder and/or symptoms of psychological distress
54 interfering with an individual's psychological state and usual activities, and is defined as:

55 Signs and symptoms that impact how a person thinks, feels, communicates, or
56 behaves. Some common symptoms of mental health issues include changes in a
57 person's mood, changes in how a person interacts with others, and changes in how a
58 person deals with daily stressors. A person with a mental health issue may find it
59 difficult to complete tasks that are part of daily life (Livingston, Tugwell, Korf-Uzan,
60 Cianfrone, & Coniglio, 2013, p. 967).

61 Rather than the traditional focus on the prevalence of MHIs (Gouttebarga et al., 2018a;
62 Gouttebarga, Kerkhoffs, & Lambert, 2016; Wolanin, Gross, & Hong, 2015), recent research
63 has started to focus on the experience of athletes with MHIs (cf. Doherty, Hannigan, &
64 Campbell, 2016; Newman, Howells, & Fletcher, 2016). Much of this research has focused on
65 the experience of the athletes themselves without paying the same attention to the perspective
66 of key stakeholders. Given the nature and importance of relationships in elite sport

67 (Ringland, 2016), exploring mental health from the coach's perspective should provide
68 important insights into the athlete's experience.

69 As a parallel issue, while interest in (elite) athletes' mental health and its impact on
70 performance and wellbeing has rapidly grown (Rice et al., 2016; Schaal et al., 2011), less
71 attention has been paid to young and developing athletes (Hill, MacNamara, Collins, &
72 Rodgers, 2016). Yet, young elite athletes involved in Talent Development (TD) environments
73 (e.g., regional/national sport academies, national junior programmes) can train up to 15-20
74 hours a week and compete early on in national and international youth competitions (Sabato,
75 Walch, & Caine, 2016). Like elite athletes, these young athletes commit their time and
76 energy to competing at the highest level in their chosen sport and experience some success at
77 that standard in their age category (ranging from under-13 to under-21; Sabato et al., 2016).
78 The need to investigate MHIs in young elite athletes is particularly important since
79 adolescence and young adulthood are known to be critical periods when it comes to the
80 development and, perhaps even, prevention of MHIs (Kessler et al., 2005; MacNamara &
81 Collins, 2015). Due to the significance of the athlete-coach relationship (Jowett & Cockerill,
82 2003) and the supportive role coaches can play in a young athlete's life (Gulliver et al., 2012;
83 Mazzer & Rickwood, 2015a), examining TD coaches' experience of working with young
84 elite athletes facing MHIs is important, from both a research and applied perspective.

85 **The Contextual Backdrop**

86 Successful elite athletes (see Swann, Moran, & Piggott, 2015) have to deal with both
87 the stressors inherent to human life and the stressors and demands associated with their high-
88 pressured sporting life and career (MacNamara & Collins, 2015; Schaal et al., 2011). Given
89 the demands placed on athletes from an early age, young, developing athletes are also subject
90 to a tremendous number of stressors as they progress on the pathway to elite status. In
91 addition to the stressors that are characteristic of childhood (e.g., starting school, period of

92 growth and development, family changes; Mental Health Foundation, 2016), adolescence
93 (e.g., increased academic workload, changes in friendship groups, puberty, exam pressures;
94 Mental Health Foundation, 2016), and young adulthood (e.g., transition to University or work;
95 Mental Health Foundation, 2016), young elite athletes also face sport specific stressors and
96 pressures.

97 The timing of the TD journey is, therefore, salient. Childhood and adolescence are at-
98 risk periods for the first onset of MHIs (Kessler et al., 2005; Mazzer & Rickwood, 2009), with
99 about 10% of children (aged 5 to 16) in the U.K. experiencing MHIs (e.g., emotional
100 disorders, anxiety disorders, conduct disorders, and attention-deficit/hyperactivity disorder;
101 Green, McGinnity, Meltzer, Ford, & Goodman, 2005; Kessler et al., 2005). The prevalence
102 rate of MHIs is thought to increase during the adolescence (Green et al., 2005). 25% of
103 young adults aged between 16 to 34 suffer from symptoms and/or disorders such as
104 depression, anxiety, panic disorder, substance abuse, or eating disorders (Gulliver et al., 2012;
105 Gulliver, Griffiths, Mackinnon, Batterham, & Stanimirovic, 2015) - an age group that also
106 corresponds to the peak competitive years for elite performers (Rice et al., 2016). This is
107 even more important as MHIs in young people can have long-term effects which tend to carry
108 on in later life (Mazzer & Rickwood, 2009; Patel, Flisher, Hetrick, & McGorry, 2007).
109 Young ~~developing~~ elite performers may, therefore, be an at-risk cohort in relation to the onset
110 of MHIs given their age and the additional sport-related stressors they experience (e.g.,
111 relocation, performance issues and injury; Gulliver et al., 2015; Rice et al., 2016). However,
112 if MHIs can be caused or worsened by high-level sport participation (Reardon & Factor,
113 2010; Roberts et al., 2016), it has also to be noticed that, in other cases, MHIs may have
114 “nothing to do” with an athlete’s sport participation whose athletic journey may continue
115 unimpeded (Reardon & Factor, 2010, p. 963). Likewise, for some athletes, sport participation
116 is used a means to cope with pre-existing stressors or condition(s) (e.g., ADHD; Klinkowski,

117 Korte, Pfeiffer, Lehmkuhl, & Salbach-Andrae, 2008; Newman et al., 2016; Reardon & Factor,
118 2010). Nevertheless, when negatively affecting young people's overall wellbeing and
119 personal development, MHIs may also lead to a derailment from the TD pathway (Hill,
120 MacNamara, & Collins, 2015). Yet, despite the impact of MHIs on athletes' performance and
121 quality of life, young athletes are often reluctant to seek help (Gulliver et al., 2012). Young
122 athletes have, for example, been shown to have a relatively poor knowledge about mental
123 health and mental health services (Gulliver et al., 2012). The competitive nature of TD
124 environments has also been shown to exacerbate the social stigma associated with MHIs (e.g.,
125 "weak not sick"; Jorm & Wright, 2008) and, as a consequence, athletes are often unwilling to
126 reveal any sign of vulnerability to others, especially coaches, teammates and competitors
127 (Gulliver et al., 2012; Mazzer & Rickwood, 2009; Schaal et al., 2011).

128 Notably, when young athletes do seek help, they tend to solicit support and advice
129 from people they trust and are familiar and comfortable with such as coaches (Ferguson,
130 Swann, Liddle, & Vella, 2018; Gulliver et al., 2012; Jowett & Cockerill, 2003; Mazzer &
131 Rickwood, 2009, 2015a). Indeed, in addition to their coaching role (e.g., training and
132 developing athletes' potential, instructing in relevant skills and providing encouragement), the
133 importance of the varied other roles of the coach, such as confidantes, role models and/or
134 mentors for their athletes (Ferguson et al., 2018; Jowett & Cockerill, 2003; Mazzer &
135 Rickwood, 2015a), is well supported in the literature. This presents a potential conundrum;
136 although coaches might not be the most qualified or suitable individuals to deal with MHIs
137 (Roberts et al., 2016), they have a role to play in facilitating the early detection of MHIs and
138 fostering subsequent help-seeking behaviours (Ferguson et al., 2018; Gulliver et al., 2012;
139 Mazzer & Rickwood, 2015a). Due to their regular contacts with athletes over a prolonged
140 period of time, coaches seem well placed to notice any behavioural change(s) that may act as
141 warning sign(s) or symptom(s) of a MHI (Hill et al., 2015; Mazzer & Rickwood, 2015a;

142 Sebbens, Hassmén, Crisp, & Wensley, 2016). Given that early detection and intervention has
143 been shown to lead to a better chance of recovery (Kamm, 2008), coaches seem well
144 positioned to enable the early identification of MHIs (Ferguson et al., 2018; Hill et al., 2015;
145 Hill et al., 2016; Mazzer & Rickwood, 2015a), support their athletes' mental health needs
146 (Sebbens et al., 2016), encourage help-seeking behaviours (Gulliver et al., 2012), and refer
147 them to a mental health professional (if necessary). However, given the specificities of high-
148 performing environments and given that different sports are associated with different risks of
149 MHIs (Reardon et al., 2019; Rice et al., 2016; Schaal et al., 2011), it would be preferable that
150 such mental health professionals were knowledgeable in performance environments and in
151 that particular sport (Hill et al., 2015; Hill et al., 2016). Furthermore, despite their desire to
152 help and support their athletes' mental health, coaches must also recognise the boundaries
153 within which they (should) operate. As such, it is important that coaches acquire sufficient
154 knowledge about mental health and MHIs to be effective in this role (Ferguson et al., 2018;
155 Mazzer & Rickwood, 2015a). Relevant knowledge about MHIs can aid the recognition,
156 management or prevention of MHIs (Lauber, Nordt, Falcato, & Rössler, 2003). Therefore, the
157 ability to recognise early signs of MHIs or specific mental health disorders, and understanding
158 where to get further information and access professional help and treatment is an important
159 consideration for coaches (Lauber et al., 2003).

160 Reflecting these issues, the main purpose of this study was to investigate TD coaches'
161 experience of working with young elite athletes suffering from MHIs. We were also
162 interested in understanding the needs of TD coaches and TD environments in order to best
163 support TD coaches and their young performers. This in-depth investigation of coaches'
164 experiences and needs regarding MHIs should further inform the design of future
165 interventions and guidelines for health and sport professionals working in TD environments.

166

167

Method

168 **Philosophical Orientation and Design**

169 Given the aims of this study, a qualitative methodology was deemed the most
170 appropriate approach as the objective was to better understand a phenomenon such as the
171 human condition in different contexts and situations (Bengtsson, 2016). At the same time, we
172 wanted to enable participants to freely share their experiences (Jones, Brown, & Holloway,
173 2013). For this study, data were treated inductively through a thematic content analysis such
174 that the themes produced were closely linked to the data set (Braun & Clarke, 2006). Patterns
175 of data were defined, examined and reported without these being embedded within any
176 established theoretical framework. Thematic analysis can be a realist or a constructionist
177 method (Braun & Clarke, 2006). For the present study, a realist approach focusing on
178 participants' experience, meaning and reality was chosen (Braun & Clarke, 2006). Whilst this
179 approach is realist and inductive, the themes were generated at a semantic level. Finally the
180 data analysis was driven by the data and not by the interview guide nor the researchers'
181 theoretical interest (Braun & Clarke, 2006).

182 **Participants**

183 Through a network of personal and professional contacts, 11 coaches (two females and
184 nine males; Mean age = 42.55; SD = 11.13; max= 62 years, min= 30 years) working in TD
185 environments were recruited to take part in this study. All participants were English speakers,
186 were coaching young athletes involved in TD environments and competing in an individual or
187 team sport (e.g., Football, Rugby, Hockey, Judo, Swimming, Athletics) within the U.K., and
188 were working or have worked in high-level TD environments for at least four years (Mean
189 working experience = 16.36; SD = 9.33; max= 30 years, min= 4 years). Most of the coaches
190 in the present sample had experience of working with various age groups (from under 8 years
191 old to 21+) during their coaching career. Finally, all had, at some point during their career,

192 encountered athletes experiencing MHIs. Information which might enable participants'
193 identification is omitted or changed in order to ensure confidentiality to the participants and
194 their athletes.

195 **Procedure**

196 Following ethical approval from the authors' university ethics committee, prospective
197 participants received an invitation email that included an information sheet explaining the
198 purpose of this project and inviting them to take part in the present study. Participants
199 meeting the inclusion criteria and expressing an interest in taking part in this study were
200 invited to contact the first author. Individual interviews were then organised at a convenient
201 time and location. Prior to the beginning of each interview, participants were reminded of the
202 aim of the study, that their participation was entirely voluntary, and all signed a consent form.
203 Interviews lasted between 54 and 134 minutes (Mean 93.36; SD = 27.54), were conducted
204 face-to-face, were recorded and transcribed verbatim.

205 **Interview Guide.** A semi-structured interview guide was used with all participants as
206 a means to ensure consistency between the interviews. This interview guide was specifically
207 created for the purpose of this study. The researchers used this guide to lead the interview
208 and give the opportunity to the participants to share their experiences without restrictions
209 (Jones et al., 2013). The interview guide contained questions enabling us to gain more insight
210 into coaches' experience of coaching young elite athletes with MHIs. The interview started
211 by inquiring on the participants' background in their sport. Following this introductory phase,
212 a series of open-ended questions explored coaches' experience of MHIs in young elite
213 athletes. These questions included:

- 214 1. Based on your experience, can you describe what kind of mental health issues
- 215 athletes you coached have suffered from?
- 216 2. How did you learn about those issues?

217 3. What have you done in each of those situations?

218 4. What have you learned from those experiences?

219 Probes and prompts were used to help participants to clarify and/or elaborate on their answers

220 (Jones et al., 2013).

221 **Pilot study.** Interviews were piloted with three participants (three males; Mean age =

222 39; SD = 9.54) matching the inclusion criteria. After the interview, these participants gave a

223 feedback on the structure and content of the interview. Following their comments, no

224 adjustment was deemed necessary to the interview guideline.

225 **Data Analysis**

226 Transcripts were analysed inductively by the first author through a thematic content

227 analysis using Braun and Clark's (2006) step-by-step guide. This procedure allows the

228 researchers to define, examine, and report patterns of data. To enable familiarization with the

229 raw data, multiple active readings of each transcript were completed before starting the

230 analysis (Braun & Clarke, 2006; Jones et al., 2013). Coding was performed by use of a

231 qualitative data analysis software (Nvivo 11; QSR International Pty Ltd., 2015). Initial codes

232 were generated from the raw data and organised in meaningful units (Braun & Clarke, 2006).

233 Initial codes and sub-codes sharing a similar meaning were then brought together to generate

234 common themes in relation to the phenomenon studied. Themes were then reviewed and

235 refined into broader categories. This procedure was repeated until all meaningful units of raw

236 data were ordered into the existing codes (Braun & Clarke, 2006). Ensuing from this

237 analysis, data were finally organised into higher order themes. Examples of codes and themes

238 will be reported in the results section by means of participants' quotes. To respect

239 participants' confidentiality, no information enabling their identification will be reported and

240 numbers will be used in the result section when mentioning participants' quotes.

241 **Trustworthiness.** To assure the credibility and trustworthiness of the data, two
242 validation methods, peer-debriefing and member-reflection, were employed (Jones et al.,
243 2013; Smith & McGannon, 2017). After the analysis was conducted by the first author, the
244 data analysis and its ensuing codes and themes were individually reviewed by the second
245 author who had previous experience in qualitative methods. The first and second authors then
246 engaged in an open discussion about the development of the codes and themes, as well as the
247 interpretation that came out of it. The second author challenged the first one until a consensus
248 between the two was found while authors 3 and 4 acted as critical friends. This peer
249 debriefing process enabled all the researchers involved in the study to establish and then
250 critically share an understanding of the codes and themes generated (Jones et al., 2013).
251 Occurring throughout every stages of the present research, peer-debriefing process helped
252 guide the analysis and interpretation of the data (Jones et al., 2013).

253 For member reflection (Smith & McGannon, 2017), the themes obtained at the end of
254 the analysis stage were sent back, along with a brief description, to each participant who then
255 had the opportunity to reflect and comment on the researchers' interpretation of the findings
256 and themes generated from their transcripts. Seven participants out of eleven responded and
257 shared their feedback. While they all agree that the findings accurately represented their
258 views, a few offered some enriching reflections. Those reflections included, for example, the
259 importance of the club/academy policy regarding athletes' wellbeing, the impact of athletes'
260 age in regard to their understanding of what was happening to them, coaches' needs of
261 education, the need to have a multi-disciplinary approach to support athletes, and the
262 importance of good and open communication between all the protagonists (e.g., coaches,
263 players, parents, etc.). Once member-reflection and validation were completed, discussions
264 between the research team continued until a final agreement on hierarchical structure and
265 themes was reached (Jones et al., 2013).

266

Results

267 The purpose of this study was to examine TD coaches' experience of working with
268 young elite athletes suffering from MHIs. Whilst participants in the present sample have
269 worked, throughout their coaching career, with young athletes aged from 8 years old to 21+,
270 at the moment of this study, Coaches 2, 3, 4 were predominantly working with athletes under
271 16 years old, whereas Coaches 1, 5, 6, 7, 8, 9, 10 were coaching athletes from 16 years old.
272 Coach 11 was the only one coaching athletes from 8 years old to 21 years old. Over the years,
273 participants had worked with performers facing a wide range of MHIs (e.g., from subclinical
274 to clinical levels); these ranged from "issues" perceived as distressing (e.g., bullying, self-
275 confidence issues, anxiety, body dissatisfaction and disappointment) to clinically diagnosed
276 disorders (e.g., depression, eating disorder, OCD, ADHD, psychotic episode). However, and
277 given the amount of data generated from the participants' interviews, the following section
278 will focus on three main higher themes identified in relation to the cases of MHIs reported;
279 namely, coaches' perceived role when confronted with young elite athletes suffering from
280 MHIs regardless of their severity, coaches' knowledge about MHIs, and the areas for
281 improvements identified in order to improve the support offered to those athletes and their
282 coaches in regard to MHIs. A summary of the themes is presented in Table 1.

283 **TD Coaches' Perceived Role**

284 **Monitoring and Supporting Athletes' Performance and Overall Wellbeing.** The
285 role of the TD coach is diverse with monitoring and supporting athletes' performance and
286 wellbeing are being a big part of their everyday job. As explained by Coach 4:

287 Monitoring and supporting young players is a massive part of the job. We are in the
288 best position to get a picture of how the child is doing and to notice any changes in
289 them. Particularly, when things are not going so well. There may be a number of

290 reasons as to why that is the case and it is important that this information is shared
291 amongst staff.

292 ***Gathering and Sharing Information.*** Monitoring their athletes over time allows coaches to
293 get a picture of what is happening for their athletes, to monitor their progress and to notice
294 any changes. When it comes to athletes' mental health, coaches can sometimes-learn about
295 any potential problem via the athletes themselves – although this is not the most common
296 route – or via a third party such as an athlete's teammates, their parents or another member of
297 staff. The latter reportedly occurred especially when coaches have the chance to work within
298 an interdisciplinary team (e.g., lifestyle manager, physiologist, nutritionist, doctor and sport
299 psychologist). It is, however, predominantly through their regular contact with the athletes
300 they coach and through their own observation that participants became aware of a mental
301 health concern. As highlighted by Coach 6 in the following example:

302 I think it would be through observation, through communication with the player. I'd
303 suggest that in most cases it is observation, it is probably a tacit thing of having seen a
304 very large number of boys, young men at that age. And also knowing that individual
305 and knowing what their average behaviour is. And seeing how their body language
306 and seeing how their training behaviour, how their behaviour generally changes.

307 Behavioural, physical (e.g., eating disorders, body dissatisfaction), social and performance
308 changes over time were some of the main indicators identified by the coaches, as warning
309 signs. Given their regular interactions with their young athletes, the accumulation of changes
310 from their performers' habitual pattern of behaviours particularly raised concerns - a point
311 reflected in the data as follows:

312 It was about 4 years ago and the boy's behaviour, an outgoing boy really good fun,
313 great to work with, got on with the job, very competitive in a football sense, and just a
314 smashing lad to work with. All of a sudden, he became withdrawn. Didn't come up to

315 you, when he turned up to training very quiet, totally different character. And I
316 spotted this, and I thought you know 'He's not right, this is not right' ... we decided
317 we'd monitor it and if we still thought that he wasn't improving we'd ask a question.
318 So, nothing changed and the following week we said 'Are you OK, is there something
319 wrong?' And he just broke down, he just burst into tears. So then obviously we
320 realised something was wrong. (Coach 2)

321 In a similar manner, Coach 4 described how:

322 There was a change in his mood, a change in his attitude, a change in his application.
323 Just a change in attitude. Change in level of performance, behaviour slightly
324 changing. All those sorts of things were signs and indicators just saying to you
325 something is not quite right. (Coach 4)

326 Once a concern had been raised, coaches working within an interdisciplinary team
327 shared their concerns and information they might have about it with other relevant members
328 of staff (e.g., lifestyle manager, physiologist, nutritionist, and psychologist) as two main goals
329 - first, to draw a whole picture of the situation and, then, to come up with a plan on how to
330 handle that situation; as typified by Coach 6:

331 Very often we would work in an interdisciplinary manner ... So, we would have a
332 weekly meeting to discuss how different players were going on, we would have a critical
333 incident or a critical player bit at the start where we would discuss 'Right what's come
334 up this week' and then we would also discuss other players who were on a regular cycle
335 ... I think that very often it would be the sharing of concern within the staff group. That
336 is then monitored. In whatever way that was. And then the decision was taken to, to
337 seek further help, or not. Um, and in this particular case [concerns of OCD] it was
338 monitored over a period of weeks.

339 It has, however, to be noted that all the coaches interviewed did not have the same support
340 network at their disposal. Coach 8, for example, recognised that he “*was privileged that I had*
341 *a sport psychologist and I had a doctor. 99% of coaches, 99.999% of coaches don't have that,*
342 *they're on their own*”. Supporting this, Coach 11 explained that, in her case, sport
343 psychologists involved within her federation only worked on short-term contracts (in their
344 performance enhancing capacity). Only a few athletes (elite performers) had access to them.
345 Working predominantly with young aspiring elite athlete (from age 8 to 21), Coach 11,
346 therefore, did not have access to sport psychologists:

347 ... at that time, the best they had was a lifestyle manager. They had a couple of
348 different um sport psych's who seemed to do a little bit of work at the higher end with
349 the elite lot but they, in fact [Sport Psych's Name] has done some and [2nd Sport
350 Psych's Name]. So, people you know but they've done some but each of them seems
351 to have had a fairly, short-term role.

352 Coach 7 further stressed the variations in support staff available by describing how:

353 When you get to a high enough level where there's the resources to do that, somebody
354 is there to monitor the individual quite intensely as to what they're doing what they're
355 not doing. Whereas at the levels below there isn't the resources to co-ordinate all that
356 so 'yeah' I think that's a grey dangerous zone sometimes ... if the player wasn't a
357 promising player, would the same support have been accessible? And we go back to
358 that kind of sub-elite. So, when you're in an environment and the resources are there
359 to pass them onto, it can be dealt with. But where you're in an environment where the
360 resources aren't there – because either the sport isn't evolved enough to become a
361 power sport or you're at a level that isn't quite. Then, would that support would have
362 happened? So, within some squads you can have players on different levels of
363 funding. So, if you're player A, and you have access to all the funding and have an

364 issue, there'd be a mechanism there to support you. If you were player C with not the
365 same amount of funding, because you're not perceived to be as high a potential.

366 ***Supporting their Athletes.*** Caring and being supportive of their athletes is one of the
367 biggest components of a coach's role and this was exemplified by many of the coaches when
368 they described how "*We [coaches] are duty bound to ensure that we look after them*" (Coach
369 4). In this way, the coaches interviewed explained how they tried to emotionally support their
370 athletes with MHIs by being understanding and tolerant, and showing they cared which
371 mainly consisted in talking and listening to their players. As Coach 4 explained:

372 Without prying too much, you speak to them ... A talk is cheap. I think you have to
373 ensure you know when you have got something you keep an eye out for that. A real
374 conscious effort to ensure, don't dismiss it ... Don't just talk for the sake of talking.
375 Something positive has to come out of it at the end of the day. But just that constant
376 encouragement I think does help.

377 In addition to emotional support, coaches also provided informational support by, for
378 example, coming up with a strategy with the staff members or/and with the child "*so that he*
379 *feels engaged, empowered, and part of the process, rather than removed from the process*"
380 Coach 10). Besides, once aware of the existence of a potential MHI(s), monitoring those
381 concerns more closely was a significant part of coaches' strategy as explained hereafter by
382 Coach 7:

383 I think that made me more sensitive to my players at the time who were of a concern to
384 me, because the behaviours that I was hearing of in other environments I was more
385 sensitive to monitoring in mine. And I tended to put some mechanisms in place where
386 even though it wouldn't have looked like it, I was probably monitoring those issues ...
387 So, without being intrusive I could keep an eye on some stuff. ... It was integrated in
388 anyhow, it's part of our daily practice so the players never saw that as a change. So, I

389 think the difference was that I introduced the mechanism for one reason, and that had
390 been going on for a while. But then actually saw the same mechanism as another method
391 to actually monitor some of the concerns.

392 Being flexible and able to adapt their coaching behaviours and expectations to particular
393 situations was another aspect of the coaching and informational support provided to their
394 athletes. Interestingly, the coaches were aware of both the positive and negative impact they
395 could have on their athletes' wellbeing and, as such, emphasized the need to be careful in
396 regard to their coaching behaviours and practices. As Coach 3 reported:

397 I have to acknowledge that sometimes, I may have unwittingly caused or exacerbated
398 the problem. For example, "if you don't start paying attention to us coaches, you
399 won't last long at this club" interpreted as "I'm going to be chopped" with all the
400 consequent anxiety.

401 Furthermore, when deemed appropriate, the coaches described how they would try to educate
402 and increase their athletes' awareness about some common issues "*through the nutritionist,*
403 *through the psych. You know around healthy eating or body images or whatever it might be*"
404 (Coach 10).

405 Depending on the type of MHI(s), on its severity and on the context (e.g., what does
406 the athlete want), coaches also provided tangible support. That form of support involved, as
407 one example, removing the athlete experiencing MHIs from the sport environment [e.g., "*He*
408 *wanted to leave the environment and he had a free invite to come back in whenever he wanted*
409 *to*" (Coach 6)]. However, they all seemed to agree on the importance of involving qualified
410 mental health professionals (e.g., doctor, psychologist). The reason to include a mental health
411 professional was mainly twofold – firstly, as coaches, to get some help and advice on how to
412 manage such a situation, but also to refer their athletes to a trained professional as clarified by
413 the following example:

414 I have worked with one player who we thought might be suffering from depression,
415 and to be honest as soon as we got to that point where we became concerned, we got
416 our Doctor involved, who I think to be honest then involved [Academy Psychologist's
417 Name]. So, from a coach's point of view it was a bit, you know, that needs someone
418 who is qualified for this. (Coach 1)

419 ***Coaches' Perceived Role Limits.*** While supporting their athletes was perceived as
420 definitely part of a coach's role, all agreed that dealing with MHIs (e.g., having more than a
421 supportive role) was not. All our sample recognised not being qualified nor trained to do so.
422 They, therefore, preferred to pass it on to qualified professionals as illustrated below:

423 I think something like that is so sensitive that unless you are qualified to deal with it,
424 you can do more damage. I think it's sometimes recognising that you can't be the
425 person who can fix it, and I wasn't that person. Because I think 'um', there is a level
426 where expertise is needed, and you have to realise where your level of expertise is and
427 isn't. And where it's not, then you have to, you have to not dabble, not having that
428 knowledge is a dangerous thing, and I think 'um', for me this was a clear case that
429 there were some expertise that was needed there that went outside my skill set (Coach
430 7)

431 In addition, it was the participants' opinion that, in high-performance environments, coaches
432 might not be the person an athlete would go to talk. Athletes' reluctance to talk about MHIs
433 was kind of obvious for the present coaches and could, according to them, be explained by the
434 fear of the consequences of disclosing MHIs, MHIs being often considered as a sign of
435 weakness. In addition to the athletes' reluctance to talk about MHIs, participants mentioned
436 the conflict of interest some of them could be subject to, from a coach's' perspective, when it
437 came to MHIs and selection. Coach 7 described how:

438 At the end of the day a Coach will always select or drop a player and therefore a
439 conversation with a Coach is not always the best because they determine the outcome
440 of selection. So even though sometimes you may want to help, you're never going to
441 be perceived as that because ultimately you're going to be perceived as the person that
442 makes the decision whether the player goes or not and that will always be the first
443 thing in the player's mind ... Whereas other people then can actually take on more of a
444 kind of supporting role because, not that they're more trusted because I wouldn't say I
445 wasn't trusted, but coaches are powerful in that they do ultimately make the decision.
446 There was a divergence of opinion, however, with Coach 1 suggesting that "*... as a player*
447 *you can feel you might be giving someone an excuse to drop you. I would never do that for*
448 *that reason ... I think that is crap.*" In contrast, however, other coaches disclosed the
449 uncomfortable situation they were in when making decisions about their team selection in
450 regard to their funding was dependent on their athletes' and/or teams' performances. Coach
451 8, for example, explained that:

452 It was pretty clear to me that if those athletes didn't perform then they would be out
453 of the national centre and that I'd be joining them; I wouldn't be there either ... I think
454 the positions that I have held have made it more difficult, you know I was the Head
455 Coach of a national programme deciding whether people were in or out of national
456 training centres but also whether they were gonna be funded or not funded. So,
457 wearing 2 caps as a coach definitely challenged; a position for me as head coach of a
458 national programme and also coaching TD was extremely difficult ... I think there was
459 a level of an underlying tone in my later position of dishonesty through fear of what
460 the repercussions of telling me what some issues might be.

461 **Coaches' Perceived Knowledge about Mental Health Issues**

462 **Perceived Level of Knowledge and Understanding.** Level of knowledge about
463 MHIs varied across participants. One participant self-reported his knowledge and
464 understanding about MHIs as moderate whereas, ten participants out of eleven rated their
465 knowledge as poor or limited [e.g., “*quite poor knowledge I would say very poor knowledge*”
466 (Coach 5); “*I’d probably say that it’s still very limited, very basic*” (Coach 7)]. This
467 discrepancy between implicit and perceived knowledge and understanding about MHIs as
468 demonstrated through their interviews might arise from the way those coaches acquired their
469 knowledge.

470 **Knowledge Acquisition.** While a few gained some formal knowledge via lectures,
471 readings, or workshops, most coaches in the present study acquired their knowledge over the
472 years through their coaching experience, via the media or through personal experiences (e.g.,
473 family members, friends, own personal experience, etc.). Coach 11, for example, reported
474 that:

475 I get mildly depressive. I have depressive issues. My Grandmother was on
476 medication for years, but my father was a diagnosed manic depressive ... I have
477 various experiences of mental health issues personally through family, and within
478 sport I have come to realise there is a lot more happening for a lot more people than
479 you might think on the surface. And so, there is a lot of learned experience and then
480 through and somewhat with child development in my teaching degree, I have had
481 some formal education with psychology. But very limited.

482 **Areas for Improvements**

483 **Coaches’ Identified Needs.** Reflecting on their own experiences, coaches identified
484 the need to increase coaches’ and athletes’ knowledge about mental health and MHIs in order
485 “*to have a better awareness of it, a better understanding of it and possibly be more ready for*
486 *potential red flags*” (Coach 1). They also highlighted the importance of having a professional

487 network and support around them (e.g., doctor, clinical or sport psychologist) to support the
488 athletes as much as possible but also to support the coaches and other staff members.

489 ***Increasing Coaches' Knowledge about MHIs.*** Most participants highlighted the need
490 for coaches to increase their knowledge about MHIs but also for more guidance on what they
491 should/can or should not/cannot do. As exemplified by Coach 5 in the following quote, they
492 also described how they wanted to learn how to talk to athletes about MHIs and interact with
493 those athletes in order to better support them.

494 ... what do you say? And almost how do you open up in terms of trying to get him to
495 open up ... what skills I would need? I think it's probably more of an awareness and
496 how to maybe speaking to, if they are undergoing treatment how to dialogue with that
497 person, which techniques to use when you're having those interactions, which
498 techniques are they to use when I'm coaching, teaching. So, the biggest one would be
499 the awareness and then you've got that backup, the backup would be that technique.

500 Discriminating between "normal" behaviours or reactions and signs of MHIs was one
501 of the biggest difficulties encountered by those coaches. While being able to spot red flags
502 was considered as important, the participants acknowledged that they did not possess the
503 necessary knowledge or confidence in regard to recognising MHIs. Indeed, even following an
504 initial assessment of MHIs, the coaches acknowledged that they were unsure about the next
505 course of action. Spotting red flags was particularly viewed as challenging for those coaches
506 working with young athletes and adolescents- as exemplified by Coach 2 working with young
507 athletes under 14 years old in the following quote.

508 Puberty's kicking in. There is all sorts of things going on 12s, 13s, so we look at
509 them and think 'Ah yeah you know it's that, that's what's happening. And we allow
510 for that. But sometimes, it could be something more serious ... For example, with the
511 age of the players we deal with, and with so much going on in their lives, can we

512 really identify what is a MHI as opposed to just growth or life issues. In fact, do
513 people experiencing MHIs necessarily know they have them? Or, does better
514 education on MHIs make people more likely to report them? Or be able to put a label
515 on something which, in previous years was just feeling down at the moment.”

516 In a similar manner, Coach 7, who has worked with a range of different age groups during her
517 career, went further in regard to the education coaches would need and explained how for her:

518 It is important to differentiate the ages of performers and how the approach to MH
519 needs to be tailored to match the age ranges is essential. This in turn will influence the
520 content which needs to be embedded within our coach education structure to support
521 coaches ... I think the content needs to consider early warning signs and where the
522 professional boundaries of the coach lie. Additionally, the information in such
523 educational packages need to consider access to specialist, when and how this is done
524 and perhaps consider the challenges this might present at different levels of the
525 performance pathway. I think such educational packages need to be separated into one
526 for coaches and a separate one for athletes and parents/significant others.

527 ***Increasing Athletes' Awareness about Mental Health.*** Increasing knowledge about
528 mental health was not only deemed important for the coaching environment, but was felt to be
529 an issue for the athletes themselves. As illustrated by Coach 9:

530 I think education would be a useful thing for the athletes to sort of know that right
531 potentially these are the stresses in life. So, certainly that kind of knowledge, so that
532 athletes know. In the same way that they are given education in terms of anti-doping
533 and stuff like that. You know what to take, what not to take, where are the sources to
534 go to get whatever you need.

535 In regard to athletes, the present participants particularly highlighted the need to not only
536 increase ~~the~~ athletes' knowledge about MHIs (e.g., via the use of role models) but also

537 giving them the means to cope. Coach 9, for example, clarified his earlier thoughts by
538 explaining that:

539 Just as I try to get them strong in a gym, I think we should also train the mind to be to
540 work effectively for the athlete if you understand me ‘yeah’? And if that takes training
541 then train it ... I personally just do believe that in helping sports people to, provide
542 them with coping skills I think that will help them to be better sportspeople but equally
543 better people, human beings as well.

544 **Risks of such Interventions.** Although aware of the need to increase their
545 understanding and knowledge, Coach 10 wondered if “*Is that putting health that isn’t needed,*
546 *is that softening them because they don’t? Do you get what I mean? Do they actually need it?*
547 *Or is it just something that we react to once it shows its head?*”. Reflecting Coach 10’s
548 comments, seven other participants raised concerns about the risks associated with
549 interventions targeting MHIs and mental health. One of the risks would be, for TD coaches,
550 to become overcautious and see MHIs everywhere. As mentioned by Coach 3:

551 There are normal ups and downs in life. I don’t want to become paranoid with all the
552 mental health issues and you going back on the field and saying ‘Oh yeah’ this one
553 may have depression, this one may have eating disorders’ no, that’s not the point.

554 While other coaches, typified by Coach 8, were afraid of the risks inherent in coaches’
555 overconfidence in their own knowledge and abilities to deal with MHIs:

556 I think a lot of damage can be done, you know, it’s really at the forefront obviously
557 mental health and if coaches are out there with a little bit of knowledge trying to help
558 athletes with mental health issues that it could just be misdiagnose, you know,
559 identifying things that aren’t there.

560 **Requirements for Sport Environments.** Additionally, participants suggested the
561 creation and implementation of a support network with health professionals, in particular, for

562 those who do not already work within an interdisciplinary team as well as an increase in the
563 support (e.g., psychological support) available for both coaches and athletes.

564 ***Creation of a support network with health professionals.*** In addition to mental health
565 interventions and due to the concerns raised in this regard, coaches emphasized the need to
566 have an extended support network of health professionals (e.g., sport psychologist, clinical
567 psychologist, nutritionist, doctor, etc.) available in the environment. This is even more
568 important as such extended support networks seem to be rare in TD environments, as
569 summarised by Coach 10:

570 It is down to the Club as a whole to decide what value it places on athlete's wellbeing
571 and how it wants to support. Does it want to promote the support network, and utilize
572 experienced staff to support players at varying times in their contracts and careers?
573 ...There's no clinical psych linked to this club. There's a sports psych but he's got no
574 clinical support mechanisms, where do we go? ... I'm not saying that every club should
575 have a clinical psychologist aligned to them but what I am saying is that we should have
576 an outlet for people that have clinical issues because none of us here are skilled enough
577 to deal with it.

578 ***More support for coaches.*** Finally, in addition to more professional support for their
579 athletes, some coaches highlighted the need for more support regarding their own mental
580 health. Indeed, within the present sample, and as aforementioned, seven coaches out of
581 eleven were exposed to one or more members of their family suffering from MHIs, while it
582 was also noticed that five coaches experienced some MHIs themselves. Coach 8, for
583 example, witnessed that "*depression within coaching is, is just as much if not more than it is*
584 *within the athlete population*".

585 **Discussion**

586 The primary aim of the present study was to explore TD coaches' experience of
587 working with young elite athletes experiencing MHIs. A second objective was to determine
588 coaches' and sport environments' needs in order to best support TD coaches and their young
589 performers. The participants identified their role as varied but centred on monitoring and
590 supporting their athletes' performance and health in various ways. Further to coaches' lack of
591 knowledge regarding MHIs, they also noted the reluctance of athletes to talk about such issues
592 with their coaches and the potential conflict of interest that might arise from such a situation.
593 Finally, the coaches suggested that further support should be offered to coaches in regard to
594 mental health as well as the development of a referral network within the sport that they could
595 tap into in order to better support athletes with MHIs.

596 Being mindful of, monitoring, and supporting athletes' performance and overall
597 wellbeing were seen as central to the role of a TD coach. Although differentiating between
598 signs of MHIs and normal range of reactions or feelings to adverse events can be difficult
599 (Cornford, Hill, & Reilly, 2007; Gulliver et al., 2012), coaches seem well positioned to notice
600 red flags such as any accumulation of, and persistent changes in, their athletes' behaviours
601 and/or performance over time (Hill et al., 2016; Lebrun, MacNamara, Rodgers, & Collins,
602 2018) due their regular interactions with their athletes. Once mental health concerns have
603 been raised, coaches are well placed to provide support (e.g., emotional, informational, and/or
604 tangible support) and promote help-seeking behaviours in order to prevent the development or
605 the exacerbation of a MHI (Ferguson et al., 2018; Mazzer & Rickwood, 2015a). However, as
606 found elsewhere in the literature (Ferguson et al., 2018; Mazzer & Rickwood, 2015a), TD
607 coaches in this study did not believe that dealing with MHIs was part of their role.
608 Furthermore, and unlike previous studies where coaches reported a confidant role due to their
609 established, trusted relationship and familiarity with their athletes (Ferguson et al., 2018;
610 Gulliver et al., 2012; Jowett & Cockerill, 2003; Mazzer & Rickwood, 2009, 2015a), our

611 participants reported a reluctance on the part of their athletes to talk about MHIs with them as
612 well as a reluctance on the part of coaches to intervene due to a lack of understanding of the
613 phenomenon, a fear of the consequences of initiating such discussion as well as potential
614 conflict of interest arising from their performance role as a coach. Despite a divergence of
615 opinion in this regard, some coaches acknowledged some difficulties juggling with being
616 both a coach and a selector or head coach. The potential conflict of interest highlighted in
617 these situations was more likely determined by the way funding was allocated to those
618 coaches and/or sports (e.g., depending on athletes' and/or team's performances). More
619 research is warranted in regard to the conflict of interest TD and elite coaches may face when
620 working high-performing athletes suffering from MHIs.

621 While it might be expected that TD coaches would hold more information about mental
622 health than community levels coaches (Ferguson et al., 2018), participants in the present study
623 identified their knowledge and understanding about MHIs as limited and insufficient. The
624 detection of early signs of MHIs can be challenging. Accordingly, coaches recognized the need
625 to increase their knowledge and understanding about mental health and MHIs to be effective in
626 their role (Ferguson et al., 2018; Mazzer & Rickwood, 2015a). Targeting coaches' knowledge
627 and understanding about mental health and MHIs may help them better assist their athletes by
628 acquiring the "ability to gain access to, understand, and use information in ways which promote
629 and maintain good mental health" (Lauber et al., 2003, p. 248). It could also, in return,
630 encourage their athletes to talk to them given that young elite athletes' perception of their
631 coaches' literacy influences their willingness to talk to or seek support from them about MHIs
632 (Swann et al., 2018). Similarly, interventions promoting mental health (e.g., knowledge,
633 attitudes, support available and skills) could also be offered, in parallel, to those young athletes
634 and their family as a way to provide them with a holistic support package (Hill et al., 2016) and
635 help to prevent young and promising athletes with MHIs to derail from their TD pathway.

636 Nonetheless, while acknowledging the merits of, and needs for, increasing coaches'
637 knowledge and understanding about mental health and MHIs, participants also highlighted the
638 potential risks of such an approach. They not only emphasized the importance of adapting
639 mental health interventions to meet their needs and their athletes' particular needs by stressing
640 the importance of quality and specificity (e.g., sport, age) in the delivery of any intervention.
641 Therefore, in line with Liddle et al.'s (2017) recommendation, coaches stressed the importance
642 to carefully identify the content, format, audience and outcomes targeted by mental health
643 interventions. Context-specific mental health training (e.g., sport- and age-related), specially
644 designed for TD and elite sport environments, might, for example, be of interest, especially as
645 symptoms (Doherty et al., 2016) and prevalence of certain type of MHIs can differ from one
646 sport to another (Rice et al., 2016; Schaal et al., 2011). Interventions targeting coaches' mental
647 health knowledge and awareness should aim to empower them with adequate knowledge *and*
648 skills to fulfil their supportive role (e.g., emotional and information support, referrals options
649 and confidence in their competences; Mazzer & Rickwood, 2015a; Swann et al., 2018) while,
650 at the same time, addressing the operationalisation of the support provided (e.g., "what do you
651 say?", challenge versus support) and their concerns in such situation (Mazzer & Rickwood,
652 2015b).

653 In addition to increasing coaches', athletes', and staff members' knowledge and
654 understanding about mental health, participants also highlighted the advantages of working as
655 part of an interdisciplinary team. In this regard, some of the participants described how the
656 interdisciplinary makeup of the staff within their clubs or academies, and their access to
657 medical and/or psychological expertise (e.g., club doctor, sport psychologist), was seen as an
658 advantage in the detection of MHIs as well as in the support provided to them and their
659 athletes. Working as an interdisciplinary team (including health professionals such as sport
660 psychologist, clinical psychologist, nutritionists, physiotherapists) by recognizing the unique

661 skills set of each member and the benefits of working in an integrative approach (Kamm,
662 2008; Reardon et al., 2019) is especially valuable as it can aid the early detection of
663 psychological distress and provide better (proactive and retroactive) support to those
664 concerned (Gouttebarga, Backx, Aoki, & Kerkhoffs, 2015; Gouttebarga et al., 2018b). Yet,
665 not all environments have the opportunity to hire multiple specialists interacting with each
666 other. There is, therefore, a need to develop and implement a referral network that coaches
667 can access for support (e.g., advice) and referral. The ethical implications of such actions will,
668 however, need to be considered in much greater depth (e.g., confidentiality, expectations;
669 Anderson & Pierce, 2012; Roberts et al., 2016). Finally, athletes are not the only one that
670 require assistance. As stressed by the participants, coaches need help and support to care for
671 their athletes but also vis-à-vis their own mental health. Unfortunately, while the literature on
672 athletes' mental health is growing (cf. Doherty et al., 2016; Gouttebarga et al., 2015;
673 Gouttebarga et al., 2018a; Kamm, 2008; Rice et al., 2016), studies looking into coaches'
674 mental health are still lacking. Further research is, therefore, warranted on TD and elite
675 coaches' mental health.

676 This study has important implications for the role of TD coaches in supporting young elite
677 athletes experiencing MHIs, and for how TD sport environments could better assist and
678 support their coaches working with athletes with MHIs. However, the present study was not
679 without limitations and findings must, therefore, be interpreted with caution. Firstly, given the
680 methodology employed, some memory recall issues might have impacted the results as it is
681 often the case in retrospective studies. Another issue raising from any qualitative approach is
682 the social desirability that might impact the results given the sensitivity of the present topic.
683 Participants might have overvalued or undervalued their role or the support they perceived
684 having offered to their athletes experiencing MHIs. The findings must, therefore, not be
685 viewed as an exact 'at the time' recollections of events and actions. Furthermore, participants

686 varied in terms of diversity and types of sports (individual or team sports), career length,
687 gender, and coaching age-group, factors that could have influenced their experiences of
688 athletes with MHIs (e.g., in terms of type and number of MHIs cases experienced during their
689 career). The chosen population, the diversity of sports included and the sample size do not
690 enable a naïve generalisation of the current results (Jones et al., 2013). Future research might,
691 therefore, be interested in studying the differences between the support offered by coaches
692 and sport organisations to athletes suffering from MHIs across sports, levels, ages or/and
693 gender. Finally, it is also probably worth commenting on the language used by us and the
694 participants throughout the present manuscript. Although aware that some may see some
695 stigma attached to certain terms such as “suffering from” or “issues”, this was not our
696 intention. This manuscript does not intend to stigmatize those who live with poor mental
697 health, to the contrary.

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852 *Table 1. TD Coaches' perception of their role, knowledge and needs regarding MHIs.*

Higher order theme	Third order theme	Second order theme	First order theme
TD Coaches' perceived role.	Monitoring and supporting athletes' performance and overall wellbeing.	Gathering and sharing information.	Through interdisciplinary staff meetings. Through coach's observation. Through the parents. Through other athletes. Through the athletes themselves.
		Supporting their athletes.	Emotional support. Informational support. Tangible support.
		Coaches' perceived role limits.	Aware of their limits as coaches. Athletes' reluctance to talk about MHIs with coaches. Conflict of interest.
TD Coaches' perceived knowledge about mental health issues.	Perceived level of knowledge and understanding regarding MHIs.	Poor and/or limited.	-
		Moderate.	-
	Knowledge acquisition.	From formal knowledge.	-
		From personal experiences.	-
		From coaching experiences.	-

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Higher order theme	Third order theme	Second order theme	First order theme
Areas for improvements.	Coaches' identified needs.	Increasing coaches' knowledge about MHIs.	Increased awareness. Increased set of skills Context-specific approach.
		Increasing athletes' awareness about MHIs.	Increased awareness. Increased set of skills Use of role models
		Risks of mental health interventions.	Over-cautious. Over-confident.
Requirements for sport environments	More support for coaches.	Increasing the awareness on coaches' MHIs.	
	Creation of a support network with health professionals.	Sport Psychologist. Clinical Psychologist.	